



Nebraska Olmstead Plan Evaluation (RFP 125999 03)

Corporate Overview & Technical Response

Submitted by:



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

July 27, 2026

Table of Contents

Corporate Overview	3
Bidder Identification & Information.....	3
Financial Statements.....	3
Change of Ownership.....	3
Office Location.....	3
Relationships with the State	3
TAC's Employee Relations to State	4
Contract Performance	4
Summary of TAC's Corporate Experience	4
Summary of TAC's Proposed Personnel/Management Approach	6
Project Management Approach	6
Proposed Personnel & Roles.....	7
Subcontractors	11
Technical Response	14
Understanding of the Project Requirements.....	14
Project Description & Scope of Work	14
Proposed Development Approach	16
Technical Requirements	18
Detailed Project Workplan	19
Deliverables & Due Dates.....	22
Appendix A - Financial Statements & Required Forms	25
Most recent audited financial statement	25
Banking reference	25
Certificate of Good Standing.....	25
Signed Original Contractual Agreement Form	25
II. Terms and Conditions.....	25
III. Vendor Duties with noted exceptions.....	25
IV. Payment.....	25
Appendix B - TAC Staff & Subcontractor Resumes	26
Appendix C - Work Examples	27

Corporate Overview

Bidder Identification & Information

The Technical Assistance Collaborative, Inc. (TAC) is pleased to submit this proposal to the Nebraska Department of Health and Human Services (DHHS) to provide a Nebraska Olmstead Plan Evaluation. TAC is a 501(c)(3) nonprofit organization who maintains its company headquarters at 15 Court Square, 11th Floor, Boston, Massachusetts 02108. TAC was incorporated to do business in the Commonwealth of Massachusetts in 1992, and works nationally to provide policy leadership, technical assistance, and expert consultation to federal, state, and local government agencies, policymakers, advocates, and service providers in the homelessness, affordable housing, health care, and human services sectors. Neither TAC's company name nor form of organization has changed since it was first organized.

Financial Statements

TAC's audited financial statements for the year end 06/30/2025 are included in **Appendix A**, along with the required bank reference. No such condition exists relating to judgments, pending or expected litigation, or other real or potential financial reversals that may materially affect the viability or stability of the organization.

Change of Ownership

No change of ownership or control of the company is anticipated during the twelve months following the due date of this solicitation response.

Office Location

TAC's primary office is located at 15 Court Square, 11th Floor, Boston, Massachusetts 02108, and organized in a manner to support consulting staff who live and work remotely in states across the country. TAC consultants are equipped to provide onsite work anywhere in the country and have the technology to perform fully remote work.

Relationships with the State

Over the past ten years, TAC has had two contracts with DHHS, Division of Developmental Disabilities for the Nebraska Olmstead Plan. The first contract was in effect from July 2018 through March of 2019; however, the contract documents TAC retains do not indicate a contract number. TAC subsequently entered into a second contract (contract number 86151 O4) in May of 2019 to continue support with Nebraska's Olmstead Plan, including assisting DHHS in the development of a process and infrastructure to implement the Plan. This contract concluded in April of 2022.

TAC's Employee Relations to State

No party named in TAC's response to this solicitation is or was an employee of the State of Nebraska (State) within the past twenty-four months. Furthermore, no employee of any agency of the State is employed by TAC or is a subcontractor to TAC as of the due date for submission of this response.

Contract Performance

Neither TAC nor any proposed subcontractor has had a contract terminated for default, convenience, non-performance, non-allocation of funds, or any other reason during the past ten years.

Summary of TAC's Corporate Experience

As a leader in the development, implementation, and monitoring of Olmstead plans across the country, TAC is eager to support Nebraska DHHS with the evaluation of its Olmstead Plan and to provide technical assistance (TA) to DHHS and the Olmstead advisory committee in recommending updates and revisions to the plan. TAC has over 30 years of experience providing TA and expert consultation to states on community integration; Olmstead; Medicaid and community-based services; affordable and accessible supportive housing; and other best practices for individuals with disabilities and those who are homeless or at risk, living in institutions, or at risk of institutionalization. TAC is widely recognized by state and federal agencies, national associations, and advocates as a leader in planning, TA, and consultation on Olmstead and on Title II of the Americans with Disabilities Act (ADA).

At the state level, government agencies (e.g., disability, Medicaid, housing) regularly engage TAC on disability and Olmstead policy, particularly related to Olmstead planning and the implementation and monitoring of settlement agreements. TAC has recently consulted on Olmstead planning or implementation in Massachusetts, Minnesota, North Carolina, and Pennsylvania, and has consulted on Olmstead in Nebraska, North Dakota, and Oregon in the past five years. Several consultants assigned to this project recently worked with Minnesota on its Olmstead Plan revision process, as well as with both North Carolina and Massachusetts on their Olmstead planning and implementation.

All of TAC's Olmstead-related engagements have brought together state agencies and other stakeholders to facilitate planning, financing, design, implementation, and evaluation of progress and/or impact. The TAC team is experienced at evaluating Olmstead-related activities through quantitative and qualitative data collection and analyses and facilitating multi-agency and stakeholder processes, workgroups, and advisory structures to facilitate decision-making and generate recommendations and actions, including plan revisions.

Included in **Figure 1** is a summary of TAC's experience with three previous projects similar in size, scope, and complexity to the Scope of Work outlined in this solicitation. These projects showcase our work in states on Olmstead planning, implementation, and evaluation and reflect our strong ability, capacity, and skills to perform this work with Nebraska. Included

for each project is a client reference and contact information (fax numbers were not available.)

Figure 1: TAC's Experience with Similar Projects

Client & Contact	Project Description & Time Period	Planned/Actual Completion & Budget
Aisha Elmquist Minnesota Olmstead Implementation Office (formerly) aisha.elmquist@gmail.com (612) 405-4153	Since May 2025, TAC has been the prime contractor with the Minnesota Department of Human Services, providing consultation on updates to the State's Olmstead Plan. The contract consists of two primary tasks. The first was development of a best practices report on strategies and practices with demonstrated effectiveness in achieving equitable, positive outcomes that promote community integration in 8 topic areas: education; employment; health & health care; home and community-based services; housing; positive supports; the prevention of abuse and neglect; and transportation. The second task involves the provision of subject matter expertise to teams of state agencies and Inclusion Consultants (individuals living with disabilities) as they co-created new Olmstead Plan goals.	The original contract was for \$395,500 through July 2026. The contract was extended through September 2026 with an additional \$60,000 added for an expanded scope of work that included in-person and virtual meeting facilitation & drafting & revision of DHS Olmstead plan goals.
Deb Goda North Carolina Department of Health and Human Services deborah.goda@dhhs.nc.gov (919) 855-4800	In October 2023, TAC was selected as the prime contractor to assist the North Carolina Department of Health and Human Services (DHHS) with a 2024 Olmstead plan update, building on TAC's earlier work assisting DHHS with developing and implementing its plan in 2020. TAC is currently supporting a more recent plan revision to be completed in August 2026. The broad plan includes actions related to community integration across disabilities and supports, such as housing, employment, education, and transportation. TAC identified and shared best practices with the state and stakeholder planning groups and organized and facilitated numerous stakeholder groups, including the disability community, to inform the Plan. TAC is currently helping the state to routinely monitor progress on the state's Olmstead goals and activities, and prepares and presents quarterly progress reports to the Olmstead Plan Stakeholder Advisory group. TAC also provides training to providers and managed care plan staff on Olmstead-related activities including best practice service delivery and monitoring under a separate contract. As part of this Olmstead engagement, HSRI worked as a subcontractor to TAC to evaluate the extent to which the State was adhering to its Olmstead Settlement Agreement to provide services in the least restrictive setting appropriate to individuals' needs.	The original year-long contract began in October 2023 in the amount of \$122,405; it has twice since been annually renewed for \$122,405 (for a total of \$367,215.) The current projected end date is October 2026.

Client & Contact	Project Description & Time Period	Planned/Actual Completion & Budget
	HSRI analyzed claims/encounter data from Medicaid and state-funded services for individuals transitioning from adult care homes to independent living as part of the state's Transitions to Community Living Initiative which resulted from the state's Settlement Agreement, and later for the broader population of people with disabilities in the state.	
Linn Torto Massachusetts Executive Office of Health and Human Services (617) 974-4366 linntorto@gmail.com	From October 2023 - December 2024, TAC was the prime contractor who completed support for Massachusetts' Olmstead Plan update. The update built on TAC's more extensive earlier work (2016 to 2018) updating the state's 2008 Olmstead Plan. TAC worked with multiple state agencies to create a snapshot of the system as a baseline, identify system strengths and gaps, and prioritize areas to build or improve upon. At TAC's suggestion, the state formed a Leadership Team of key state agencies representing housing, services, and Medicaid, as well as a broader cross-agency Planning Committee and an external Stakeholder Advisory Committee. TAC assisted the State in the development of an RFI to seek community feedback and to analyze the results. TAC also conducted two sets of public listening sessions, and key informant interviews with individuals receiving disability services. Based on the input received, TAC drafted an updated Olmstead Plan addressing the core components for the system to support community integration of people with disabilities. The draft underwent public review and TAC worked with the Leadership Team to incorporate feedback into the final updated Olmstead plan.	The original end contract end date was June 2024; however, the state extended TAC's contract by 6 months to allow for the addition of consumer stories, for which TAC conducted interviews & drafted case studies. This work concluded in December 2024. The planned and total budget for the work was \$157,000.

Summary of TAC's Proposed Personnel/Management Approach

Project Management Approach

TAC's approach to the management of this project involves assigning an experienced Project Director who is supported by TAC's organizational leadership and a strong, multidisciplinary team with the combined experience, knowledge, and skills to successfully perform all contract activities and deliverables.

Rebecca Boss will serve as the Project Director for this work. In this role, she will be the primary point of contact for DHHS and will be responsible for overall workplan execution, communication with DHHS, assignment of subject matter experts to perform contract-related tasks and activities, and for the development of all contract deliverables, in addition to serving as a subject matter expert (SME) on Olmstead and community integration for people with disabilities on the project.

For the purposes of this project, Ms. Boss will report to and take advisement from TAC's Senior Director for Behavioral Health and Medicaid, Shawn Thiele Sacks. Ms. Thiele Sacks is a nationally recognized leader in community-integrated services and supports and in Medicaid and is a senior leader within the organization. In addition to playing an advisory/SME support role to Ms. Boss and the project team, Ms. Thiele Sacks will be accountable for final review of all contract deliverables, ensuring quality oversight, as well as on time and within budget completion.

TAC Senior Consultants Lisa Sloane and Laura Conrad will serve as project SMEs; Ms. Sloane brings her expertise in Olmstead plan development and key focus areas including the development and implementation of affordable, accessible housing across disability groups and transportation access issues, while Ms. Conrad brings extensive experience in Medicaid, behavioral health, child and family services, and education, and related policy and practice.

Other Key TAC staff include Senior Associate Megan Lee, who will lend her recent experience with Olmstead planning frameworks, facilitating stakeholder engagement and advisory groups, measuring and reporting on implementation progress, and community-integrated services and supports; and Amy Horton, who will provide project management and overall logistical support and SME to Ms. Boss and the team. Communications Director Sara Burke and Communications Designer & Accessibility Manager Jeff Nguyen will produce the communications plan and supporting material, as well as handling editing, production design, and ADA/508 compliance of contract deliverables.

We have also included a core group of key subcontractors/consultants, including HSRI who will lead data collection and evaluation plan activities and contribute their data analytic and disability-related expertise to the drafting of the evaluation plan report, Virginia Selleck who brings decades of experience supporting the integration of supported employment services into states' Olmstead planning and implementation; and Kelly Nye-Lengerman who is an accomplished researcher, educator, and visionary leader with 25 years of experience driving disability inclusion initiatives through strategic planning, program development, research, and effective organizational management.

Ms. Boss will facilitate weekly internal meetings to ensure coordination across TAC and subcontractor staff on all contract tasks and activities. With the exception of Ms. Thiele Sacks, all project staff and subcontractors will report to Ms. Boss regarding work assigned and performed on this project.

Proposed Personnel & Roles

The team assembled for this project includes TAC staff members and identified subcontracting partners who round out our team. Collectively, they are leading experts on community integration and Olmstead, with subject matter expertise in Olmstead planning, implementation and evaluation; best practices in the design, financing, and operation of affordable housing; community-based services, education, and employment programs, and other services and supports (e.g., transportation) that support integration; and ensuring service quality, accountability, and continuous systems improvement. Team members also have extensive experience working with state agency partners, advisory groups, and the disability community, with stakeholder engagement, and in direct services, government, and consulting, making us uniquely qualified for the complexities associated with this project.

Brief bios outlining qualifications for key personnel assigned to the project are included below. The required three-page resumes with references are included in **Appendix B**.

TAC Staff

Rebecca Boss, MA, Senior Consultant, will be TAC's Project Director for this work and is a highly regarded leader of behavioral health care and developmental disabilities services with special expertise in addiction and recovery solutions. At TAC, she engages with federal, state, and philanthropic organizations to promote effective responses to the evolving needs of the behavioral health care system. She currently leads TAC's Olmstead planning work in Minnesota, our efforts to evaluate North Carolina's Olmstead plan progress, and our recent work with the state of Massachusetts to evaluate and update its Olmstead plan. Ms. Boss spent 15 years in state government, including as director of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, where she oversaw the state's publicly funded system for people with mental illness, substance use disorders, and developmental disabilities. Among her achievements was the expansion of employment opportunities and community integration for individuals with intellectual/developmental disabilities (I/DD) and successful compliance with the state's related Consent Decree. Wellness, recovery, and parity were consistent themes of her leadership as she advanced efforts to promote inclusion and to eliminate fear and discrimination directed toward individuals living with disabilities.

Ms. Boss's career has been focused on promoting systems that support continued engagement with family and community for all individuals living with disabilities. In North Carolina, Ms. Boss participates in quarterly Olmstead Plan Stakeholder Advisory meetings, a group of state staff and community members. During these meetings, she is regularly called upon to present the state's progress on *Olmstead* goals. In Minnesota, Ms. Boss leads a project that includes development of an *Olmstead* best practices report, and provision of subject matter expertise to teams of state agencies and Inclusion Consultants (individuals living with disabilities) as they develop new *Olmstead* Plan goals. She also provides subject matter expertise for staff and Inclusion Consultants to both Minnesota's Department of Human Services and the Department of Direct Care and Treatment.

Shawn Thiele Sacks, MSW, LCSW, is TAC's Senior Director for behavioral health and Medicaid and will have quality oversight responsibility for all contract deliverables and products, in addition to lending her expertise on community-integrated services and supports, and related financing and accountability mechanisms. Shawn has over 30 years of experience in behavioral health program development and service delivery, managed care, and government and Medicaid health care consulting, and is highly skilled at advancing and aligning clinical models, financing approaches, with evidence-based (i.e., ACT, Supported Employment - IPS) and promising (High-fidelity Wraparound) practices, and in strengthening quality management systems to ensure programs achieve intended outcomes for children, youth, and adults across public systems. Ms. Thiele Sacks provides TA and consulting to states and localities on Medicaid behavioral health transformation, including Section 1115 waiver design, implementation, and performance oversight. Her expertise includes development of clinical practice guidelines, program evaluation, and continuous quality improvement grounded in data and outcomes. Prior to joining TAC, Shawn served as a Principal at Mercer, where

she advised states on behavioral health system design, managed care implementation, and Medicaid policy compliance. She also held executive leadership roles at Magellan Health Services, where she oversaw child and adult systems of care, spearheaded innovations in recovery-oriented and community-based models and supported Medicaid-funded service expansions addressing complex populations and social determinants of health.

Lisa Sloane, MPA, is a TAC Senior Housing Consultant who has 40 years of experience working with federal, state, and local governments, as well as nonprofit agencies, to address the supportive housing needs of people with disabilities and of individuals and families experiencing homelessness. At TAC, she manages complex consulting projects for state agencies and collaborates with federal and nonprofit partners to develop and implement affordable and supportive housing programs for people with disabilities and people experiencing homelessness. Ms. Sloane recently contributed subject matter expertise for TAC's Olmstead plan update work in Minnesota and Massachusetts related to best practices in affordable, accessible housing and transportation which she will similarly lend to this work in Nebraska. She has played a key role in the development of innovative cross-disability housing programs, including a housing locator system, a state housing bond fund, and a state home modification loan program. Ms. Sloane has worked extensively with state and local housing authorities and also has expertise in housing development programs, including the Low Income Housing Tax Credit program. Prior to joining TAC, Ms. Sloane was principal of Sloane Associates, a woman-owned business that provided affordable housing and human services consultation, specializing in the development of housing programs and policies for persons with disabilities, including those experiencing homelessness.

Laura Conrad, MSW, is a TAC Senior Medicaid Consultant and a behavioral health care leader with over 20 years of experience in government administration in child-serving systems including Medicaid and child welfare. She has experience in behavioral health policy and services design, development, and implementation, with extensive experience in Medicaid authority and financing, managed care, and contract and project management, as well as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) litigation. At TAC, Laura has supported state systems to align, finance, and implement community-based services with housing opportunities, and served as an education and child welfare system expert for the Minnesota Olmstead plan update work. She will lend similar expertise on this project. Prior to joining TAC, Laura worked for MassHealth, serving as the interim court compliance officer for *Rosie D. v. Romney*. Since joining TAC, she has worked on projects focused on designing, operationalizing, and implementing Medicaid Supportive Housing services. Her work also focuses on providing expertise at the state and federal levels identifying policy, programmatic, and financing strategies aimed at improving access to care for youth with behavioral health conditions including those with co-occurring autism.

Megan Lee, MA, LPC, Senior Associate, has nearly 15 years of experience working with federal, state, and local government; providers and community partners; and other stakeholders to address the needs of people with behavioral health conditions. Her work at TAC focuses on supporting state and local agencies to complete system assessments and subsequent implementation planning and execution; supporting states' Olmstead planning and initiatives; and criminal justice and crisis interoperability and reform. Among other projects, Mrs. Lee has worked with Massachusetts, Minnesota, North Carolina, and Pennsylvania on their Olmstead planning and/or implementation efforts. Most recently she developed a

comprehensive community engagement strategy for North Carolina as they embarked on the second revision to the state's Olmstead Plan. In Minnesota, she provided meeting facilitation and expertise on range of best practices to the state's Department of Human Services and Inclusion Consultants with disabilities. Ms. Lee will lend stakeholder engagement and facilitation support on this project, as well as expertise related to ensuring services quality and accountability and workforce support.

Prior to joining TAC, Mrs. Lee served in the Colorado Behavioral Health Administration, where she oversaw the development of a multimodal statewide behavioral health crisis system; her focus was on change management through landscape analysis, strategic planning, and TA and problem solving to promote innovation and adherence to evidence-based practices. She was involved in extensive engagement with providers, law enforcement leaders, people with lived experience, and other stakeholders to improve access to care across the state, including in rural and underserved areas. Mrs. Lee has previous experience in community-based settings in program development and management and delivering direct services to individuals and families experiencing serious mental illness; delivering trauma-informed care; addressing the social-economic needs of individuals and families; and promoting stability through meaningful engagement and intervention. Her experience also includes starting Colorado's first coordinated specialty care team to address the needs of individuals experiencing their first episode of psychosis and provide support and education to their families and communities.

Amy Horton is a TAC Senior Associate who has over 14 years of experience managing TAC's TA, training, evaluation, and consultative initiatives. Currently, she manages TAC's Massachusetts Medicaid Children's Behavioral Health Initiative TA, evaluation and quality improvement contract. She recently supported TAC's Minnesota Olmstead work with project management and overall coordination of team logistical support and will similarly support the Project Director and team on this project. Ms. Horton is a highly skilled project manager with demonstrated experience in program evaluation, data collection, analysis and reporting, and Continuous Quality Improvement, including the Plan-Do-Study-Act (PDSA) cycle method.

Sara Burke is TAC's Communications Director and has over 25 years' experience in nonprofit communications leadership, with specific expertise in the fields of public health, education, and social justice. She is well-versed in meeting the intersecting priorities of funders, constituents, and consumers, and is familiar with the specialized communications requirements of federal, state, and local agencies. Ms. Burke oversees TAC's outreach and education projects; supervises the Communications Designer & Accessibility Manager; manages social media accounts; oversees the organization's website; maintains TAC's relationship with related vendors; and edits reports, presentations, and a wide range of deliverables.

Jeff Nguyen, MA, is TAC's Communications Designer & Accessibility Manager. Mr. Nguyen has a decade of experience helping people and institutions clearly communicate their visions by designing with the mission in mind. Through his zeal for language and problem-solving to scale, he collaborates with stakeholders to carry out design solutions that engage new audiences across the print and digital hypersphere while satisfying growing demands for maximal accessibility. Mr. Nguyen manages design, production, and accessibility remediation of TAC's business-to-business deliverables for federal and state clients in accordance with Section 508 protocols. In addition to consolidating long-form proposals, reports, and data-

rich infographics, he supports the Communications Director with internal publications, brand management, and digital strategy.

Subcontractors

Human Services Research Institute (HSRI)
2336 Massachusetts Ave, Cambridge, MA 02140
(617) 876-0426

HSRI will partner with TAC on this project, lending its evaluation and disability policy expertise, as well as its work with numerous federal agencies, all 50 states and more than 100 cities and counties across all fields of health and human services, including behavioral health, child and family welfare, housing and homelessness, population health, intellectual and developmental disabilities, and aging and physical disabilities. HSRI is a 501(c)(3) nonprofit organization and long-standing TAC partner whose mission is to improve the systems that change lives. They achieve this by crafting community-based, person-driven service systems that rely on their unique model of collaborative, inclusive, and participatory research. HSRI researchers, data scientists, and policy analysts work with government agencies to improve public health services and systems. They will perform approximately 19% of the performance hours on this contract.

HSRI has experience on several projects that inform disability policy development, including its work with ACL and CMS on the National Center on Advancing Person-Centered Practices and Systems (NCAPPS), an initiative that helps states, Tribes, and Territories implement person-centered thinking, planning, and practice in line with U.S. Department of Health and Human Services policy. Through targeted TA, topic-specific learning collaboratives, monthly public webinars, and actionable resources, NCAPPS works to promote system change that makes person-centered principles not just an aspiration but a reality in the lives of people who use LTSS. NCAPPS priorities include promoting cross-system collaboration to promote whole-person supports, and engaging people with lived experience of systems in policy and system design efforts. NCAPPS produced a Person-Centered Practices Self-Assessment for Governmental Agencies That Oversee Human Services, which several states have used to establish baselines and track progress in systems change with HSRI's support and TA.

HSRI Staff

Bevin Croft, MPP, PhD, is Director of Behavioral Health Research at HSRI and will support TAC with evaluation plan activities and lend her 20 years of experience in the behavioral health field, with subject matter expertise in person-centered practices, peer-delivered services, quality improvement, and workforce development. She recently co-directed the National Center on Advancing Person-Centered Practices and Systems (NCAPPS), funded by the Administration for Community Living (ACL), and conducts research on self-direction with a focus on how to adapt a model to meet the needs of individuals with behavioral health conditions. Bevin works closely with state and county behavioral health leadership to engage in rigorous systems analysis to support system transformation, with a focus on increasing the system's capacity to understand and respond to the needs and preferences of people with lived experience. In all of these projects, Bevin has used qualitative research (e.g., focus groups, listening sessions) and quantitative research (e.g., claims data analysis, analysis of

national datasets) to generate information to drive programmatic changes and support policy decision-making.

Rachael Gerber, MPH, is a data specialist and director of operations for HSRI's behavioral health team, who will serve as a data analyst and subject matter expert on this project. Rachael brings over 15 years of experience in the behavioral health field as a data analyst and mixed methods researcher. She has served as lead data analyst on projects funded by federal, state, and local agencies. She has led analysis of Medicaid claims data to examine service utilization patterns for state-level system assessments in New Hampshire, South Dakota, and North Dakota, as well as for Olmstead-related projects in North Carolina and Louisiana. As lead analyst, she develops evaluation plans, data collection tools, and protocols; drafts and coordinates data requests; conducts and synthesizes quantitative and qualitative analyses; and adapts data into visuals for reporting. In her role as director of operations for HSRI's behavioral health team, she oversees standard operating procedures to ensure data quality control and the delivery of high-quality products.

Kristin Battis, MPH, is a data scientist at HSRI and will provide additional data analytic support on this project. Kristin has more than 18 years of research and data analysis experience supporting federal, state, and local health initiatives. She is skilled in collecting, managing, and analyzing quantitative data; conducting quality assurance activities; performance reporting; and disseminating findings through written reports and data visualizations. She also has experience developing data collection protocols and tools and creating materials for training and TA. Kristin has 10 years of claims-based analytics experience with public and private health insurance data. She has served as a health data analyst for Maine and Colorado's All Payer Claims Databases and for the Colorado Behavioral Health Service Gap Analysis, the latter in which she examined demographics, behavioral and physical health diagnoses, service utilization (including telehealth), and provider network adequacy across counties and geographies. She analyzed Medicaid claims for Olmstead-related projects in North Carolina and Louisiana.

Virginia M. Selleck, PhD
2510 N Glencoe St., Denver, CO 80207
(612) 616-0666

Virginia Selleck, PhD, has worked in psychiatric rehabilitation for over 40 years and has experience in recovery systems reform, program development and implementation, funding issues, legislation, and policy. She has held leadership positions in state government in Minnesota and Missouri, and with community mental health providers in rural Illinois, urban Chicago, and St. Louis. She has extensive speaking, training, and consulting experience in a number of states about issues germane to psychiatric rehabilitation – employment in particular – and systems change. Dr. Selleck has provided consultation and subject matter expertise to states under the Department of Labor's Office of Disability Employment Programs. Her consulting work with TAC includes supporting the integration of supported employment services for the State of Washington under its Medicaid 1115 Demonstration Waiver, and for the State of Louisiana on a U.S. Department of Justice (DOJ) settlement agreement target population with serious mental illness. Ms. Selleck served as lead author for the Employment Section of TAC's Olmstead Best Practices Report for Minnesota and provided policy consultation to the Minnesota Department of Employment and Economic Development and assigned Inclusion Consultants with disabilities. Virginia will serve as a subject matter

expert on competitive, integrated employment and will perform approximately 3% of the performance hours on this contract.

Kelly Nye-Lengerman
2 Lancaster Street Dover NH 03820
(507) 319-2489

Kelly Nye-Lengerman, PhD, MSW, specializes in disability policy and services in employment and community living for people with disabilities. Her work is focused on building evidence to ensure public policies and systems work for people. Kelly's work has focused on improving health and human service systems to advance whole person well-being, community participation, and economic mobility. This includes planning, design, and implementation of state and provider level actions to improve Medicaid Home and Community Based Services, as well as state level Olmstead Plan implementation. Kelly is skilled at navigating system, provider, and individual level nuances to collectively advance system improvement that enhance quality and compliance. Additionally, her expertise includes service development and delivery for transition-age youth with disabilities, individuals with Autism and Intellectual and Developmental Disabilities, and those who experience mental health challenges and substance use disorder. She has provided thousands of hours of professional training and TA in person centered service delivery, family centered supports, disability system navigation, organizational transformation and competitive integrated employment. Kelly previously served as a Research Professor and director of the Institute on Disability at the University of New Hampshire and directed the Community Living and Employment area at the Institute on Community Integration at the University of Minnesota. She has a diverse publication record across a spectrum of human and social service topics and is national and international speaker on disability policy and service design. She will perform approximately 3% of the performance hours on this contract.

The total percentage of performance hours across all subcontractors is approximately 25%.

Technical Response

Understanding of the Project Requirements

Project Description & Scope of Work

Project Background

TAC understands that the Nebraska Department of Health and Human Services (DHHS), through the Division of Developmental Disabilities, seeks an experienced evaluation and technical assistance (TA) partner to assess implementation of Nebraska's Olmstead Plan and support the State's continued refinement of a practical, measurable, and stakeholder-informed roadmap for community integration. The RFP calls for a two-year services contract to conduct a Nebraska Olmstead Plan Evaluation, including evaluation of successes, identification of barriers, recommendations for plan revisions, TA to DHHS and the Olmstead Advisory Committee, and development of communication materials to share findings with stakeholders.

This work is situated within Nebraska's longstanding commitment to the principles of Olmstead v. L.C. and the State's vision that people with disabilities should be able to live, learn, work, and participate fully in community life in the most integrated settings appropriate to their needs and preferences. Nebraska's updated SFY 2026-2031 Olmstead Plan, Strengthening Pathways to Access, advances this vision through five focus areas—Community Supports, Education, Employment, Housing, and Transportation—each with goals, activities, key partners, and data measures designed to strengthen access, accountability, and cross-system coordination.

TAC also understands that Nebraska's Olmstead work is grounded in statutory requirements. LB570 established the State's obligation to develop a comprehensive strategic plan for providing services to qualified persons with disabilities in the most integrated community-based settings, consistent with Olmstead, and directed DHHS to collaborate with multiple state agencies, convene a stakeholder advisory committee, consult with an independent consultant as needed for continued analysis and revision, assess whether benchmarks, deadlines, and timeframes are in substantial compliance with the strategic plan, and submit reports and the completed plan electronically to the Legislature every three years (next due December 2027).

TAC further understands that LB737 and AM2986 reinforce legislative oversight and public accountability by requiring the Health and Human Services Committee and Urban Affairs Committee of the Legislature to hold an annual joint public hearing, on or before October 1, to assess progress of the Olmstead Plan during the previous calendar year in the areas of housing, employment, education, community supports, and transportation, and to consider potential legislative solutions, with findings reported electronically to the Clerk of the Legislature by December 31. TAC will design evaluation activities and reporting products with these legislative expectations in mind, so that findings can support DHHS's statutory reporting responsibilities and help inform the Legislature's annual review of progress and policy needs.

Scope of Work

TAC understands that the Scope of Work for this solicitation requires both rigorous evaluation and hands-on TA. The selected vendor must work in consultation with Nebraska DHHS to develop an evaluation plan; collect and monitor qualitative and quantitative indicators; design or refine survey and assessment tools; conduct interviews and focus groups with program staff, partner agencies, stakeholders, and people with lived experience; review program records and subrecipient reports; prepare a draft and final evaluation report; recommend updates to outcomes, benchmarks, structure, and language; develop communication materials; and facilitate meetings and monthly touchpoints with DHHS throughout the contract period.

We understand that this evaluation must do more than describe activity. It must assess whether Nebraska's Olmstead implementation is producing meaningful progress toward community integration, person-centered access, service continuity, timely supports, accessible housing, competitive integrated employment, inclusive education, and transportation access. The evaluation should surface implementation strengths, identify barriers that cut across systems, assess whether current measures are feasible and meaningful, and translate findings into actionable recommendations that DHHS, the Olmstead Advisory Committee, workgroups, and partner agencies can use.

Workplan

TAC's workplan organizes the project into connected phases that align with the RFP deliverables and will support steady progress over the two-year contract period. We anticipate beginning with project initiation and document review, including review of the SFY 2026-2031 Olmstead Plan, prior evaluations, available administrative data, workgroup materials, legislative reporting requirements, and relevant program records. This phase will establish a shared understanding of evaluation questions, data sources, stakeholder engagement priorities, timelines, roles, and decision points.

The next phase will focus on evaluation design and data collection. TAC will work with DHHS to develop a practical evaluation plan that identifies indicators, data collection methods, interview and focus group protocols, survey tools, analytic approaches, and reporting formats. Data collection will include both quantitative review of available outcomes and benchmarks and qualitative engagement with DHHS staff, partner agencies, Advisory Committee members, workgroups, providers, advocates, and stakeholders with lived experience. TAC will then synthesize findings into an evaluation report and recommendations that are clear, evidence-informed, and implementation-oriented. Detailed steps with a proposed timeline by deliverable may be found in the latter sections of this proposal titled *Detailed Project Work Plan* and *Deliverables and Due Dates*.

Throughout the project, TAC will provide TA to DHHS and the Olmstead Advisory Committee to interpret findings, consider revisions to the plan, refine performance measures, and prepare for dissemination. Monthly touch-base meetings will provide a consistent structure for sharing progress, raising issues early, coordinating stakeholder engagement, and ensuring that deliverables remain responsive to DHHS expectations.

Because LB737 contemplates annual legislative hearings focused on the five current Olmstead focus areas, TAC will organize data collection, interim findings, and TA in a way that can

generate timely, focus-area-specific information on implementation progress, barriers, and potential policy solutions. This alignment will help ensure that the evaluation is not only retrospective, but also useful for annual legislative review, stakeholder engagement, and ongoing plan refinement.

Technical Requirements

TAC understands that our technical response must demonstrate a clear command of evaluation design, disability policy, Olmstead implementation, stakeholder engagement, data analysis, facilitation, TA, and accessible communications. Our approach integrates mixed-methods evaluation with practical implementation support. Quantitative analysis will focus on available outcome and performance measures, service utilization trends, benchmarks, and progress indicators. Qualitative analysis will capture the experience of implementation, including barriers, promising practices, cross-system coordination challenges, and opportunities for strengthening the plan.

TAC will also ensure that engagement methods are accessible, trauma-informed, and respectful of the expertise of people with disabilities, families, self-advocates, providers, and state agency partners. Because Nebraska's current plan embeds data considerations across all five focus areas, TAC will assess not only whether activities are underway, but whether measures are defined, collectible, useful for decision-making, and aligned with the plan's broader goals. Where measures are not yet mature or data are incomplete, TAC will identify practical recommendations for strengthening definitions, collection processes, reporting, and accountability.

Our TA will be grounded in TAC's national experience with housing, behavioral health, Medicaid, disability services, community integration, and systems transformation. TAC will bring an implementation lens to the evaluation, helping Nebraska translate findings into usable recommendations that support plan revisions, legislative reporting, stakeholder communication, and ongoing workgroup action. The *Technical Requirements* section below provides additional information via detailed responses to each of the questions posed in *Attachment A*.

Deliverables

TAC understands the RFP requires five primary deliverables, supported by meeting facilitation, monthly coordination with DHHS, and ongoing TA. In all deliverables, TAC will prioritize clarity, usefulness, accessibility, and alignment with Nebraska's implementation context. Our goal is to produce an evaluation process and set of products that help DHHS document progress, understand barriers, strengthen accountability, and continue advancing the State's vision that Nebraskans with disabilities can live, learn, work, and thrive in the communities of their choice. The *Deliverables and Due Dates* section below further outlines TAC's approach to each deliverable and the proposed associated due dates.

Proposed Development Approach

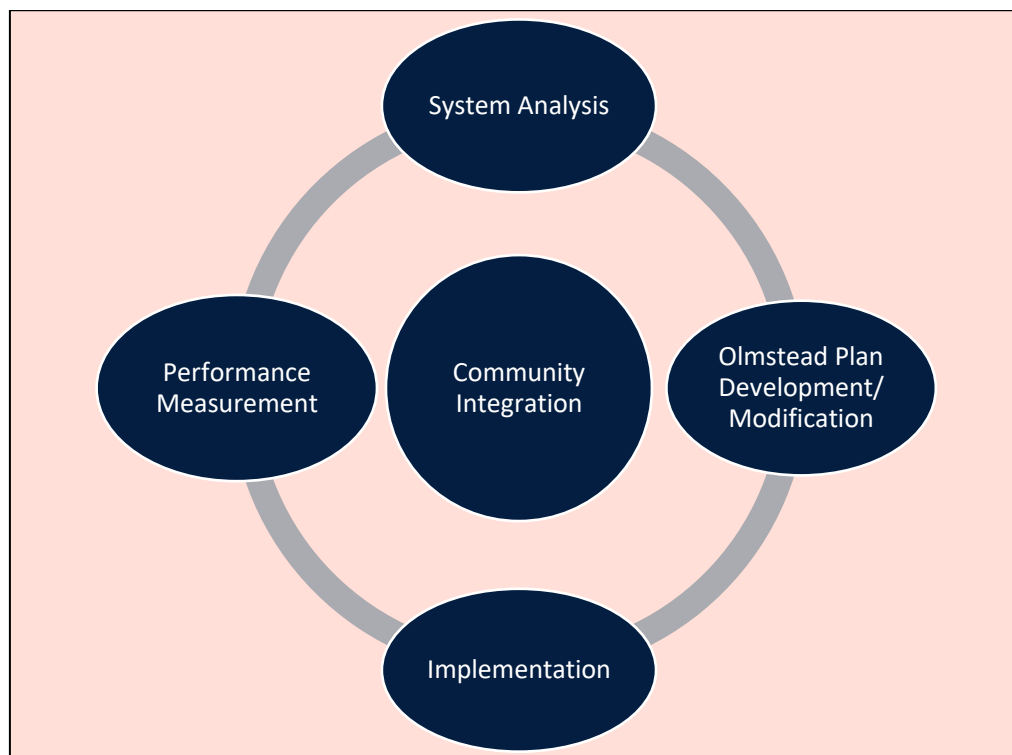
Overall Approach

TAC proposes to provide a development approach that builds on the work and evolution of Nebraska DHHS's Olmstead Plan and previous evaluations, leveraging TA experience in

community integration and Olmstead via a phased approach, represented in **Figure 2**, consistent with the approach TAC has used in other states involving:

- **System assessment and analysis:** working with the state to understand system strengths, weaknesses, and opportunities to serve people with disabilities in integrated settings;
- **Olmstead Plan development/modification:** using the system analysis to develop and/or revise, with the state and key stakeholders, actionable and measurable activities and goals, as well as a performance improvement process to measure plan performance and progress toward outcome achievement;
- **Implementation:** carrying out the specific activities identified in the plan designed to serve people in integrated settings; and
- **Performance evaluation and outcomes:** evaluating the state’s performance in carrying out plan activities and achieving stated goals.

Figure 2. Cycle of Olmstead Planning



Tailored for Nebraska

TAC understands that DHHS is seeking a consultant to perform work related to the system assessment and analysis and development of modification recommendations to advance and implement a comprehensive, effective working plan for people with disabilities who are currently receiving or are eligible for services. TAC has extensive experience engaging and involving stakeholders across disabilities, including service recipients and family members, and views this activity as critical to each phase of this work. Further, TAC's involvement in Olmstead implementation and settlement monitoring work has also made us keenly aware of measurable goals and objectives that signify real systems change related to community integration and how to assist states to develop and/or adapt quality management systems to evaluate and adjust implementation activities to achieve Olmstead integration goals.

TAC will approach the work with particular attention to the current plan's emphasis on data-informed decision-making, cross-agency alignment, rural access, transitions across the lifespan, workforce capacity, communication access, and public transparency. We also understand the importance of balancing accountability with feasibility: the evaluation should recognize changing fiscal, policy, and regulatory conditions while maintaining Nebraska's core commitment to civil rights, self-determination, and meaningful community participation.

Technical Requirements

See following pages

ATTACHMENT A
Technical Requirements
RFP 125999 O3
Nebraska Olmstead Plan Evaluation

1. Provide a narrative of the bidder's experience evaluating state Olmstead plans or similar, including the use of quantitative and qualitative methods as well as using continuous quality improvement approaches or processes to achieve better results.

The Technical Assistance Collaborative, Inc. (TAC) has direct experience supporting Olmstead planning, evaluation, implementation, and monitoring in multiple states, including North Carolina (NC), Massachusetts, Minnesota, Oklahoma, and Nebraska (NE). This experience is directly relevant to NE DHHS because Nebraska's Olmstead work is framed as a roadmap for a strong state where people with disabilities can live, learn, work, and enjoy life in the most integrated setting. Nebraska's current plan, Strengthening Pathways to Access: Nebraska's Olmstead Plan, builds on the state's initial 2019 plan, the 2023 update, and the statutory requirement for DHHS to collaborate with the Olmstead Advisory Committee, self-advocates, and stakeholders with lived experience and expertise in disability services and supports.

In partnership with Human Services Research Institute (HSRI), TAC has supported evaluation and development of state Olmstead plans and related system assessments using mixed quantitative and qualitative methods. In North Carolina, TAC and HSRI partnered on the 2021 assessment of North Carolina's system of services and supports for people with disabilities to inform development of the state's Olmstead Plan. HSRI led the quantitative analysis of Medicaid claims, administrative data, and state-funded service data to describe service utilization patterns and characteristics of people served across target populations, including development of detailed data requests, analytic tables, and data visualizations for the final report.

In Louisiana, HSRI partnered with TAC to support the Office of Behavioral Health in meeting requirements of a settlement agreement with the Department of Justice by leading a needs assessment of inpatient treatment, HCBS services, outpatient treatment, and crisis services for adults with mental health conditions and substance use disorder, including analysis of PASRR Level II assessment data to identify opportunities for diversion from, or transition out of, institutional care into community settings.

Currently, TAC with subject matter input from HSRI is leading the Minnesota Olmstead project for the development of a new plan. This project has included identifying and documenting best practices related to person-centered planning for HCBS, informed choice, workforce development, and positive supports through environmental scans, literature reviews, and key informant interviews. Currently, TAC provides policy consultation and subject matter expertise to all of the Olmstead subcabinet agencies responsible for implementing the Minnesota Olmstead Plan.

In TAC's work across multiple states, including prior Nebraska Olmstead evaluation and revision work, we completed a thorough analysis of progress on current goals and strategies, including review of state-level data compared with national benchmarks when available, review of state and national best practices, survey development, focus group facilitation, and synthesis of research, data analysis, survey results, and stakeholder engagement findings. Across these examples, we use both qualitative methods—such as public listening sessions, facilitated discussions, written feedback, RFIs, surveys, key informant interviews, and focus groups—and quantitative or programmatic methods, including review of administrative data, Medicaid claims and encounter data, HCBS access indicators, public use sources such as the American Community Survey, service utilization data, public dashboards, progress reporting, and national or state benchmarks. HSRI's mixed-methods approach analyzes qualitative and quantitative data iteratively as they are collected, centering the perspectives of people who use services and their families and organizing qualitative data thematically using rapid qualitative techniques, stories, and illustrative quotes. Quantitative data are examined by demographic characteristics whenever possible—including age, race, ethnicity, primary language, living setting, geography, and other relevant factors—to identify potential disparities in need, access, quality, outcomes, and system performance. When comparing values across years, regions, or population subgroups, HSRI obtains margins of error where possible to distinguish meaningful differences from chance or sampling error and presents statistically significant findings with clear visual cues and plain-language explanations. On needs assessment projects, HSRI develops a detailed data analysis plan that crosswalks project aims and research questions with available data sources and measures to identify data gaps and plan supplemental analyses.

ATTACHMENT A
Technical Requirements
RFP 125999 O3
Nebraska Olmstead Plan Evaluation

TAC's approach emphasizes continuous quality improvement (CQI) by gathering feedback, analyzing data on services and service performance, identifying strengths and gaps, setting measurable goals with benchmarks and timeframes, reporting back to stakeholders, and using findings to guide resource decisions, provider training, implementation changes, and service expansion. HSRI strengthens this CQI approach by treating data collection, analysis, and stakeholder engagement as iterative activities, regularly reviewing emerging findings with project partners, state agencies, and advisory groups to validate interpretations, refine subsequent analyses, inform supplemental data requests, and guide targeted outreach to populations whose experiences may be underrepresented in available data. In NC, TAC has implemented a CQI approach to service delivery for the state's Olmstead settlement population, working in collaboration with the MCOs to engage and offer training and coaching for providers of community-based behavioral health services, and to conduct quality service reviews aimed at improving service delivery quality and related community integration outcomes, and creating a feedback loop with the state.

2. Describe the bidder's experience evaluating partnerships, including identifying partners and stakeholders not currently represented.

TAC has deep experience designing and evaluating community engagement strategies that identify current partners, assess gaps in representation, and recruit perspectives that may not already be represented. For NE DHHS, this includes honoring Nebraska's existing Olmstead infrastructure and history of collaboration with the Olmstead Advisory Committee, self-advocates, and stakeholders with lived experience and expertise in disability services and supports, while also identifying communities and perspectives that may not yet be consistently represented.

TAC's community engagement approach identifies stakeholder groups such as community members, state agencies, provider organizations, advocacy organizations, community-based organizations, peer networks, and existing advisory bodies. We use multiple identification pathways, including credible messengers, advocacy groups, provider organizations, community-based organizations, peer networks, public calls, advisory boards, and partnership maps. We also distinguish between engagement levels—such as involving community members and state agencies while consulting provider and advocacy organizations—based on the purpose of the engagement and the role each group should play. We build recruitment around culturally relevant and accessible materials, compensation, accessible accommodations for meetings and trainings, training, clear roles and responsibilities, and assurance of follow-through and accountability. HSRI further supports representativeness by administering a brief demographics survey to participants in listening sessions, interviews, and focus groups, collecting information such as gender, race, ethnicity, age group, and region of the state. Survey results are reviewed throughout a project to assess whether participants reflect the diversity of the community, identify populations whose perspectives may be underrepresented, and refine outreach and recruitment strategies. For virtual engagement, participants receive a survey link after the session; for in-person engagement, participants may complete the survey by QR code or paper form.

HSRI complements this approach with a structured community partnership mapping, or asset mapping, process used to help state agencies and partners identify existing assets, relationships, and gaps across the continuum of care. As part of system assessment work, HSRI guides state agencies and key partners through a mapping process, typically held over two to three meetings with a group of approximately eight to ten representatives, using templates that categorize partnership types such as hospitals and primary care, crisis services, services for people with disabilities, councils, coalitions, and other resources. The resulting map provides a descriptive list of organizations and resources available to support behavioral health and related needs of the target population, while an accompanying spreadsheet documents partnership type, whether formal or informal, contact information, notes, and future action steps. HSRI developed a toolkit for partnership mapping: [Toolkit for Stakeholder Asset Mapping](#) through its work leading the former National Center for Advancing Person-Centered Practices and Systems and has refined and applied similar tools in North Dakota, New Hampshire, and Forsyth County, North Carolina.

For NE DHHS, TAC will work with the state to identify the right mix of in-person and virtual focus groups, listening sessions, surveys, RFIs, written feedback opportunities, partnership mapping

ATTACHMENT A
Technical Requirements
RFP 125999 O3

Nebraska Olmstead Plan Evaluation

activities, and ongoing engagement mechanisms to reach people with disabilities, families, providers, advocacy organizations, state agencies, community-based organizations, rural residents, home-bound participants, people who rely on transportation supports, people seeking community-based services, and others who may not be represented in current structures. We would also review whether proposed strategies and best/promising practices reflect lived experience through engagement processes, surveys, or feedback mechanisms, and we would seek input directly from advocacy groups or community representatives where that voice is not evident. This approach allows us to evaluate partnership representation, identify missing voices, and design engagement processes that reduce barriers to participation and shift power toward people with lived expertise.

3. Provide a narrative of the bidder's experience with evaluating the quality and implementation of strategic plan objectives and activities (e.g., state cancer plan, organizational strategic plan).

TAC has extensive experience evaluating the quality and implementation of strategic plan objectives and activities through Olmstead plan implementation, revision, behavioral health system improvement, and system transformation projects. For Nebraska, this work must be grounded in the state's Olmstead vision that people with disabilities are living, learning, working, and enjoying life in the most integrated setting, as well as the current plan's focus areas of community supports, education, employment, housing, and transportation. In North Carolina, we have supported work organized around priority areas, strategies, and action steps intended to make the plan's principles operational. These principles focus on ensuring that people with disabilities can make their own choices, be part of the community, receive the right help at the right time, live in accessible and affordable places, and be supported by systems that work together across the lifespan. Proposed priority areas for North Carolina's in-progress Plan revision include access to housing and related supports, crisis services and community stabilization, sustainable and equitable access to community-based services and supported employment, workforce development, quality and stability, and communication and engagement.

HSRI adds extensive experience supporting strategic planning and implementation monitoring. Following a statewide behavioral health system needs assessment that HSRI led in North Dakota in 2018, the North Dakota Department of Health and Human Services engaged HSRI to continue supporting behavioral health system improvement by working with the Governor-appointed Behavioral Health Planning Council and other system experts to develop a strategic plan and monitor progress. HSRI facilitated a four-phase strategic planning process that included creating the planning process and protocol, prioritizing and refining strategic goals, initiating action on the strategic plan, and ongoing monitoring and sustaining. The resulting plan included strategic goals spanning 13 aims, detailed objectives, action steps, and indicators of progress, with quarterly public dashboards showing progress. HSRI continues to support Phase 4 monitoring and sustaining by convening the Behavioral Health Planning Council and lead staff to monitor progress, troubleshoot implementation issues, and initiate new goals, objectives, and action steps as previous activities are accomplished.

In other States, TAC assesses current Olmstead goals and strategies, reviewing state-level data against national benchmarks where available, identifying successes, gaps, and challenges, and establishing measurable goals with clear benchmarks and realistic timeframes. In Minnesota, we have supported Plan co-creation by developing a best/promising practices report and continue to help ICs and Olmstead subcabinet agencies ensure recommendations are consistent with Olmstead, actionable, and measurable. In Massachusetts, TAC helped create a system snapshot as a baseline, identify system strengths and gaps, prioritize areas for improvement, conduct public listening sessions, implement and analyze an RFI, draft an updated plan, and incorporate public review comments into the final plan.

For NE DHHS, we would bring this same or similar approach to assess whether strategic objectives are well-framed, whether activities align with Nebraska's values and guiding principles, whether activities are feasible and responsive to stakeholder input, and whether implementation can be measured and improved over time.

ATTACHMENT A
Technical Requirements
RFP 125999 O3
Nebraska Olmstead Plan Evaluation

4. Describe how the bidder proposes to produce evaluation reports using existing and programmatic data. Provide an example of reports completed for previous work.

TAC proposes to produce evaluation reports for NE DHHS by combining existing administrative and programmatic data with information gathered through engagement activities, then translating findings into clear recommendations, measurable goals, benchmarks, and implementation timeframes. This reporting approach will reflect Nebraska's Olmstead planning context, including the state's statutory reporting obligations, the evolution from the initial 2019 plan through subsequent updates, and the current plan's emphasis on strengthening pathways to access across community supports, education, employment, housing, and transportation. We would synthesize existing data on people using services, service performance, waiting lists, access, outcomes, implementation progress, and related program measures with qualitative feedback from listening sessions, workshops, written comments, surveys, RFIs, focus groups, and other engagement opportunities. TAC proposes a draft report incorporating and leveraging Nebraska's previous Olmstead reports for consistency and thematic continuity while bringing in research, data analysis, surveys, and community engagement; identifying successes, gaps, and challenges; and establishing measurable goals with clear benchmarks and timeframes.

Relevant prior products include public-facing presentations, stakeholder summaries, action reports, implementation trackers, dashboards, best/promising practices reports, accessible plain language reports, and feedback-loop summaries that explain what was heard, how it was incorporated, and how stakeholders can stay informed of progress. TAC's [2024 MA Olmstead Update Report](#) (also included in Appendix C) is an example of a report that synthesized data in order to update a state's Olmstead plan. TAC's [Olmstead quarterly progress reports](#) developed for NC are also good examples of periodic evaluation summary reports developed by TAC using existing and programmatic data. In Minnesota, TAC and HSRI created a best/promising practices report based on literature review, national resource review, key informant interviews, subject matter expert input, and review of state data sources, with both technical and plain language accessible versions. These reports are included in the Work Examples in Appendix C of this proposal. HSRI's complimentary experience strengthens TAC's approach, including development of an interactive dashboard of Minnesota HCBS access indicators, use of multiple data sources such as assessments and waiver data, and experience designing and supporting surveys such as HCBS CAHPS and National Core Indicators. TAC will leverage this expertise for Nebraska DHHS.

5. Provide a narrative of how the bidder will work with NE DHHS to provide technical assistance and support the revision of the Olmstead plan. The bidder may provide an example of previous work.

TAC would work with NE DHHS by providing structured technical assistance throughout the Olmstead plan revision process, including project kickoff, work plan development, data and document review, stakeholder engagement design, facilitation, synthesis of feedback, strategy development, reporting, accessibility review, and accountability planning. We would begin by aligning with NE DHHS on project goals, decision-making structure, timeline, roles, deliverables, and communication expectations, including how the work will connect to Nebraska's current Olmstead vision, values, guiding principles, statutory requirements, and focus areas. We would then work with NE DHHS to identify stakeholders who need to be involved, select appropriate engagement pathways, recruit participants through accessible and culturally relevant methods, facilitate engagement opportunities, summarize input, and translate themes into plan goals, strategies, action steps, benchmarks, and timeframes. Our proposal provides a model for an approach, including regular meetings with the state designated point of contact/DHHS team, monthly progress reports, review of focus group guides and surveys, identification of relevant data sources, in-person and virtual focus groups, survey distribution, synthesis of findings, draft and final reports, public comment support, and accessible presentations. Our Minnesota Olmstead work provides an enhanced approach in which TAC and HSRI support a best/promising practices report, onboard policy consultants, prepare agency and Inclusion Consultant meetings, provide accessible materials and plain language resources, and help agency teams ensure that strategies are consistent with Olmstead, actionable, measurable, and aligned across agencies. For NE DHHS, all of the above would be tailored with immediate activities to include listening sessions, workshops, recruitment of consultants with lived experience, RFIs, written feedback opportunities,

ATTACHMENT A
Technical Requirements
RFP 125999 O3

Nebraska Olmstead Plan Evaluation

surveys, and agency interviews. Longer-term support could include co-creating plan goals and actions with community members, workshopping draft goals with advocacy organizations, building tailored feedback loops, and developing accountability structures for agencies responsible for fulfilling commitments and executing goals.

6. Describe the bidder's experience identifying systemic issues and developing inter-agency and statewide solutions.

TAC has substantial experience identifying systemic issues across disability service systems and developing statewide, inter-agency solutions. This experience aligns closely with Nebraska's Olmstead Plan, which recognizes that meaningful community integration depends on coordinated action across community supports, education, employment, housing, and transportation, rather than on any one program or agency alone. In North Carolina, our Olmstead planning work is organized around systemic priorities such as housing, crisis response, long-term community-based services and supports, workforce, data and quality assurance, employment, community transitions, and integrated health care. We examine these areas in systems terms: housing work focuses on aligning housing availability with supports that help people get and keep housing; crisis work focuses on diverting people from hospitals, jails, and other institutional settings; long-term services and supports focus on helping people remain in the community rather than investing primarily in institutional care; community transitions focus on services, benefits, housing, and care management needed to return people to the community; and whole person health focuses on access to quality physical and behavioral health care and coordination across systems. Our Minnesota work reinforced our view that Olmstead requires an all-of-government approach and that recommendations in one agency area, such as housing, must align with services discussed in other agency teams. TAC has facilitated multi-agency steering committees, subcommittees, subcommittees, and cross-agency teams with planning, financing, design, implementation, and evaluation responsibilities. TAC is also leading work in states through the federally-sponsored Housing and Services Partnership Accelerator, providing technical assistance to cross-agency teams from Medicaid, housing, aging, and disability sectors. In other states, we proposed engagement with state agencies responsible for operationalizing recommendations and coordination across agencies. For NE DHHS, we would use this experience to surface barriers such as funding, workforce, access, service coordination, transportation, housing availability, employment pathways, education transitions, and data limitations, and translate them into inter-agency strategies and statewide implementation actions.

7. Provide a narrative of the bidder's experience with creating documentation for disseminating results for a variety of audiences. This could include but is not limited to success stories, presentations, infographics, fact sheets, and health impact statements. Provide an example completed for previous work.

TAC has extensive experience creating documentation and communication products for multiple audiences, including presentations, stakeholder summaries, action reports, public announcements, surveys, feedback reports, implementation trackers, dashboards, technical reports, plain language reports, fact sheets, and accessible slide decks. For Nebraska, these products should reinforce the state's Olmstead vision and clearly communicate how the plan supports people with disabilities to live, learn, work, and enjoy life in the most integrated setting. In North Carolina, we developed public-facing materials explaining Olmstead, the purpose of the engagement process, proposed foundational principles, priority areas, breakout discussion prompts, next steps, and ways to stay involved through written feedback and survey participation. TAC's [Olmstead quarterly progress reports](#) (included in Appendix C) highlight progress on Olmstead strategies and actions. These are posted on the NC Olmstead website for public viewing. TAC also reports these findings in a PowerPoint presentation to the [NC Olmstead Plan Stakeholder Advisory committee](#). Additionally, our community engagement approach also includes accessible summaries, action reports, public announcements, and continuous feedback loops to report what was heard, how it was incorporated, and how stakeholders can stay informed.

TAC proposes an accessible final report, printed and electronic copies as requested by NE DHHS, and accessible plain language slide decks for presentations to state staff, partners, community organizations, and mixed audiences. In Minnesota, TAC and HSRI proposed producing both technical and plain language versions of a best/promising practices report, fully

ATTACHMENT A
Technical Requirements
RFP 125999 O3

Nebraska Olmstead Plan Evaluation

accessible and 508-compliant. TAC's communications team includes expertise in plain language editing and accessible document production, including WCAG/508-compliant reports, webinar decks, forms, and resources. For NE DHHS, we would tailor dissemination products to the needs of state agencies, providers, advocacy organizations, community members, people with lived experience, and other audiences while promoting transparency, accessibility, and accountability.

8. Describe bidder's experience with survey / assessment tool development and focus group design. The bidder may provide an example of previous work.

TAC has substantial experience developing surveys, assessment tools, focus group guides, and facilitated discussion processes for Olmstead planning, HCBS quality improvement, system assessment, and stakeholder engagement. In North Carolina, we used several sessions, opportunities for written feedback, a public survey, listening sessions, workshops, and facilitated breakout discussions. TAC's detailed survey approach included questions about strengths of community-based systems, gaps that increase risk of segregated settings, challenges for families, individuals, and providers, and priority actions to expand integrated community living ([Services for People with Disabilities in North Carolina](#)). Discussion guides were organized around priority areas and asked participants to identify the single most impactful change, what is working that should continue, what problem the change would solve, barriers to implementation, and who should lead the change. In Minnesota, TAC developed interview guides for key informants, facilitated meetings with Inclusion Consultants with lived experience and Olmstead subcabinet agencies, reviewed current goals and progress, and presented national best/promising practices to support goal development.

HSRI adds deep survey and assessment tool expertise through development and support of experience-of-care surveys, HCBS CAHPS, Minnesota HCBS access indicators, and qualitative data collection through focus groups and key informant interviews. HSRI's decades of survey and assessment tool development experience includes nearly three decades leading the development, implementation, and continuous refinement of the National Core Indicators® (NCI®) performance measurement system, which helps state agencies collect standardized data on service outcomes and system performance. More than 40 states participate in one or both National Core Indicators surveys (<https://www.nationalcoreindicators.org/>), including National Core Indicators Intellectual and Developmental Disabilities (NCI-IDD) and National Core Indicators Aging and Disabilities (NCI-AD). The NCI framework includes approximately 100 indicators spanning individual outcomes, family outcomes, system performance, health and safety, and costs, with data collected through standardized instruments such as in-person consumer interviews, family surveys, and provider surveys. The consumer interview, a cornerstone of NCI, is administered directly with people receiving services and has been refined over time to capture emerging priorities such as health and wellness, employment, self-direction, community inclusion, and person-centered outcomes among people with intellectual and developmental disabilities, older adults, and people with physical disabilities. HSRI has also designed and implemented state and community-level surveys, including a statewide multi-mode survey for the Massachusetts Commission for the Blind to identify the social and vocational needs of blind and visually impaired residents, and has designed tools to gather standardized process and output data. On a recent New Hampshire HCBS system assessment, HSRI also organized and facilitated focus groups in all counties in the state.

For NE DHHS, TAC will design tools and facilitation structures that elicit actionable qualitative and quantitative data, assess needs and gaps, identify implementation barriers, and support synthesis into plan priorities, strategies, and implementation recommendations. The tools developed will speak directly to Nebraska's plan priorities and lived-experience questions, including access to individualized community-based services and supports, safe and affordable accessible housing, services in the most integrated setting, competitive integrated employment, statewide transportation, data-driven accountability, and workforce capacity.

TAC's extensive experience planning and facilitating focus groups with people who use services and their family members includes developing focus group guides, conducting sessions both in person and virtually, and compensating people with lived experience who participate outside of a paid role. At the beginning of sessions, the team discusses the voluntary nature of participation, including that participants may skip questions, take breaks, or end participation at any time. Focus

ATTACHMENT A
Technical Requirements
RFP 125999 O3
Nebraska Olmstead Plan Evaluation

groups are facilitated by experienced staff with a second team member present to take notes.

In partnership with NE DHHS, TAC will confirm an approach that includes the appropriate number of in-person and/or virtual focus groups during the evaluation plan development as well as the recommendations review and decision process. (We propose two rounds of two In-person focus groups, 4-6 virtual sessions, and two interviews, as well as other feedback tools such as surveys). In all of these activities we will pay close attention to participation by rural, home-bound, and digitally engaged participants, and to the need for accessibility supports such as interpreters, captioning, and transportation.

Detailed Project Workplan

TAC brings direct historical understanding of Nebraska’s Olmstead work. TAC conducted the State’s 2021 evaluation, which identified early successes and opportunities for improvement, and we understand how Nebraska’s approach has evolved from the original plan and subsequent revisions into the current six-year plan. That history positions TAC to begin quickly, respect the progress already made, and support DHHS in producing an evaluation that is useful not only for legislative reporting, but also for continuous improvement, implementation support, and shared accountability across state agencies, advisory structures, advocates, and people with lived experience. This advanced knowledge, subject matter and Nebraska-specific expertise is reflected in the two-year timeline proposed below in **Figure 3**.

Figure 3: Proposed Project Workplan

(All proposed timelines assume a September 1, 2026 contract execution date)

Task & Timeline	Description
Project Kickoff Meeting, Establishment of DHHS Staff Coordination, Overall Project Management & Coordination	
Within two weeks of contract execution	Hold hybrid, in-person, and/or virtual kickoff meeting with DHHS; establish weekly meetings with DHHS Point of Contact.
Within one month of contract execution	Hold hybrid, in-person, and/or virtual kickoff meetings with representatives from other state agencies (i.e., Division of Medicaid and Long-Term Care, Division of Developmental Disabilities, Division of Behavioral Health, Nebraska Department of Education - Office of Special Education, Nebraska Vocational Rehabilitation, Aging and Disability Resource Centers, Nebraska Commission for the Deaf and Hard of Hearing, Department of Health and Human Services) impacted by the plan, and (if possible) identified community and organizational stakeholders as agreed upon by DHHS.
On an ongoing basis	Participate in monthly touch-base meetings with DHHS, to review progress, insights, product feedback and direction decisions.
Deliverable 1. Data Collection & Evaluation Plan	
Month 1 (September 2026)	- Meet with DHHS to determine existing data and collection mechanisms, existing indicators and any tools DHHS wants utilized or leveraged. - Solidify preferred method(s) of stakeholder engagement with DHHS. - Finalize list of stakeholders. - Draft preliminary data collection and evaluation plan.

Task & Timeline	Description
Month 2 - 3 (October 2026 & November)	• Finalize data collection and evaluation plan based on DHHS feedback (inclusive of stakeholder engagement plan). • Conduct initial scan of existing data/reports to review; discuss questions and clarifications with DHHS. • Draft and submit additional data requests.
Months 3 - 4 (November 2026 & December 2026)	• Coordinate with DHHS to schedule and communicate to stakeholders on interviews and focus groups (flyers, emails, registration, reminders, etc.) ○ Recruit/schedule participants (with accessibility considerations: interpreters, captioning, transportation) ○ Coordinate with DHHS to provide for accessibility needs • Draft and finalize survey and assessment tools with DHHS. • Review and analyze data and reports including program records and subrecipient reports (assumes receipt of existing and requested data by end of month 2).
Months 4 - 6 (December 2026 - February 2027)	• Conduct interviews and focus groups. ○ Conduct 2 in-person community focus groups ○ Conduct a minimum of 4-6 virtual focus groups, including at least 2 for disability community members only ○ Conduct at least 2 interviews (propose completing one in-person while onsite for focus groups and one virtually as agreed upon by DHHS) • Conduct targeted literature and national resource review, if required and agreed upon by DHHS. • Begin to draft findings from data analysis and stakeholder sessions.
Months 6 - 7 (February 2027 & March 2027)	• Analyze and incorporate information from interviews and focus groups. • Analyze and incorporate any relevant findings from the annual progress report due to the Legislature December 31, 2026. • Continue drafting findings from analysis. Incorporate national research if applicable.
Deliverable 2. Olmstead Plan Evaluation Report	
Months 6 - 7 (March 2027 & April 2027)	• Incorporate information and findings related to outcomes and performance measure monitoring and reporting. • Synthesize and analyze findings from research, data analysis, survey results, focus groups, and key state partner engagements.

Task & Timeline	Description
Months 7 - 8 (April 2027 & May 2027)	• Complete and provide draft Plan Evaluation Report to DHHS for consultation. • Collect and incorporate any revisions from DHHS into Olmstead Evaluation Report. • Develop an analysis of the strategic plan and a draft report on the progress of the strategic plan and recommend changes or revisions for the Legislature.
Months 8 - 10 (May 2027 - July 2027)	• In coordination with DHHS, share and socialize draft report with Olmstead advisory committee. • Finalize draft report and circulate summary to participants/stakeholders as determined by DHHS. This may include: ○ Conduct a large virtual meeting with all state agencies responsible for Olmstead implementation ○ Conduct virtual individual meetings with all of the above agencies ○ Compile findings of community and state agency engagements and circulate summary to participants • Coordinate with DHHS on preferred methods for draft distribution for public comment. • Establish mechanism for receipt and review of public comment.
By Month 15 (December 2027)	• Have final draft of 3-year Evaluation Plan report ready for submission to the Legislature by December 31, 2027.
Months 16 - 20 (January 2028 - May 2028)	• Update and finalize Evaluation Plan report to include any feedback or updates from the Legislature and/or committee review by May 1, 2028.
Deliverable 3. Communications Plan & Supporting Materials	
Months 8-10 (May 2027 - July 2027)	• Develop preliminary communication plan taking initial information and feedback into account. • Draft supporting materials to disseminate evaluation findings. <i>Note: Supporting materials will include success stories, presentations, infographics, fact sheets, and/or impact statements from interviews and focus groups</i>
Month 11 (August 2027)	• Revise draft report in response to public comment and submit to DHHS for final review.
Months 12 - 20 (September 2027 - May 2028)	• Create final report meeting all accessibility requirements. • Submit Final Report to DHHS electronically, along with 25 printed copies and 10 copies in Braille. • Develop accessible slide decks for presentations in plain language. • Facilitate up to 5 presentations of Final Report.

Task & Timeline	Description
Months 21 - 22 (June 2028 & July 2028)	Finalize Communications Plan and supporting materials based on DHHS review and approval by July 1, 2028.
As requested, ongoing	Provide presentations on the process and/or conduct additional meetings with agency teams and/or Stakeholder as determined by DHHS.
Deliverable 4. Olmstead Plan Revision Recommendation Draft Language	
Months 11 - 13 (August 2027 - October 2027)	- Present and review any recommended revisions and associated language updates resulting from evaluation plan findings to DHHS and the Olmstead advisory committee. - Provide TA on any risks, challenges, feasibility, and short-term and long-term considerations for proposed recommendations and revisions. <i>Note: This timeline aligns with legislative requirement to meet at least annually prior to October 1 and allows time for the 3-year evaluation plan to be finalized for next submission due date of December 31, 2027.</i>
Deliverable 5. Summary of TA & Final Recommendations for Plan Revisions	
Months 16 - 24 (January 2028 - August 2028)	- Schedule and facilitate TA meetings and record minutes as determined in collaboration with DHHS. - Incorporate any updates from Legislative review. - Hold additional round of interviews and focus group as agreed upon with DHHS utilizing the same format as previously outlined. - In collaboration with DHHS, finalize report and language changes to the State Olmstead Plan by August 31, 2028.

Deliverables & Due Dates

In order to ensure timely, high-quality deliverables, TAC proposes the following associated actions for achieving each of the five unique deliverables.

- First, TAC will develop a **Data Collection and Evaluation Plan** that defines evaluation questions, indicators, data sources, engagement methods, survey or assessment tools, analytic strategies, timelines, and roles. This plan will guide the collection and monitoring of evaluation indicators and provide a transparent structure for assessing plan implementation.
- Second, TAC will prepare an **Olmstead Plan Evaluation Report** that reviews program records and subrecipient reports, analyzes progress against outcomes and benchmarks, summarizes qualitative findings from interviews and focus groups, identifies successes and

barriers, and recommends changes or revisions for consideration by DHHS, the Olmstead Advisory Committee, and the Legislature.

The Evaluation Report will also acknowledge the statutory requirement for continuing analysis of the strategic plan and reporting to the Legislature every three years, including recommendations for changes or revisions. TAC will structure findings so they can be used by DHHS to meet these reporting expectations and by policymakers to understand progress, implementation barriers, and areas where legislative or administrative action may be warranted.

- Third, TAC will develop a **Communications Plan and Supporting Materials**, in consultation with and approval by DHHS, to help disseminate evaluation findings in accessible, understandable formats. These materials may include success stories, presentations, infographics, fact sheets, impact statements, and other products that communicate progress and next steps to varied audiences. The plan and materials will also contemplate the various intended audiences (e.g., legislature, providers, State agency partners, individuals) and various styles of adult learning and education to ensure understanding, invite feedback and input, and drive solutions and advancement of the Plan.
- Fourth, TAC will provide **draft language for Olmstead Plan revision recommendations**, supporting DHHS and the Advisory Committee as they consider refinements to plan structure, goals, outcomes, benchmarks, activities, or terminology.
- Fifth, TAC will submit a **Summary of TA and Final Recommendations for Plan Revisions**, including summaries of TA meetings, meeting minutes as appropriate, and final recommendations for structural or language changes to the State Olmstead Plan.

The proposed associated timeline for the completion of each deliverable is outlined in **Figure 4**. A more detailed workplan of tasks and activities is specified in the preceding proposal section, *Detailed Project Work Plan*.

Figure 4: Deliverables and Due Dates

Deliverable	Proposed Timeline (Completed by)	Key Considerations/Assumptions
Data Collection & Evaluation Plan	November 30, 2026 (Within 90 days of contract execution)	Completion assumes kick-off meeting and DHHS review occurs within one month of contract execution.
Olmstead Plan Evaluation Report	Preliminary Draft - May 31, 2027 Legislative Draft - December 31, 2027 Final Evaluation Report - May 1, 2028	Assumes all data requests are received by October 2026 and that interviews and focus groups are completed by February 2027. 3-year Evaluation Report due to the Legislature by December 31, 2027.

Deliverable	Proposed Timeline (Completed by)	Key Considerations/Assumptions
	Any Committee and public comment updates - Incorporated by end of November	
Communications Plan & Supporting Materials	Preliminary draft Communication Plan - July 31, 2027 Draft Supporting materials - September 30, 2027, and ongoing as required Final Communications Plan and supporting materials - July 1, 2028	Multiple iterations anticipated as stipulated in the detailed project plan to allow for feedback and updates from DHHS and various stakeholder groups.
Olmstead Plan revision recommendation draft language	Preliminary recommendations and proposed language updates - October 1, 2027 Final recommendations and draft language - August 2028	Aligns with legislative requirements for annual committee meeting on or before October 1.
Summary of TA & Final Recommendations for Plan Revisions	January 2028 - August 2028	



Appendix A - Financial Statements & Required Forms

Most recent audited financial statement

Banking reference

Certificate of Good Standing

Signed Original Contractual Agreement Form

II. Terms and Conditions

III. Vendor Duties with noted exceptions

IV. Payment



THE TECHNICAL ASSISTANCE COLLABORATIVE, INC

**FINANCIAL STATEMENTS IN ACCORDANCE
WITH GOVERNMENT AUDITING STANDARDS AND
THE UNIFORM GUIDANCE
JUNE 30, 2025 AND 2024**

The Technical Assistance Collaborative, Inc.

Contents
June 30, 2025 and 2024

	<u>Pages</u>
Unmodified Opinion on Financial Statements Accompanied by Supplementary Information - Not-For-Profit Entity	1 - 18
Financial Statements:	
Statements of Financial Position	2
Statements of Activities and Changes in Net Assets	3
Statements of Cash Flows	4
Statements of Functional Expenses	5
Notes to Financial Statements	6 - 14
Schedule of Expenditures of Federal Awards	15
Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With <i>Government Auditing Standards</i>	16 - 17
Report on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance Required by the Uniform Guidance	18 - 20
Schedule of Findings and Questioned Costs	21

**Unmodified Opinion on Financial Statements Accompanied by
Supplementary Information - Not-For-Profit Entity**

Independent Auditor's Report

To the Board of Directors of
The Technical Assistance Collaborative, Inc. :

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of The Technical Assistance Collaborative, Inc. (a Massachusetts nonprofit corporation) (TAC), which comprise the statement of financial position as of June 30, 2025, and the related statements of activities and changes in net assets, cash flows, and functional expenses for the year then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of The Technical Assistance Collaborative, Inc. as of June 30, 2025, and the changes in its net assets and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards (Government Auditing Standards)*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of TAC and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Other Matter – Prior Period Financial Statements

The financial statements of The Technical Assistance Collaborative, Inc. as of and for the year ended June 30, 2024, were audited by other auditors whose report dated January 31, 2025, expressed an unmodified opinion on those financial statements.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about TAC's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of TAC's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, which raise substantial doubt about TAC's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying Schedule of Expenditures of Federal Awards for the year ended June 30, 2025, as required by Title 2 U.S. Code of Federal Regulations (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, is presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the Schedule of Expenditures of Federal Awards is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated December 10, 2025, on our consideration of TAC's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of TAC's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering TAC's internal control over financial reporting and compliance.

AAFCPA, Inc.

Boston, Massachusetts
December 10, 2025

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.**Statements of Financial Position
June 30, 2025 and 2024**

Assets	2025	2024
Current Assets:		
Cash and cash equivalents	\$ 431,376	\$ 1,045,360
Contracts receivable	2,664,944	3,209,114
Prepaid expenses	126,821	91,678
Total current assets	<u>3,223,141</u>	<u>4,346,152</u>
Other Assets:		
Notes receivable	393,290	386,579
Investments	3,300,049	4,017,276
Security deposits	75,000	75,000
Right-of-use asset - operating	1,235,321	1,593,476
Total other assets	<u>5,003,660</u>	<u>6,072,331</u>
 Total assets	 <u>\$ 8,226,801</u>	 <u>\$ 10,418,483</u>
Liabilities and Net Assets		
Current Liabilities:		
Current portion of operating lease obligation	\$ 387,386	\$ 373,600
Accounts payable	805,052	950,777
Accrued expenses	335,210	767,268
Deferred revenue	136,273	1,404,158
Total current liabilities	<u>1,663,921</u>	<u>3,495,803</u>
 Operating lease obligation, net	 <u>957,920</u>	 <u>1,345,305</u>
Total liabilities	<u>2,621,841</u>	<u>4,841,108</u>
Net Assets:		
Without donor restrictions:		
Operating	5,469,566	5,559,961
Board designated funds	135,394	114
Total net assets without donor restrictions	<u>5,604,960</u>	<u>5,560,075</u>
 With donor restrictions	 -	 17,300
Total net assets	<u>5,604,960</u>	<u>5,577,375</u>
 Total liabilities and net assets	 <u>\$ 8,226,801</u>	 <u>\$ 10,418,483</u>

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.**Statements of Activities and Changes in Net Assets
For the Years Ended June 30, 2025 and 2024**

	2025	2024
Operating Revenue:		
Contracts	\$ 13,784,567	\$ 14,558,550
Grants	3,656,420	2,378,754
Appropriation of board designated net assets	141,493	254,791
Net assets released from program restrictions	17,300	-
Total operating revenue	17,599,780	17,192,095
Operating Expenses:		
Program services	12,837,189	12,406,856
Administration	4,915,764	4,755,199
Total operating expenses	17,752,953	17,162,055
Changes in net assets without donor restrictions from operations	(153,173)	30,040
Non-Operating Activities:		
Investment income, net	339,551	350,894
Appropriation of board designated net assets	(141,493)	(254,791)
Total non-operating activities	198,058	96,103
Changes in net assets without donor restrictions	44,885	126,143
Changes in Net Assets With Donor Restrictions:		
Net assets released from program restrictions	(17,300)	-
Changes in net assets with donor restrictions	(17,300)	-
Changes in net assets	27,585	126,143
Net Assets:		
Beginning of year	5,577,375	5,451,232
End of year	\$ 5,604,960	\$ 5,577,375

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

Statements of Cash Flows

For the Years Ended June 30, 2025 and 2024

	<u>2025</u>	<u>2024</u>
Cash Flows from Operating Activities:		
Changes in net assets	\$ 27,585	\$ 126,143
Adjustments to reconcile changes in net assets to net cash provided by (used in) operating activities:		
Amortization of right-of-use asset	358,155	356,679
Net realized and unrealized gain on investments	(212,305)	(262,218)
Reinvestment of interest income-impact fund	(6,711)	(10,175)
Changes in operating assets and liabilities:		
Contracts receivable	544,170	119,389
Prepaid expenses	(35,143)	(25,988)
Operating lease obligation	(373,599)	(364,658)
Accounts payable	(145,725)	265,832
Accrued expenses	(432,058)	153,003
Deferred revenue	(1,267,885)	539,558
Net cash provided by (used in) operating activities	<u>(1,543,516)</u>	<u>897,565</u>
Cash Flows from Investing Activities:		
Proceeds from sales of investments	2,649,393	3,411,074
Purchase of investments	(1,719,861)	(3,489,420)
Net cash provided by (used in) investing activities	<u>929,532</u>	<u>(78,346)</u>
Net Change in Cash and Cash Equivalents	<u>(613,984)</u>	<u>819,219</u>
Cash and Cash Equivalents:		
Beginning of year	<u>1,045,360</u>	<u>226,141</u>
End of year	<u>\$ 431,376</u>	<u>\$ 1,045,360</u>
Supplemental Disclosure of Non-Cash Transactions:		
Unrealized gains on investments	<u>\$ 212,305</u>	<u>\$ 148,935</u>

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

Statements of Functional Expenses
For the Years Ended June 30, 2025 and 2024

	2025			2024		
	Program Services	Adminis- tration	Total	Program Services	Adminis- tration	Total
Payroll and Related:						
Salaries	\$ 3,638,466	\$ 3,145,237	\$ 6,783,703	\$ 3,671,358	\$ 2,926,727	\$ 6,598,085
Payroll taxes and fringe benefits	1,203,437	758,541	1,961,978	1,066,935	740,222	1,807,157
Total payroll and related	4,841,903	3,903,778	8,745,681	4,738,293	3,666,949	8,405,242
Other:						
Consultants	5,257,857	55,034	5,312,891	5,233,796	13,162	5,246,958
Grant awards	2,120,324	-	2,120,324	1,972,948	-	1,972,948
Travel	348,156	81,600	429,756	350,687	146,549	497,236
Occupancy	-	381,543	381,543	-	381,828	381,828
Meetings and conferences	152,142	12,036	164,178	46,873	53,165	100,038
Telephone	17,646	118,060	135,706	16,628	80,456	97,084
Office supplies, events and postage	76,674	51,182	127,856	41,520	87,947	129,467
Professional fees	-	67,749	67,749	-	57,787	57,787
Donations	-	66,841	66,841	-	43,000	43,000
Repairs and maintenance	-	53,360	53,360	-	49,450	49,450
Insurance	-	40,489	40,489	-	52,390	52,390
Dues and subscriptions	5,236	27,427	32,663	4,785	44,900	49,685
Minor furniture and equipment	-	28,529	28,529	-	40,630	40,630
Miscellaneous	-	23,541	23,541	-	24,598	24,598
Printing	17,251	106	17,357	1,326	568	1,894
Advertising and recruitment	-	4,489	4,489	-	11,820	11,820
Total other	7,995,286	1,011,986	9,007,272	7,668,563	1,088,250	8,756,813
Total expenses	\$ 12,837,189	\$ 4,915,764	\$ 17,752,953	\$ 12,406,856	\$ 4,755,199	\$ 17,162,055

The accompanying notes are an integral part of these statements.

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

Notes to Financial Statements
June 30, 2025 and 2024

1. OPERATIONS AND NONPROFIT STATUS

The Technical Assistance Collaborative, Inc. (TAC) was incorporated in May 1992. TAC provides research, technical assistance, training and planning to national, state, and local governments and health, behavioral health, services, homeless, and affordable housing organizations throughout the United States. TAC focuses its work to advance housing and services solutions for those who have not been served by existing systems of care including veterans, the unhoused, people with disabilities, and unaccompanied youth.

TAC is exempt from Federal income taxes as an organization (not a private foundation) formed for charitable purposes under Section 501(c)(3) of the Internal Revenue Code (IRC). TAC is also exempt from state income taxes. Donors may deduct contributions made to TAC within the requirements of the IRC.

2. SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

TAC prepares its financial statements in accordance with generally accepted accounting standards and principles (U.S. GAAP) established by the Financial Accounting Standards Board (FASB). References to U.S. GAAP in these notes are to the FASB Accounting Standards Codification (ASC).

Cash and Cash Equivalents

For the purpose of the statements of cash flows, management considers all highly liquid investments with an initial maturity of three months or less to be cash and cash equivalents, except those funds that are included in TAC's investments (see Note 3).

Contracts Receivable and Allowance for Credit Losses

Contracts receivable are recorded at the invoiced amount, do not bear interest, and are due on demand. The need for an allowance for credit losses is assessed under Account Standards update (ASU) 2016-13, *Financial Instruments - Credit Losses (Topic 326)*. Topic 326 represents management's judgment of an estimated amount of lifetime expected losses that may be incurred on outstanding receivables at the statement of financial position date. This estimate, if any, is based on historical losses, an expectation of supportable future economic conditions, and payment performance of TAC's clients. There was no allowance for credit losses as of June 30, 2025 and 2024.

Notes Receivable and Allowance for Credit Losses

Notes receivable are presented at amortized cost basis net of an allowance for credit losses as of June 30, 2025 and 2024 (see Note 7).

The allowance for credit losses under Topic 326 represents management's judgment of an estimated amount of lifetime expected losses that may be incurred on outstanding notes at the statement of financial position date. This estimate is based on the risk characteristics of the loan, historical losses and defaults, an expectation of supportable future economic conditions, and payment performance of TAC's borrowers. The allowance is measured and recorded upon the initial recognition of a financial asset. The allowance is then reduced by charge-offs (net of recoveries of previous losses) and is increased and decreased by a provision (recovery) for credit losses, which is recorded as a current period expense (revenue). As of June 30, 2025 and 2024, TAC determined that no allowance for credit losses was deemed necessary (see Note 7).

2. SIGNIFICANT ACCOUNTING POLICIES (Continued)

Leases

TAC determines if an arrangement is a lease or contains a lease at inception of a contract. A contract is determined to be a lease or contain a lease if the contract conveys the right to control the use of identified property, plant or equipment (an identified asset) in exchange for consideration.

TAC determines such assets are leased because TAC has the right to obtain substantially all of the economic benefits from and the right to direct the use of the identified asset. Assets in which the supplier or lessor has the practical ability and right to substitute alternative assets for the identified asset and would benefit economically from the exercise of its right to substitute the asset are not considered to be or contain a lease because TAC determines it does not have the right to control and direct the use of the identified asset. TAC's lease agreements do not contain any material residual value guarantees or material restrictive covenants.

In evaluating its contracts, TAC separately identifies lease and non-lease components, such as common area and other maintenance costs, in calculating the right-of-use (ROU) assets and lease liabilities for its office buildings, apartments, equipment, and vehicles. TAC has elected the practical expedient to not separate lease and non-lease components and classifies the contract as a lease if consideration in the contract allocated to the lease component is greater than the consideration allocated to the non-lease component.

Leases result in the recognition of ROU assets and lease liabilities on the statements of financial position. ROU assets represent the right to use an underlying asset for the lease term, and lease liabilities represent the obligation to make lease payments arising from the lease, measured on a discounted basis. TAC determines lease classification as operating or finance at the lease commencement date.

At lease inception, the lease liability is measured at the present value of the lease payments over the lease term. The ROU asset equals the lease liability adjusted for any initial direct costs, prepaid or deferred rent, and lease incentives. TAC uses the implicit rate when readily determinable. As most of the leases do not provide an implicit rate, TAC uses the U.S. Department of the Treasury's risk-free rate based on the information available at the commencement date to determine the present value of lease payments.

The lease term may include options to extend or to terminate the lease that TAC is reasonably certain to exercise. Lease expense is generally recognized on a straight-line basis over the lease term.

TAC has elected not to record leases with an initial term of twelve months or less on the statements of financial position. Lease expense on such leases is recognized on a straight-line basis over the lease term.

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

Notes to Financial Statements
June 30, 2025 and 2024

2. SIGNIFICANT ACCOUNTING POLICIES (Continued)

Net Assets

Net assets without donor restrictions are those net resources that bear no external restrictions and are generally available for use by TAC. TAC has grouped its net assets without donor restrictions into the following categories:

- **Operating net assets** represent amounts relating to program and operating activities and are available for operations.
- **Board Designated net assets** represent funds that require prior Board approval to be spent. Beginning in fiscal year 2025, TAC's policy is to appropriate 4% of the average investment balance to be used in the following fiscal year for various administrative projects which are not funded through outside sources. At June 30, 2025, \$135,394 of net assets have been designated by the Board but not yet expended by TAC. During the years ended June 30, 2025 and 2024, investment income that was designated by the board of directors to be appropriated for operations totaled \$141,493 and \$254,800, respectively.

Net assets with donor restrictions consist of donations and grants that are designated by donors for specific purposes or for a specified time. These donations are recorded as net assets with donor restrictions until they are expended for their designated purposes or the time restrictions have lapsed. Net assets with donor restrictions were program restricted as of June 30, 2024. There were no net assets with donor restrictions as of June 30, 2025.

Revenue Recognition

Grants

In accordance with ASC Subtopic 958-605, *Revenue Recognition*, TAC must determine whether a contribution transaction (or a promise) is conditional or unconditional. A contribution is considered to be a conditional contribution if an agreement includes a barrier that must be overcome and either a right of return of assets or a right of release of a promise to transfer assets exists. Indicators of a barrier include a measurable performance-related barrier or other measurable barriers, a stipulation that limits discretion by the recipient on the conduct of an activity, and stipulations that are related to the purpose of the agreement. Topic 958 prescribes that TAC should not consider probability of compliance with the barrier when determining if such awards are conditional and should be reported as conditional grant advance liabilities until such conditions are met.

Contributions without donor restrictions are recorded as revenue when unconditionally received or pledged. Donor restricted contributions are recorded as revenue and net assets with donor restrictions when TAC receives a commitment. Net assets with donor restrictions are reclassified to net assets without donor restrictions as costs are incurred or time or program restrictions have lapsed. Donor restricted contributions whose restrictions are met in the year they are received are recorded as net assets without donor restrictions.

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

Notes to Financial Statements
June 30, 2025 and 2024

2. SIGNIFICANT ACCOUNTING POLICIES (Continued)

Revenue Recognition (Continued)

Contracts with Customers

A large portion of TAC's revenue and support are considered exchange transactions that are accounted for under ASC Topic 606.

TAC generally measures revenue for qualifying exchange transactions based on the amount of consideration TAC expects to be entitled for the transfer of goods or services to a customer, then recognizes this revenue when or as TAC satisfies its performance obligations under a contract, except in transactions where U.S. GAAP provides other applicable guidance. TAC evaluates its revenue contracts with customers based on the five-step model under ASC Topic 606: (1) Identify the contract with the customer; (2) Identify the performance obligations in the contract; (3) Determine the transaction price; (4) Allocate the transaction price to separate performance obligations; and (5) Recognize revenue when (or as) each performance obligation is satisfied.

TAC provides research and technical consulting services to Federal, governmental and non-profit agencies on an as-and-when needed basis. Each contract represents a performance obligation, for which related revenue is recognized at a point in time as services are performed.

Advance receipts of contract income are classified as deferred revenue until earned. The timing of revenue recognition, billings and cash collections results in billed accounts receivable. The deferred revenue balance as of July 1, 2023, was \$3,328,503.

The beginning and ending contract receivables were as follows:

	<u>July 1, 2023</u>	<u>June 30, 2024</u>	<u>June 30, 2025</u>
Receivables	<u>\$ 3,328,503</u>	<u>\$ 3,209,114</u>	<u>\$ 2,664,944</u>

Expense Allocation

The costs and expenses of TAC are summarized on a functional basis in the statement of activities and changes in net assets, program functions versus general and administrative functions. Program service expenses consist primarily of the cost of satisfying performance obligations under contracts and grants. The statement of functional expenses presents the natural classification detail of expenses by function.

Expenses related to a program or contract are charged directly to that program or contract, while other expenses that directly relate to the general operation of TAC are charged to general and administrative functions. Certain payroll and related expenses are allocated between programs and functions based on actual time reports or management's estimates of the percentage of the expense attributed to each program or supporting function.

Advertising Costs

TAC expenses advertising costs in the period the costs are incurred. There were no advertising costs during fiscal years 2025 or 2024.

2. SIGNIFICANT ACCOUNTING POLICIES (Continued)

Estimates

The preparation of financial statements in accordance with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Fair Value Measurements

TAC follows the accounting and disclosure standards pertaining to ASC Topic, *Fair Value Measurements*, for qualifying assets and liabilities. Fair value is defined as the price that TAC would receive upon selling an asset or pay to settle a liability in an orderly transaction between market participants.

TAC uses a framework for measuring fair value that includes a hierarchy that categorizes and prioritizes the sources used to measure and disclose fair value. This hierarchy is broken down into three levels based on inputs that market participants would use in valuing the financial instruments based on market data obtained from sources independent of TAC. Inputs refer broadly to the assumptions that market participants would use in pricing the financial instrument, including assumptions about risk. Inputs may be observable or unobservable. Observable inputs are inputs that reflect the assumptions market participants would use in pricing the financial instrument developed based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available. The three-tier hierarchy of inputs is summarized in the three broad levels as follows:

Level 1 - Inputs that reflect unadjusted quoted prices in active markets for identical assets at the measurement date.

Level 2 - Inputs other than quoted prices that are observable for the asset either directly or indirectly, including inputs in markets that are not considered to be active.

Level 3 - Inputs that are unobservable and which require significant judgment or estimation.

An asset or liability's level within the framework is based upon the lowest level of any input that is significant to the fair value measurement.

Investments

Investments are recorded in the financial statements at fair value. If an investment is directly held by TAC and an active market with quoted prices exists, the market price of an identical security is used to report fair value. Reported fair values of shares in mutual funds are based on share prices reported by the funds as of the last business day of the fiscal year.

All assets, including investments, are valued using level 1 inputs.

Income Taxes

TAC accounts for uncertainty in income taxes in accordance with ASC Topic, *Income Taxes*. This standard clarifies the accounting for uncertainty in tax positions and prescribes a recognition threshold and measurement attribute for the financial statements regarding a tax position taken or expected to be taken in a tax return. TAC has determined that there are no uncertain tax positions that qualify for either recognition or disclosure in the financial statements at June 30, 2025 and 2024. TAC's information returns are subject to examination by the Federal and state jurisdictions.

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

Notes to Financial Statements
June 30, 2025 and 2024

2. SIGNIFICANT ACCOUNTING POLICIES (Continued)

Statements of Activities and Changes in Net Assets

Transactions deemed by management to be ongoing, major, or central to the provision of program services are reported as operating revenues and operating expenses in the accompanying statements of activities and changes in net assets. Non-operating activities include investment activity.

Subsequent Events

Subsequent events have been evaluated through December 10, 2025, which is the date the financial statements were available to be issued. There were no events that met the criteria for recognition or disclosure in the financial statements.

3. INVESTMENTS

The following table presents investments at June 30, 2025 and 2024, that TAC measures fair value on a recurring basis, by level, within the fair value hierarchy:

	2025			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	\$ 18,065	\$ -	\$ -	\$ 18,065
Mutual Funds:				
Domestic large cap	1,367,947	-	-	1,367,947
Domestic fixed income securities	1,051,237	-	-	1,051,237
Domestic other	445,521	-	-	445,521
International equity securities	417,279	-	-	417,279
Total investments	\$ 3,300,049	\$ -	\$ -	\$ 3,300,049

	2024			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	\$ 468,974	\$ -	\$ -	\$ 468,974
Mutual Funds:				
Domestic large cap	1,413,696	-	-	1,413,696
Domestic fixed income securities	1,171,145	-	-	1,171,145
Domestic other	417,877	-	-	417,877
International equity securities	545,584	-	-	545,584
Total investments	\$ 4,017,276	\$ -	\$ -	\$ 4,017,276

4. LEASES

Operating Lease

TAC leases office space under an eight-year and four-month (100 month) agreement expiring in November of 2028. The lease agreement requires base monthly payments that commenced at approximately \$29,480 and escalate to approximately \$33,862 throughout the term of the lease. Additionally, TAC received a rent "holiday" for the first two months of the lease term, as well as in October of 2021 and November of 2022.

TAC's security deposit related to this space is \$75,000.

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

Notes to Financial Statements
June 30, 2025 and 2024

4. LEASES (Continued)

Operating Lease (Continued)

Future minimum payments under the office lease are as follows:

<u>Fiscal Year</u>	<u>Amount</u>
2026	\$ 387,386
2027	395,124
2028	403,027
2029	<u>169,310</u>
Total future undiscounted lease payments	1,354,847
Less - present value discount	9,541
Less - current portion	<u>387,386</u>
Operating lease liabilities, net	<u>\$ 957,920</u>

The discount rate imputed on the lease obligation was .40%, which represents the risk-free rate at the time of TAC's transition to ASC Topic 842 effective July 1, 2021. Required payments for TAC's proportionate share of real estate tax increases are not included in the record lease obligation and asset since they are variable payments that do not depend on a specified index or rate. They are recorded to expense as they are incurred.

Operating lease costs included in occupancy in the accompanying statements of functional expenses were \$372,300 and \$368,421 for the years ended June 30, 2025 and 2024, respectively.

Cash paid for amounts included in the measurement of operating lease liabilities was approximately \$379,800 and \$372,300 for the years ended June 30, 2025 and 2024, respectively.

5. RETIREMENT PLANS

Annually, TAC's Board of Directors elects to contribute an amount to a qualified retirement plan for its employees. For the years ended June 30, 2025 and 2024, the Board of Directors elected to contribute 10% of eligible compensation, resulting in contributions totaling approximately \$582,000 and \$510,000, respectively, which are included in payroll taxes and fringe benefits in the accompanying statements of functional expenses.

6. FUNDING AND CONCENTRATIONS

Credit Risks

TAC maintains its cash and cash equivalents in various banks in Massachusetts. At certain times during the year, the balance in some of the accounts exceeded the maximum amount of insurance provided by the Federal Deposit Insurance Corporation. TAC has not experienced any losses in such accounts. TAC believes it is not exposed to any significant credit risk in cash.

Funding and Concentrations

TAC receives significant funding under contracts with departments of the Federal government and state agencies. This funding is subject to audit by various governmental agencies. In the opinion of management, the results of such audits, if any, will not have a material effect on the financial position of TAC as of June 30, 2025 and 2024, or on the changes in net assets without donor restrictions for the years then ended.

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

Notes to Financial Statements
June 30, 2025 and 2024

6. FUNDING AND CONCENTRATIONS (Continued)

Funding and Concentrations (Continued)

TAC received approximately 46% and 60% of its total operating support and revenue from two and three agencies, respectively, under various contracts during the years ended June 30, 2025 and 2024, respectively.

Contracts receivable included approximately 36% and 39% of accounts receivable from two agencies as of June 30, 2025 and 2024, respectively.

During fiscal year 2025, certain Federal funding agencies experienced funding freezes. The extent to which the funding freeze impacts the state and local budgets that could impact TAC's operations, financial results, and cash flows, both current and future, depend on future developments, which are highly uncertain and cannot be predicted with any measure of certainty or probability.

7. NOTES RECEIVABLE-IMPACT FUND

TAC has two Impact Notes Receivable (\$250,000 and \$124,641) from the Enterprise Community Loan Fund, Inc., a not-for-profit 501(C)(3) corporation. The notes have interest rates of 2.0% and 3.5%, respectively, and they mature on May 26, 2026 and May 31, 2029, respectively. Interest on these notes is due annually on September 30, however TAC has elected to reinvest the annual interest payments that are received so the amounts are available for futures notes that are issued. The loan funds are intended to be used by the Enterprise Community Loan Fund, Inc. to deliver innovative financial products and technical assistance to mission-aligned organizations to acquire, develop, and preserve quality affordable housing for low and moderate-income families, and to revitalize their communities by providing access to good jobs, quality affordable housing, schools, transportation, and healthy-living environments. Repayment of the notes is dependent upon the Enterprise Community Loan Fund's financial condition and operations. Interest received and reinvested for the years ended June 30, 2025 and 2024, were \$6,711 and \$10,175, respectively.

Based on the lack of historical data available, under Topic 326, TAC has valued these individual notes at their anticipated net realizable value determined through a qualitative assessment of future forecasted repayments and other economic factors. As a result of this assessment performed, as of June 30, 2025 and 2024, TAC has determined that no allowance for credit losses was deemed necessary.

8. FINANCIAL ASSETS AND LIQUIDITY RESOURCES

Financial assets and liquidity resources available for general expenditure, that is, without donor or other restrictions limiting their use within one year of the date of the statement of financial position comprise the following at June 30:

	<u>2025</u>	<u>2024</u>
Financial Assets:		
Cash and equivalents	\$ 431,376	\$ 1,045,360
Contracts and grants receivable	<u>2,664,944</u>	<u>3,209,114</u>
Total financial assets available within one year	<u>\$ 3,096,320</u>	<u>\$ 4,254,474</u>

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

Notes to Financial Statements
June 30, 2025 and 2024

8. FINANCIAL ASSETS AND LIQUIDITY RESOURCES (Continued)

As part of TAC's liquidity management, TAC has a policy to structure its financial assets to be available as its general expenditures, liabilities, and other obligations become due. Additionally, in the event of an unanticipated liquidity need, TAC has investments available (see Note 3) of approximately \$3,300,000 and \$4,017,000 in which funds may be drawn at any time to fund operations. As of June 30, 2025 and 2024, the Agency had financial assets equal to approximately two and three months, respectively, of operating expenses.

9. RECLASSIFICATIONS

Certain amounts in the June 30, 2024 financial statements have been reclassified to conform with the June 30, 2025 presentation.

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

Schedule of Expenditures of Federal Awards
For the Year Ended June 30, 2025

Federal Grantor/ Pass-Through Grantor/ Program or Cluster Title	Assistance List Number	Pass-Through Entity Identifying Number	Federal Expenditures
U.S. Department of Housing and Urban Development:			
Direct Funding:			
Community Compass Technical Assistance and Capacity Building	14.259	N/A	\$ 3,736,062
U.S. Department of Veterans Affairs:			
Direct Funding:			
VA Supportive Services for Veteran Families Program	64.033	N/A	<u>4,347,402</u>
Total Expenditures of Federal Awards			<u><u>\$ 8,083,464</u></u>

Note 1. **Basis of Presentation**

The accompanying Schedule of Expenditures of Federal Awards includes the Federal assistance activity of TAC and is presented on the accrual basis of accounting. The information in this schedule is presented in accordance with the requirements of Title 2 U.S. Code of Federal Regulations (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*.

Indirect Cost Rate

Note 2. TAC has elected not to use the 10% de minimis cost rate for its Federal programs.

**Report on Internal Control Over Financial Reporting and on Compliance and Other Matters
Based on an Audit of Financial Statements Performed in Accordance
With Government Auditing Standards**

Independent Auditor's Report

To the Board of Directors of
The Technical Assistance Collaborative, Inc.:

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of The Technical Assistance Collaborative, Inc. (TAC), which comprise the statement of financial position as of June 30, 2025, and the related statements of activities and changes in net assets, cash flows and functional expenses for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated December 10, 2025.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered TAC's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of TAC's internal control. Accordingly, we do not express an opinion on the effectiveness of TAC's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of TAC's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether TAC's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of TAC's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering TAC's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

AAFCPA, Inc.

Boston, Massachusetts
December 10, 2025

**Report on Compliance for Each Major Federal Program and Report on Internal Control
Over Compliance Required by the Uniform Guidance**

Independent Auditor's Report

To the Board of Directors of
The Technical Assistance Collaborative, Inc.:

Report on Compliance for Each Major Federal Program

Opinion on Each Major Federal Program

We have audited The Technical Assistance Collaborative, Inc. (TAC) compliance with the types of compliance requirements identified as subject to audit in the *OMB Compliance Supplement* that could have a direct and material effect on TAC's major Federal program for the year ended June 30, 2025. TAC's major Federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

In our opinion, TAC complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major Federal program for the year ended June 30, 2025.

Basis for Opinion on Each Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*); and the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of TAC and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for the major Federal program. Our audit does not provide a legal determination of TAC's compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred on the previous page and for the design, implementation and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules, and provisions of contracts or grant agreements applicable to TAC's Federal program.

Auditor's Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to on the previous page occurred, whether due to fraud or error, and express an opinion on TAC's compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to on the previous page is considered material if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about TAC's compliance with the requirements of the major Federal program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding TAC's compliance with the compliance requirements referred to on the previous page and performing such other procedures as we considered necessary in the circumstances.
- Obtain an understanding of TAC's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of TAC's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Report on Internal Control Over Compliance

A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a Federal program on a timely basis. *A material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a Federal program will not be prevented, or detected and corrected, on a timely basis. *A significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a Federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the Auditor's Responsibilities for the Audit of Compliance section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance. Given these limitations, during our audit we did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, material weaknesses or significant deficiencies in internal control over compliance may exist that were not identified.

Report on Internal Control Over Compliance (Continued)

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

AAFCPA, Inc.

Boston, Massachusetts
December 10, 2025

THE TECHNICAL ASSISTANCE COLLABORATIVE, INC.

Schedule of Findings and Questioned Costs
June 30, 2025

1. SUMMARY OF AUDITOR'S RESULTS

Financial Statements

Type of auditor's report issued on whether the financial statements audited were prepared in accordance with U.S. GAAP: Unmodified

Is a "going concern" emphasis-of-matter paragraph included in the auditor's report? _____ Yes X No

Internal control over financial reporting:

- Material weakness(es) disclosed? _____ Yes X No
- Significant deficiency(ies) disclosed? _____ Yes X None Reported

Noncompliance material to financial statements disclosed? _____ Yes X No

Federal Awards

Internal control over the major Federal program:

- Material weakness(es) disclosed? _____ Yes X No
- Significant deficiency(ies) disclosed? _____ Yes X None Reported

Type of auditor's report issued on compliance for the major Federal program: Unmodified

Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)? _____ Yes X No

Identification of the major Federal program:

<u>Name of Federal Program or Cluster</u>	<u>Assistance Listing Number</u>
Community Compass Technical Assistance and Capacity Building	14.259

Dollar threshold used to distinguish between Type A and Type B programs: \$750,000

Auditee qualified as low-risk auditee? _____ Yes X No

2. FINANCIAL STATEMENT FINDINGS

None

3. FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

None



Housing and services strategies *that work for people.*

Vendor Information:

Vendor Name: Technical Assistance Collaborative, Inc.

Remittance Address: 15 Court Square, 11th Floor

Remittance City: Boston State: MA Zip Code: 02108

Contact Name: John Abbott Phone #: 617-266-5657

E-Mail Address: jabbott@tacinc.org

Banking Information:

Vendor's Bank Name: Bank of America

Bank Address: PO Box 25118

Bank's City: Tampa State: FL Zip Code: 33622

Bank Contact Name: Walter Cerros Phone #: 508-217-3025

ABA Routing #: 011000138 Account #: 466013945453

9 characters

17 characters

Account Type
(please check only one)

Checking ☒ Savings ☐

Account Classification
(please check only one)

Business (CTX) ☐ Personal (PPD) ☐ Business (CCD) ☒

15 COURT SQUARE
11th FLOOR
BOSTON, MA 02108

TEL/TTY 617 226 5657
FAX 617 266 4343
WEB www.tacinc.org

STATE OF NEBRASKA

United States of America, } ss.
State of Nebraska }

Secretary of State
State Capitol
Lincoln, Nebraska

I, Robert B. Evnen, Secretary of State of the
State of Nebraska, do hereby certify that

TECHNICAL ASSISTANCE COLLABORATIVE, INC.

a Massachusetts corporation is authorized to transact business in Nebraska;

**that all fees, taxes, and penalties owed to Nebraska wherein payment is
reflected in the records of the Secretary of State and to which nonpayment
affects the good standing of the corporation have been paid;**

**that its most recent biennial report required by section 21-19,172 has been
delivered to the Secretary of State;**

that a Certificate of Withdrawal has not been filed.

*This certificate is not to be construed as an endorsement,
recommendation, or notice of approval of the entity's financial
condition or business activities and practices.*

In Testimony Whereof,



I have hereunto set my hand and
affixed the Great Seal of the
State of Nebraska on this date of

July 7, 2026

A handwritten signature in black ink, appearing to read "Robert B. Evnen".

Secretary of State

CONTRACTUAL AGREEMENT FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Contractual Agreement Form, the bidder guarantees compliance with the provisions stated in this solicitation and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder is not owned by the Chinese Communist Party.

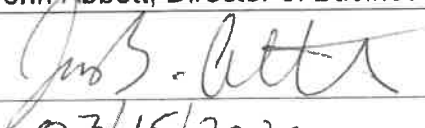
Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603, DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Vendors. This information is for statistical purposes only and will not be considered for contract award purposes.

____ NEBRASKA VENDOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Vendor. "Nebraska Vendor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this Solicitation. All vendors who are not a Nebraska Vendor are considered Foreign Vendors under Neb. Rev Stat § 73-603 (c).

____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. § 71-8611 and wish to have preference considered in the award of this contract.

THIS FORM MUST BE SIGNED MANUALLY IN INK OR BY DOCUSIGN

COMPANY:	Techical Assistance Collaborative, Inc
ADDRESS:	15 Court Sq, 11th Floor, Boston, MA 02108
PHONE:	617-266-5657
EMAIL:	jabbott@tacinc.org
BIDDER NAME & TITLE:	John Abbott, Director of Business Operations
SIGNATURE:	
DATE:	07/15/2026

VENDOR COMMUNICATION WITH THE STATE CONTACT INFORMATION (IF DIFFERENT FROM ABOVE)

NAME:	
TITLE:	
PHONE:	
EMAIL:	

II. TERMS AND CONDITIONS

Bidder should read the Terms and Conditions within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Terms and Conditions Within Section as Written" in the table below. If exception is not taken to a provision, it is deemed accepted as stated. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Terms and Conditions Within Section as Written (Initial)	Exceptions Taken to Terms and Conditions Within Section as Written (Initial)	Exceptions: (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
		N/A

The bidders should submit with their solicitation response any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the solicitation response as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award has been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one (1) Party has a particular clause, then that clause shall control,
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together,
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

1. The contract resulting from this Solicitation shall incorporate the following documents:
 - a. Solicitation, including any attachments and addenda;
 - b. Questions and Answers;
 - c. Bidder's properly submitted solicitation response, including any terms and conditions or agreements submitted by the bidder;
 - d. Addendum to Contract Award (if applicable); and
 - e. Amendments to the Contract. (if applicable)

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) Executed Contract and any attached Addenda 3) Addendums to the solicitation and any Questions and Answers, 4) the original solicitation document and any Addenda or attachments, and 5) the Vendor's submitted solicitation response, including any terms and conditions or agreements that are accepted by the State.

Unless otherwise specifically agreed to in writing by the State, the State's standard terms and conditions, as executed by the State, shall always control over any terms and conditions or agreements submitted or included by the Vendor.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Bidder and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered personally; electronically, return receipt requested; or mailed, return receipt requested. All notices, requests, or communications shall be deemed effective upon receipt.

Either party may change its address for notification purposes by giving notice of the change and setting forth the new address and an effective date.

C. BUYER'S REPRESENTATIVE

The State reserves the right to appoint a Buyer's Representative to manage or assist the Buyer in managing the contract on behalf of the State. The Buyer's Representative will be appointed in writing, and the appointment document will specify the extent of the Buyer's Representative authority and responsibilities. If a Buyer's Representative is appointed, the bidder will be provided a copy of the appointment document and is expected to cooperate accordingly with the Buyer's Representative. The Buyer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the contract.

D. GOVERNING LAW (Nonnegotiable)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. BEGINNING OF WORK & SUSPENSION OF SERVICES

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Vendor. The Vendor will be notified in writing when work may begin.

The State may, at any time and without advance notice, require the Vendor to suspend any or all performance or deliverables provided under this Contract. In the event of such suspension, the Contract Manager or POC, or their designee, will issue a written order to stop work. The written order will specify which activities are to be immediately suspended and the reason(s) for the suspension. Upon receipt of such order, the Vendor shall immediately comply with its terms and take all necessary steps to mitigate and eliminate the incurrence of costs allocable to the work affected by the order during the period of suspension. The suspended performance or deliverables may only resume when the State provides the Vendor with written notice that such performance or deliverables may resume, in whole or in part.

F. AMENDMENT

This Contract may be amended in writing, within scope, upon the agreement of both parties.

G. CHANGE ORDERS OR SUBSTITUTIONS

The State and the Vendor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Vendor may not claim forfeiture of the contract by reasons of such changes.

The Vendor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Vendor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Vendor's solicitation response, were foreseeable, or result from difficulties with or failure of the Vendor's solicitation response or performance.

No change shall be implemented by the Vendor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

In the event any good or service is discontinued or replaced upon mutual consent during the contract period or prior to delivery, the State reserves the right to amend the contract to include the alternate product at the same price.

*****Vendor will not substitute any item that has been awarded without prior written approval of DHHS*****

H. RECORD OF VENDOR PERFORMANCE

The State may document the vendor's performance, which may include, but is not limited to, the customer service provided by the vendor, the ability of the vendor, the skill of the vendor, and any instance(s) of products or services delivered or performed which fail to meet the terms of the purchase order, contract, and/or specifications. In addition to other remedies and options available to the State, the State may issue one or more notices to the vendor outlining any issues the State has regarding the vendor's performance for a specific contract ("Contract Compliance Request"). The State may also document the Vendor's performance in a report, which may or may not be provided to the vendor ("Contract Non-Compliance Notice"). The Vendor shall respond to any Contract Compliance Request or Contract Non-Compliance Notice in accordance with such notice or request. At the sole discretion of the State, such Contract Compliance Requests and Contract Non-Compliance Notices may be placed in the State's records regarding the vendor and may be considered by the State and held against the vendor in any future contract or award opportunity. The record of vendor performance will be considered in any suspension or debarment action.

I. NOTICE OF POTENTIAL VENDOR BREACH

If Vendor breaches the contract or anticipates breaching the contract, the Vendor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

J. BREACH

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by email, delivery receipt requested; certified mail, return receipt requested; or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time.

The State's failure to make payment shall not be a breach, and the Vendor shall retain all available statutory remedies.

K. NON-WAIVER OF BREACH

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

L. SEVERABILITY

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

M. INDEMNIFICATION

1. GENERAL

The Vendor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and

expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Vendor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Vendor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. **INTELLECTUAL PROPERTY**

The Vendor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Vendor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Vendor prompt notice in writing of the claim. The Vendor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Vendor has indemnified the State, the Vendor shall, at the Vendor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Vendor, and the State may receive the remedies provided under this Solicitation.

3. **PERSONNEL**

The Vendor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Vendor.

4. **SELF-INSURANCE**

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01. If there is a presumed loss under the provisions of this agreement, Vendor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,239.01 to 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Neb. Rev. Stat. § 81-8,294), Tort (Neb. Rev. Stat. § 81-8,209), and Contract Claim Acts (Neb. Rev. Stat. § 81-8,302), as outlined in state law and accepts liability under this agreement only to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

N. ATTORNEY'S FEES

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if ordered by the court, including attorney's fees and costs, if the other Party prevails.

O. ASSIGNMENT, SALE, OR MERGER

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Vendor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Vendor's business. Vendor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Vendor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

P. CONTRACTING WITH OTHER NEBRASKA POLITICAL SUBDIVISIONS OF THE STATE OR ANOTHER STATE

The Vendor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. § 81-145(2), to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

The Vendor may, but shall not be required to, allow other states, agencies or divisions of other states, or political subdivisions of other states to use this contract. The terms and conditions, including price, of this contract shall apply to any such contract, but may be amended upon mutual consent of the Parties. The State of Nebraska shall not be contractually or otherwise obligated or liable under any contract entered into pursuant to this clause. The State shall be notified if a contract is executed based upon this contract.

Q. FORCE MAJEURE

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event") that was not foreseeable at the time the Contract was executed. The Party so affected shall immediately make a written request for relief to the other Party and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

R. COMPLIANCE WITH PRESIDENTIAL EXECUTIVE ORDERS 14151 AND 14173

Executive Order 14151, issued by President Donald Trump on January 20, 2025, and Executive Order 14173, issued by President Donald Trump on January 21, 2025, prohibit discriminatory "diversity, equity, and inclusion" (DEI) programs and "diversity, equity, inclusion, and accessibility" (DEIA) mandates, policies, programs, preferences, and activities in the federal government. If the Contract involves federal funds, Contractor shall not use contract funds for any DEI program or for any DEIA mandate, policy, program, or preference. Contractor shall assure its compliance and the compliance of any subcontractors with all requirements of Executive orders 14151 and 14173.

S. CONFIDENTIALITY

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than \$5,000.

T. EARLY TERMINATION

The contract may be terminated as follows:

1. The State and the Vendor, by mutual written agreement, may terminate the contract, in whole or in part, at any time.
2. The State, in its sole discretion, may terminate the contract, in whole or in part, for any reason upon thirty (30) calendar day's written notice shall be delivered by email, delivery receipt requested; certified mail, return receipt requested; or in person with proof of delivery to the Vendor. Such termination shall not relieve the Vendor of warranty or other service obligations incurred under the terms of the contract. In the event of termination, the Vendor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.
3. The State may terminate the contract, in whole or in part, immediately for the following reasons:
 - a. if directed to do so by statute,
 - b. Vendor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business,
 - c. a trustee or receiver of the Vendor or of any substantial part of the Vendor's assets has been appointed by a court,
 - d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Vendor, its employees, officers, directors, or shareholders,
 - e. an involuntary proceeding has been commenced by any Party against the Vendor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Vendor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Vendor has been decreed or adjudged a debtor,
 - f. a voluntary petition has been filed by the Vendor under any of the chapters of Title 11 of the United States Code,
 - g. Vendor intentionally discloses confidential information,
 - h. Vendor has or announces it will discontinue support of the deliverable; and,

- i. In the event funding is no longer available.

U. CONTRACT CLOSEOUT

Upon termination of the contract for any reason the Vendor shall within thirty (30) days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State,
2. Transfer ownership and title to all completed or partially completed deliverables to the State,
3. Return to the State all information and data unless the Vendor is permitted to keep the information or data by contract or rule of law. Vendor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Vendor's routine back up procedures,
4. Cooperate with any successor Vendor, person, or entity in the assumption of any or all of the obligations of this contract,
5. Cooperate with any successor Vendor, person, or entity with the transfer of information or data related to this contract,
6. Return or vacate any state owned real or personal property; and,
7. Return all data in a mutually acceptable format and manner.

Nothing in this section should be construed to require the Vendor to surrender intellectual property, real or personal property, or information or data owned by the Vendor for which the State has no legal claim.

V. AMERICANS WITH DISABILITIES ACT

Vendor shall comply with all applicable provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12131–12134), as amended by the ADA Amendments Act of 2008 (ADA Amendments Act) (Pub.L. 110–325, 122 Stat. 3553 (2008)), which prohibits discrimination on the basis of disability by public entities.

W. LONG-TERM CARE OMBUDSMAN (Nonnegotiable)

Vendor must comply with the Long-Term Care Ombudsman Act, per Neb. Rev. Stat. § 81-2237 et seq. This section shall survive the termination of this contract.

X. OFFICE OF PUBLIC COUNSEL (Nonnegotiable)

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Vendor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. § 81-8,240 et seq. This section shall survive the termination of this contract.

Y. LOBBYING

1. No federal or state funds paid under this RFP shall be paid for any lobbying costs as set forth herein.
2. Lobbying Prohibited by 31 U.S.C. § 1352 and 45 CFR §§ 93 et seq, and Required Disclosures.
 - a. Contractor certifies that no federal or state appropriated funds shall be paid, by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this award for: (a) the awarding of any federal agreement; (b) the making of any federal grant; (c) the entering into of any cooperative agreement; and (d) the extension, continuation, renewal, amendment, or modification of any federal agreement, grant, loan, or cooperative agreement.
 - b. If any funds, other than federal appropriated funds, have been paid or will be paid to any person for influencing or attempting to influence: an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with Contractor, Contractor shall complete and submit Federal Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
3. Lobbying Activities Prohibited under Federal Appropriations Bills.
 - a. No funds paid under this RFP shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation of the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any state or local government itself.

- b. No funds paid under this RFP shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than normal and recognized executive legislative relationships or participation by an agency or officer of an State, local or tribal government in policymaking and administrative processes within the executive branch of that government.
 - c. The prohibitions in the two sections immediately above shall include any activity to advocate or promote any proposed, pending, or future federal, state or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.
- 4. **Lobbying Costs Unallowable Under the Cost Principles.** In addition to the above, no funds shall be paid for executive lobbying costs as set forth in 45 CFR § 75.450(b). If Contractor is a nonprofit organization or an Institute of Higher Education, other costs of lobbying are also unallowable as set forth in 45 CFR § 75.450(c).

III. VENDOR DUTIES

Bidder should read the Vendor Duties within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Vendor Duties Within Section as Written" in the table below. If exception is not taken to a provision, it is deemed accepted as stated. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Vendor Duties Within Section as Written (Initial)	Exceptions Taken to Vendor Duties Within Section as Written (Initial)	Exceptions: (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
		TAC proposes reduced insurance requirements in Section J due to the nature of the services proposed to be performed under this Scope of Work. Specifically TAC requests a reduction/elimination of the insurance requirements relating to: Medical Payments - Reduction to \$5,000 coverage per occurrence Damage to Rented Premises - Reduction to \$100,000 coverage per occurrence Abuse & Molestation Coverage - Elimination Umbrella/Excess Liability - Elimination (TAC's current General Liability is \$1,000,000 over the requirement) Cyber Liability - Reduction to \$1,000,000 coverage Commercial Crime - Reduction to \$400,000

A. INDEPENDENT VENDOR / OBLIGATIONS

It is agreed that the Vendor is an independent Vendor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Vendor is solely responsible for fulfilling the contract. The Vendor or the Vendor's representative shall be the sole point of contact regarding all contractual matters.

The Vendor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Vendor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the bidder's solicitation response shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Vendor to the contract shall be employees of the Vendor or a subcontractor and shall be fully qualified to perform the work required herein. Personnel employed by the Vendor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Vendor or the subcontractor respectively.

With respect to its employees, the Vendor agrees to be solely responsible for the following:

1. Any and all pay, benefits, employment taxes and/or other payroll withholding,
2. Any and all vehicles used by the Vendor's employees, including all insurance required by state law,
3. Damages incurred by Vendor's employees within the scope of their duties under the contract,
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law,
5. Determining the hours to be worked and the duties to be performed by the Vendor's employees; and,
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Vendor, its officers, agents, or subcontractors or subcontractor's employees).

If the Vendor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the solicitation response. The Vendor shall agree that it will not utilize any subcontractors not specifically included in its solicitation response in the performance of the contract without the prior written authorization of the State. If the Vendor subcontracts any of the work, the Vendor agrees to pay any and all subcontractors in accordance with the Vendor's agreement with the respective subcontractor(s).

The State reserves the right to require the Vendor to reassign or remove from the project any Vendor or subcontractor employee.

Vendor shall ensure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Vendor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

B. FOREIGN ADVERSARY CONTRACTING PROHIBITION ACT CERTIFICATION (Nonnegotiable)

The Vendor certifies that it is not a scrutinized company as defined under the Foreign Adversary Contracting Prohibition Act, Neb. Rev. Stat. Sec. § 73-903 (5); that it will not subcontract with any scrutinized company for any aspect of performance of the contemplated contract; and that any products or services to be provided do not originate with a scrutinized company.

C. EMPLOYEE WORK ELIGIBILITY STATUS

The Vendor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Vendor is an individual or sole proprietorship, the following applies:

1. The Vendor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at <https://das.nebraska.gov/materiel/docs/pdf/Individual%20or%20Sole%20Proprietor%20United%20States%20Attestation%20Form%20English%20and%20Spanish.pdf>
2. The completed United States Attestation Form should be submitted with the Solicitation response.
3. If the Vendor indicates on such attestation form that he or she is a qualified alien, the Vendor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Vendor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
4. The Vendor understands and agrees that lawful presence in the United States is required, and the Vendor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. § 4-108.

D. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Nonnegotiable)

The Vendor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Vendors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Vendor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Vendor shall insert a similar provision in all Subcontracts for goods and services to be covered by any contract resulting from this Solicitation.

E. COOPERATION WITH OTHER VENDORS

Vendor may be required to work with or in close proximity to other Vendors or individuals that may be working on same or different projects. The Vendor shall agree to cooperate with such other Vendors or individuals and shall not commit or permit any act which may interfere with the performance of work by any other Vendor or individual. Vendor is not required to compromise Vendor's intellectual property or proprietary information unless expressly required to do so by this contract.

F. DISCOUNTS

Prices quoted shall be inclusive of ALL trade discounts. Cash discount terms of less than thirty (30) days will not be considered as part of the solicitation response. Cash discount periods will be computed from the date of receipt of a properly executed claim voucher or the date of completion of delivery of all items in a satisfactory condition, whichever is later.

G. PRICES

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the Solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Fixed Price Contract All prices, costs, and terms and conditions submitted in the solicitation response shall remain fixed and valid commencing on the opening date of the solicitation until the contract terminates or expires.

DHHS reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

DHHS will be given full proportionate benefit of any decreases for the term of the contract.

H. PERMITS, REGULATIONS, LAWS

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Vendor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Vendor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

I. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Vendor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Vendor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

J. INSURANCE REQUIREMENTS

The Vendor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Vendor shall not commence work on the contract until the insurance is in place. If Vendor subcontracts any portion of the Contract the Vendor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor,
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Vendor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Vendor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Vendor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Vendor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within four (4) year of termination or expiration of the contract, the Vendor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and four (4) year following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Vendor elects to increase the mandatory deductible amount, the Vendor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

1. WORKERS' COMPENSATION INSURANCE

The Vendor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Vendor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter.** The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

The Vendor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Vendor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Vendor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Vendors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	\$2,000,000
Products/Completed Operations Aggregate	\$2,000,000
Personal/Advertising Injury	\$1,000,000 per occurrence
Bodily Injury/Property Damage	\$1,000,000 per occurrence
Medical Payments	\$10,000 any one person
Damage to Rented Premises (Fire)	\$300,000 each occurrence
Contractual	Included
XCU Liability (Explosion, Collapse, and Underground Damage)	Included
Independent Vendors	Included
Abuse & Molestation	Included
<i>If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.</i>	
WORKER'S COMPENSATION	
Employers Liability Limits	\$500K/\$500K/\$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	\$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	\$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
All Other Professional Liability (Errors & Omissions)	\$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	\$1,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	\$5,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

3. **EVIDENCE OF COVERAGE**

The Vendor shall furnish the Contract Manager, via email, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

125999 03

Department of Health and Human Services
Attn: Angellica Shasteen, Procurement Contracts Officer
301 Centennial Mall South, 5th Floor
Lincoln, NE 68509
dhhs.rfpquestions@nebraska.gov

These certificates or the cover sheet shall reference the solicitation number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Vendor to maintain such insurance, then the Vendor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

4. **DEVIATIONS**

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Vendor.

K. ANTITRUST

The Vendor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

L. CONFLICT OF INTEREST

By submitting a solicitation response, vendor certifies that no relationship exists between the vendor and any person or entity which either is, or gives the appearance of, a conflict of interest related to this solicitation or project.

Vendor further certifies that vendor will not employ any individual known by vendor to have a conflict of interest nor shall vendor take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

If there is an actual or perceived conflict of interest, vendor shall provide with its solicitation response a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall solicitation response evaluation.

M. ADVERTISING

The Vendor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its goods or services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

N. DISASTER RECOVERY/BACK UP PLAN

The Vendor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue delivery of goods and services as specified under the specifications in the contract in the event of a disaster.

O. DRUG POLICY

Vendor certifies it maintains a drug free workplace environment to ensure worker safety and workplace integrity. Vendor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

P. WARRANTY

Despite any clause to the contrary, the Vendor represents and warrants that its services hereunder shall be performed by competent personnel and shall be of professional quality consistent with generally accepted industry standards for the performance of such services and shall comply in all respects with the requirements of this Agreement. For any breach of this warranty, the Vendor shall, for a period of ninety (90) days from performance of the service, perform the services again, at no cost to the State, or if Vendor is unable to perform the services as warranted, Vendor shall reimburse the State all fees paid to Vendor for the unsatisfactory services. The rights and remedies of the parties under this warranty are in addition to any other rights and remedies of the parties provided by law or equity, including, without limitation actual damages, and, as applicable and awarded under the law, to a prevailing party, reasonable attorneys' fees and costs.

Q. TIME IS OF THE ESSENCE

Time is of the essence with respect to Vendor's performance and deliverables pursuant to this Contract.

IV. PAYMENT

Bidder should read the Payment clauses within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Payment clauses Within Section as Written" in the table below. If exception is not taken to a provision, it is deemed accepted as stated. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Payment Clauses Within Section as Written (Initial)	Exceptions Taken to Payment Clauses Within Section as Written (Initial)	Exceptions: (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
		N/A

A. PROHIBITION AGAINST ADVANCE PAYMENT (Nonnegotiable)

Neb. Rev. Stat. § 81-2403 states "[n]o goods or services shall be deemed to be received by an agency until all such goods or services are completely delivered and finally accepted by the agency" The standard term is to pay after deliverables and that any alteration of that standard term should be carefully considered and used only when absolutely necessary to accommodate certain critical exceptions, i.e. insurance premiums, etc. that must be paid in advance.)

Pursuant to Neb. Rev. Stat. § 81-2403, "[n]o goods or services shall be deemed to be received by an agency until all such goods or services are completely delivered and finally accepted by the agency."

B. TAXES (Nonnegotiable)

The State is not required to pay taxes and assumes no such liability as a result of this Solicitation. The Vendor may request a copy of the Nebraska Department of Revenue, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, Form 13 for their records. Any property tax payable on the Vendor's equipment which may be installed in a state-owned facility is the responsibility of the Vendor.

C. INVOICES

Invoices for payments must be submitted by the Vendor to the agency requesting the services with sufficient detail to support payment.

Invoices shall be submitted to: DHHS
Nebraska Division of Developmental Disabilities
Attn: Policy Administrator II
301 Centennial Mall South, 4th Floor
Lincoln, NE 68509-2529

The terms and conditions included in the Vendor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been

previously agreed to by the State as an amendment to the contract. The State shall have forty-five (45) calendar days to pay after a valid and accurate invoice is received by the State.

D. INSPECTION AND APPROVAL

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

E. PAYMENT (Nonnegotiable)

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. § 81-2403). The State may require the Vendor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any goods and services provided by the Vendor prior to the Effective Date of the contract, and the Vendor hereby waives any claim or cause of action for any such goods or services.

F. LATE PAYMENT (Nonnegotiable)

The Vendor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §§ 81-2401 through 81-2408).

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS (Nonnegotiable)

The State's obligation to pay amounts due on the Contract for fiscal years following the current fiscal year is contingent upon legislative or federal appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Vendor reasonable written notice prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Vendor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Vendor be paid for a loss of anticipated profit.

H. RIGHT TO AUDIT (First Paragraph is Nonnegotiable)

The State shall have the right to audit the Vendor's performance of this contract upon a thirty (30) days' written notice. Vendor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. (Neb. Rev. Stat. § 84-304 et seq.) The State may audit, and the Vendor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Vendor shall make the Information available to the State at Vendor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Vendor so elects, the Vendor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Vendor be required to create or maintain documents not kept in the ordinary course of Vendor's business operations, nor will Vendor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to Vendor.

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one percent (1%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Vendor, the Vendor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety (90) days of written notice of the claim. The Vendor agrees to correct any material weaknesses or conditions found as a result of the audit.

Appendix B - TAC Staff & Subcontractor Resumes

TAC

Rebecca Boss, M.A.

Shawn Thiele Sacks, M.S.W., L.C.S.W.

Lisa Sloane, M.P.A.

Laura Conrad, M.S.W.

Megan Lee, L.P.C.

Amy Horton

Sara Burke

Jeff Nguyen, M.A.

HSRI

Bevin Croft, M.P.P., Ph.D.

Rachel Gerber, M.P.H.

Kristin Battis, M.P.H.

Independent

Virginia Selleck, Ph.D.

Kelly Nye-Lengerman, Ph.D., M.S.W.

Rebecca Boss, M.A.

Senior Consultant

Ms. Boss is a nationally recognized leader in behavioral health care and developmental disabilities services, with special expertise in addiction and recovery solutions. Ms. Boss currently chairs the Board of Directors for Rhode Island Communities for Recovery Efforts, a nonprofit dedicated to advancing recovery through advocacy, community, and service.

Technical Assistance Collaborative, Inc. (Boston, MA)

Senior Consultant (2021 – Present)

Leads and manages consultation and technical assistance (TA) on policy and best practices in service delivery systems for persons with mental illnesses, substance use disorders (SUDs), and other disabilities with a range of clients, including federal, state, and local government, national associations, philanthropy, and other stakeholders.

Recent Projects

- Directed creation of a best practice report for Olmstead implementation in Minnesota. Coordinates and provides direct support to state agencies and inclusion consultants who co-created the state's Olmstead Plan.
- Provides TA on the North Carolina Olmstead Plan; facilitates broad-based stakeholder input and develops quarterly progress reports.
- Contributed to the development of a report on MA Olmstead Plan progress.
- Provided subject matter expertise to state leaders participating in a National Academy for State Health Policy behavioral health integration collaborative.
- Directed project to analyze State Peer Certification Alignment with the U.S. Substance Abuse and Mental Health Administration's (SAMHSA) National Model Certification Standards in support of the Peer Recovery Center of Excellence.
- Provided leadership and oversight of a project to design a Boston (MA) recovery campus for individuals with SUDs experiencing homelessness.
- Supported the state of NJ to develop a treatment model designed to meet the needs of older adults experiencing homelessness and living with SUDs.
- Provided TA to a Bipartisan Policy Center youth mental health task force.

Other Professional Experience

Georgetown University (Washington, D.C.)

2022 – 2023

Adjunct Faculty

Instructor of "Healthcare Financing" for the graduate program in Addiction Policy and Practice, Summer sessions 2022 and 2023.

Rebecca Boss, M.A., Senior Consultant

Skills & Expertise

- Olmstead Plan development & implementation
- Cross-systems collaborative approaches in state/local government
- Federal, state, & local strategies to address the opioid crisis
- Opioid treatment programs & MOUD
- Peer recovery support systems
- Integrating SUD focus into behavioral health services & health care

Education

- M.A. / 1993
(Counseling & Educational Psychology)
Rhode Island College
- B.A. / 1985
(Psychology)
U. of Rhode Island



CODAC Behavioral Healthcare, Inc. (Rhode Island)**2020 – 2021***Chief Operating Officer & Vice President of Strategic Development*

- Responsible for strategic development and programming; developed a consulting center with national scope, served as liaison for community partners and the board of directors, ensured continued financial viability of operational units, and provided national consultation and TA.
- Coordinated and implemented effort to address COVID-19 impact on service provision.
- Finalized contract to provide medication-assisted treatment induction at state's behavioral health crisis triage center.
- Established process for incorporation of employee surveys in practice improvement strategies to increase retention.
- Improved communication processes at executive leadership level and program leads.
- Facilitated process for acquisition and implementation of new electronic medical records system.
- Connected organization with measurement-based care platform.

Rhode Island Department of Healthcare, Developmental Disabilities & Hospitals**2016 – 2020***Acting Director / Director*

- Served on the governor's cabinet within the Executive Office of Health and Human Services.
- Collaborated with federal and state partners, led 1,200 employees, managed a \$500 million budget.
- Successfully managed requirements of Department of Justice Consent Decree and Interim Settlement Agreement by increasing competitive, integrated employment opportunities for individuals with disabilities and expanding community-based day services.
- Oversaw RI providers for Behavioral Healthcare and Developmental Disabilities system.
- Acted as Governing Body for Eleanor Slater Hospital.
- Co-chaired the governor's Overdose Prevention and Intervention Task Force.
- Served on the reentry committee for Department of Corrections.
- Executive Board Member for National Association of State Alcohol and Drug Abuse Directors.
- Created statewide 24/7 behavioral health crisis triage center, hotline, and mobile crisis service system.
- Testified on the opioid crisis before the U.S. House Subcommittee on Oversight and Investigations and the U.S. Senate Committee on Health, Education, Labor & Pensions.

Rhode Island Department of Healthcare, Developmental Disabilities & Hospitals**2004 – 2016***Deputy Director / Administrator of Behavioral Healthcare Services*

- Managed comprehensive statewide systems of substance abuse prevention and the promotion of mental health; treatment services for SUDs and mental illness; and recovery support activities.
- Training advisor for RI Council of Community Mental Health Organizations, the New England Addiction Technology Transfer Center, and the New England Institute of Addiction Studies.
- Responsible for licensing and monitoring of all behavioral health care providers.
- Developed the AnchorED program, peers responding to overdose survivors in the Emergency Department.
- Developed Integrated Health Homes program to enhance community-based care for individuals with serious mental illness.
- Developed and implemented RI Opioid Treatment Provider Health Home, integrating physical health care coordination in all Rhode Island licensed methadone treatment facilities.
- Developed Centers of Excellence to improve access to MAT as part of Governor's strategic plan to address the opioid overdose epidemic.

Honors & Awards

- Natasha Love Visionary Recognition Award / 2019
- National Association of State Alcohol and Drug Abuse Directors (NASADAD) Service Award / 2018
- Advocate Award for outstanding support of the Tune In & Tune Up RI Musicians Health Awareness Program / 2018
- Karen Rosene Montella Spark Award for Innovation in Women's Health / 2016
- National Treatment Network Representative of the Year / 2016
- President's Award for Exceptional Leadership, Focus, & Dedication, Rhode Island Council on Alcoholism & other Drug Dependence / 2009

Publications

Boss R., Campbell, N., Capoccia, V., Croze, C., Saubers, T., & Young, T. (2024). States' alignment with SAMHSA Model Standards for peer support certification: Current progress & future directions. Peer Recovery Center of Excellence. University of Missouri – Kansas City

Capoccia,V., Boss, R., Croze, C., Campbell, N., Gulley, J., Viera, A., Murphy, Z., Krom, L., Burke, S.(2024). States' investment in recovery support services: An exploratory analysis. *Journal of Substance Use and Addiction Treatment*, Volume 162.

Boss, R., Chalk, M., Conrad, L., Croze, C., Polk, L. (2023). *Transforming the Role of Opioid Treatment Programs: Opportunities, Considerations, and Choices in a Time of Crisis*. Boston, MA: Technical Assistance Collaborative

Peer Recovery Center of Excellence. (2023). *Optimizing Recovery Funding*. Peer Recovery Center of Excellence, University of Missouri – Kansas City

Sadwith, T., Hockenberry, S., O'Brien, J., Boss, R., Wood, L., Locke, J. *State Efforts to Improve the Continuum of Care for Substance Use Disorder and Opioid Use Disorder: A Case Study of Lessons Learned from NGA's Substance Use Disorder Collaborative in Six States*. Washington, DC: National Governors Association, Mar 2022

Gulley, J., Arienti, F., Boss, R., Woodsby, A., & Wachino, V. (2021). *Mobile crisis teams: A state planning guide for Medicaid-financed crisis response services*. Boston, MA: Technical Assistance Collaborative

Boss, R., Daly, B., & Sadwith, T. (2020). *Addressing substance use in behavioral health crisis care: A companion resource to the SAMHSA Crisis Toolkit*. Alexandria, VA: National Association of State Mental Health Program Directors

References

- 1) Aisha Elmquist, Minnesota Olmstead Implementation Office (formerly), 400 Wabasha St N Unit 400, St Paul, MN 55102, aisha.elmquist@gmail.com, (612) 405-4153
- 2) Deb Goda, North Carolina Department of Health and Human Services, 1915 Health Services Way Raleigh, NC 27607, deborah.goda@dhhs.nc.gov, (919) 855-4800
- 3) Linn Torto, Massachusetts Executive Office of Health and Human Services (formerly), 1 Ashburton Pl 11th floor, Boston, MA 02108, linn.torto@gmail.com, (617) 974-4366

Shawn Thiele Sacks, M.S.W., L.C.S.W.

Director, Human Services Practice Area

Ms. Thiele Sacks has over 30 years of experience in all aspects of behavioral health service provision and management, including grassroots prevention, community mental health and substance use counseling, programmatic development and leadership in community mental health agencies, managed care, national business development, and 12 years of government and Medicaid health care consulting.

Technical Assistance Collaborative, Inc. (Boston, MA)

Senior Director, Behavioral Health & Medicaid (2026 – Present)

Provides high-level guidance and oversight on TA and consulting projects, helping to assess client consultative needs; developing operational, budget, and staffing approaches; and ensuring effective project management, high-quality deliverables, and client satisfaction.

Recent Projects

- Engaging Medicaid, behavioral health, and other cross-system partners to improve coordination with homeless and housing resources in Connecticut and leveraging of Assertive Community Treatment (ACT) and Community Support Program (CSP) services to promote housing stability and recovery.
- Assisting with process and strategy development/implementation of fidelity and quality reviews of ACT service delivery.
- Supporting HUD 811 Supportive Housing Program for Persons with Disabilities program TA through planning and development of service delivery Community of Practice sessions.
- Supporting Washington with management and implementation of supportive housing and supported employment services in the state's Medicaid 1115 Waiver Demonstration.
- Lending internal subject matter expertise and guidance on federal *Olmstead* policy developments and Medicaid work requirements.

Other Professional Experience

Mercer (National)

2016 – 2026

Principal

- Client management and strategy as the primary liaison, leading routine client engagements, and developing tailored strategies for public-sponsored health and welfare programs.
- Assisted state and local public-sector agencies with designing, implementing, and evaluating mental health and substance use disorder programs.
- Assisted with program development by designing behavioral health programs/systems, developing clinical practice guidelines, designing and overseeing managed care operations, and implementing evidence-based practices.
- Provided TA on state and federal rules for Medicaid and behavioral health reform.

Skills & Expertise

Services & systems for complex mental health for children, youth & families, & adults
Medicaid & behavioral health care systems & regulations

- Evidence-based practice implementation & fidelity monitoring
- Cross-system design & oversight with child welfare, long-term care, corrections, & juvenile justice
- Managed care operations & compliance

Education

- M.S.W./1998 (Dual concentration in clinical & macro)
Michigan State University, East Lansing, MI
- B.A./1996 (Psychology)
Oakland University, Rochester, MI

Shawn Thiele Sacks, M.S.W., L.C.S.W., Director, Human Services Practice Area



- Assisted with quality management by conducting clinical quality reviews, analyzing clinical performance, and identifying areas for improvement.
- Provided procurement and evaluation TA by drafting requests for proposals, provider network analysis and development, and assessing service outcomes.
- Stakeholder engagement (planning, facilitation and results drafting) by collaborating with state officials, providers, advocates, and other managed care initiatives.
- Project leadership and oversight including project scoping, workplan and budget development and management, coaching, and training junior staff and overall team and deliverable management.
- Research, analysis, and report drafting to support compliance with and implementation of federal regulations, system of care design and implementation, clinical quality, and fidelity.
- Development and delivery of public-facing materials such as training, bulletins, policies, manuals, and papers. Conference attendance and presentations.
- Designed a strategic planning project for Housing Consumer Education Centers and prepared program recommendations for fiscal year 2023.

Magellan Health Services (Phoenix, AZ)

2008 – 2016

Vice President, Public Sector Business Development/Innovations (2014–2016); Deputy CEO (2011–2014); Chief, Child & Youth Services (2008–2011)

As VP, Public Sector Business Development/Innovations:

- Public sector strategy including but not limited to aligning clinical and operations with improved health outcomes, individual experience, lower costs, and health equity.
- Relationship management, including engagement with state and local government partners in order to provide behavioral health services in Medicaid and for specialized populations.
- Managing operational requirements to ensure compliance with federal and state level requirements for areas such as Medicaid, legislative action, and managed care operation.
- Service expansion via implementation initiatives related to recovery-oriented care, prevention, social determinants of health, peer services, and clinical evidence-based practice.
- As Deputy CEO:
 - Maintained strategic focus on customer long-term needs, Magellan's role in fulfilling those needs and maintaining and expanding Magellan services (e.g., renewal strategies).
 - Provided high-level consultation to customers, and negotiated customer expectations. Maintained in-depth knowledge of customer and the state, including all reporting requirements in contract.
 - Proactively developed and maintained strong relationships and contacts within the client organization, including maintaining day-to-day interface with Magellan's main point of contact(s); understood all key decisions makers within the client organization; anticipated and resolved potential problems.
 - In collaboration with the CEO, performed market research and analysis to support the development of effective growth strategies for Magellan of Arizona. Translated business/operational decisions into marketing plans. Led the development, communication, and implementation of effective growth strategies and process with a focus on cost-effective, high-quality care.
 - Oversaw compliance to ensure the company adhered to standards of federal, state, AHCCCS, ADHS, and contractual requirements. Provided management, guidance, and direction to the Chief Compliance Officer and Compliance team to develop and activate action plans to ensure continuous quality improvement in the area of compliance.
 - Led the development of provider and stakeholder meeting presentations. Represented the CEO at various meetings as designated.

As Chief, Child & Youth Services:

- Responsible for clinical, fiscal, and political strategy development, implementation, and oversight as part of the Executive Team. Built and maintained relationships in government, behavioral health, and diverse communities.
- Worked to strengthen and implement community-based treatment in Maricopa County.
- Day-to-day supervision, oversight, and management of the Child & Youth System of Care (SoC), Transitioning Services for Youth/Young Adults, Peer and Family Involvement, and Prevention System.
- Responsible for the oversight of tracking, analyzing, and monitoring the network sufficiency and capacity in conjunction with contracts and network.
- Reviewed and monitored operational data (UM, claims/encounters, provider financials, and quality performance indicators) in conjunction with clinical outcomes data to drive system functionality.
- Worked collaboratively with all operational areas of QI/QM, contracts, claims, provider liaisons, customer service, and utilization management to ensure a high-quality, cost-effective delivery management system.
- Oversaw work with Court Monitor Liaison RE: JK. Assisted the Ombudsperson in responding to communications from community members and family advocates relating to the children's SoC.
- Provided monitoring and guidance to children's PNOs and providers.
- Provided guidance, technical assistance and support to the providers and families in the implementation of the SoC Plan.
- Provided oversight and direction of the Quality Management processes, including the Practice Review.
- Provided technical leadership and support for the continued quality improvement of outpatient services delivered by the PNOs and all out of home placements in residential treatment centers, inpatient facilities, group homes, and HCTC placements.

The Hathaway Sycamores (Pasadena, CA)

2002 – 2008

Vice President: Wraparound, System of Care, Full-Service Partnership, Youth/Family Resource Support and Assistant Vice President: Wraparound, System of Care, Residential Wraparound (2004–2008); Program Director (2002–2004)

Southwest Counseling & Development Services (Detroit, MI)

1998 – 2002

Program Supervisor (2000–2002); Resource Coordinator (1998–2000)

Licensures & Certifications

- State of Michigan, LCSW No. 6801079886, Exp. 06/10/2029
- Lean Six Sigma Green Belt

References

- 1) Michael Aiello, Deputy Director II, 455 Winding Brook Drive, Glastonbury, CT 06033, Michael.Aiello@jud.ct.gov, (860) 368-3869
- 2) Laura Nelson, MD, Arizona Health Care Cost Containment System (AHCCCS), Previous Department of Mental Health (Retired), 50 N. 18th Ave., Phoenix, AZ 85007, dlauranel@aol.com, (208) 510-7567
- 3) Fatmata Williams, MPH, MSN, PMHNP-BC, Connecticut Department of Social Services, Deputy Medicaid Director, 55 Farmington Ave. Hartford, CT 06105 Fatmata.williams@ct.gov, (413) 237-2536

Lisa Sloane, M.A.

Senior Consultant

Ms. Sloane (she, her, hers) has 40 years of experience working in the development, management, and oversight of affordable housing for vulnerable populations including persons with disabilities and homeless individuals and families. She is an expert in the coordination of housing and human services programs.

Technical Assistance Collaborative, Inc. (Boston, MA)

Senior Consultant (2026- Present); Director (2021 – Present); Senior Policy Advisor (2011 – 2021); Senior Associate (2004 – 2011)

Leads and manages consultation and TA on policy and best practices in solutions to homelessness and institutionalization of people with disabilities with a range of clients, including federal, state, and local government, national associations, philanthropy, and other stakeholders.

Recent Projects

- Project manager for development of supportive housing plans for VA, OR, and MD; supports implementation of VA's plan through regional agencies.
- Project Manager for MA *Olmstead* Plan update, working with state housing and services agencies.
- Coach for federal Housing and Services Partnership Accelerator.
- Staffs Consortium for Citizens with Disabilities Housing Task Force.
- Leads TAC's *Priced Out* publication series.
- Coach/project manager for U.S. Department of Housing and Urban Development (HUD) Section 811 Project Rental Assistance (PRA) TA.
- Assisted HUD in the development of [strategies](#) to preserve existing Section 811 capital advance/PRA contract projects.
- Coached OR, VA, and ND for Centers for Medicare and Medicaid Services (CMS) Innovation Accelerator Program promoting community integration through long-term services and supports.
- Supported Money Follows the Person (MFP) housing training and TA.
- Project Manager for supportive housing implementation with the Louisiana Housing Authority.
- Co-led TAC's Housing and Healthy Communities Learning Network, working with 8 hospitals to support affordable housing planning efforts.

Skills & Expertise

- TA to state housing & human services agencies
- Consultation & program assessment on affordable housing & supportive housing
- State strategic planning for vulnerable populations
- Policy development in support of integrated housing & choice
- Training on implementing affordable housing programs for homeless families/ individuals

Education

- M.A. / 1987 (Public Administration)
Harvard U., John F. Kennedy School of Government, Cambridge, MA
- B.A. / 1982 (Psychology & Social Relations)
Harvard/Radcliffe College, Cambridge, MA

Other Professional Experience

Sloane Associates (Boston, MA)

1990 – 2004

Principal

As sole proprietor of a successful housing consulting firm, acted as interim Executive Director for two Housing Authorities; assisted numerous Housing Authorities with monitoring and compliance; and developed/implemented housing programs/policies for the Massachusetts Rehabilitation Commission.

City of Somerville, MA

1989 – 1990

Director of Housing

Responsible for oversight of Community Development Block Grant funded housing rehabilitation programs as well as housing policy for a city of 70,000 people.

Massachusetts Executive Office of Communities & Development

1987 – 1989

Program Representative / Asset Manager

Responsible for state oversight of over 20 Housing Authorities including annual budget review, monitoring, and troubleshooting.

Elder Cooperative Housing Options, Inc.

1982 – 1985

Assistant Director

Responsible for co-leading operations of this small nonprofit housing development agency.

Recent Publications

Schaak, G., Sloane, L., Arienti, F., Zovistoski, A. (2017). *Priced Out: The Housing Crisis for People with Disabilities*. Boston, MA: Technical Assistance Collaborative Inc. and Consortium for Citizens with Disabilities Housing Task Force.

Sloane, L., Stewart, L., Martone, M. (2024) *Special Purpose Voucher Programs for People With Disabilities: How They've Evolved, What We've Learned, and Where We're Headed* Cityscape: A Journal of Policy Development and Research • Volume 26, Number 2

References

- 1) Linn Torto, Massachusetts Executive Office of Health and Human Services (formerly), 1 Ashburton Pl 11th floor, Boston, MA 02108, linn.torto@gmail.com, (617) 974-4366
- 2) Aisha Elmquist, Minnesota Olmstead Implementation Office (formerly), 400 Wabasha St N Unit 400, St Paul, MN 55102, aisha.elmquist@gmail.com, (612) 405-4153
- 3) Lena Brown, MassHealth Housing, Homelessness, and Health Policy Team, 1 Ashburton Place Boston, MA 02108-1518, Lena.r.brown@mass.gov, (857) 867-1502.

Laura Conrad, M.S.W.

Senior Consultant

Ms. Conrad is a behavioral health care leader with 20+ years of experience in government administration and special expertise in child-serving systems. She has experience in behavioral health policy and service design, development, and implementation, with extensive experience in Medicaid authority and financing with contract and project management.

Technical Assistance Collaborative, Inc. (Boston, MA)

Senior Consultant (2022 – Present)

Leads and manages consultation and technical assistance on policy and best practices in service delivery systems for persons with mental illnesses, substance use disorders, and other disabilities with a range of clients, including federal, state, and local government, national associations, philanthropy, and other stakeholders.

Recent Projects

- Provided subject matter expertise for Minnesota's recent Olmstead Plan update on education and child welfare system issues and best practices.
- Provides TA, consulting and policy support to the Washington State Health Care Authority on implementation of Medicaid 1115 supportive housing and supported employment services for people with disabilities.
- Delivered TA and coaching to states participating in the HUD-HHS [Housing and Services Partnership Accelerator](#) on implementation of Medicaid-funded housing-related services and cross-system partnerships.
- Project director for TAC's work in VT to develop a Medicaid Permanent Supportive Housing (PSH) Assistance program for the VT Agency of Human Services; project lead for developing operational materials and provider training for the new program.
- Provides subject matter expertise to support federal policy proposals that address youth mental health and addiction challenges.
- Assists states on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) children's behavioral health service delivery efforts.
- Supports the Massachusetts Children's Behavioral Health Initiative with subject matter expertise in coaching, training, and workforce initiatives.
- Project lead for a statewide behavioral health crisis/911 diversion system evaluation, preparing two legislative reports with recommendations to support crisis work and 911 diversion with law enforcement.
- Directed TAC's work with the Commonwealth Fund to produce a learning series on incorporating Medicaid & best practices to prevent and resolve behavioral health crises for children and adolescents.
- Directs TAC's work to produce guidance on incorporating Medicaid and best practices to improve behavioral health supports in schools.
- Informs and supports review of statewide home modification programs to identify improvement opportunities.

Laura Conrad, M.S.W., Senior Consultant

Skills and Expertise

- Behavioral health policy & service design, development, & implementation
- Children's behavioral health continuum incl. System of Care
- EPSDT litigation response
- Medicaid authority & financing in behavioral health & public sector managed care
- Utilizing Medicaid to cover housing-related services & supports
- Government administration, incl. Medicaid behavioral health & child welfare

Education

- M.S.W. / 1999 (Macro concentration, with a Human Services Management Certificate) Boston U.
- B.S. / 1995 (Liberal Studies) California State Long Beach



Other Professional Experience

Commonwealth of Massachusetts — MassHealth

2010 – 2022

Senior Program Manager CBHI/ABA/EI; Interim Court Compliance Officer for Rosie D. v. Romney

- Supported the delivery of child and family mental health and SUD services to MassHealth members through a variety of programs and contract management of Managed Care Entities.
- Responsible for the policy, program development, implementation, and oversight of Children's Behavioral Health Initiative services in response to federal EPSDT) lawsuit.
- Oversaw implementation of Applied Behavioral Analysis (ABA) for MassHealth (approx. \$140 million of services annually), including the development of program specifications, medical necessity criteria, obtaining Medicaid authority, and standard practices across managed care entities.
- Served as liaison to the Center for Health Information and Analysis for CBHI/ABA rate development.
- Collaborated with MassHealth units, the Executive Office of Health and Human Services, Department of Children and Families, Department of Youth Services, and other state and community stakeholders regarding the policies, procedures, operations, and implementation of child, youth, and family services.

Massachusetts Department of Children & Families

1999 – 2010

Residential Program Planner / Contract Manager (2000 – 2010); Emergency Response Worker (2001 – 2003); Foster Care Recruitment Coordinator (2000); Public Affairs Associate (1999 – 2000)

- Held overall responsibility for managing contracted residential/group home and contracted foster care services, including contract and budget negotiations for congregate care and support and stabilization.
- Planned and coordinated quality assurance for programs; provided TA to area and regional staff; acted as liaison with DCF clients, residential providers, lead care coordination agencies, and state agencies.
- Oversaw and implemented an IT system for group care providers and DCF staff.
- Oversaw and managed placement process for complex youth, including youth with behavioral health needs, justice involved and intellectual and developmental delays.
- Coordinated and conducted periodic site visits to congregate care level programs and developed & implemented review tools for support and stabilization services.
- Investigated emergency allegations of neglect and abuse during after-hours.

Honors & Awards

Commonwealth of Massachusetts 2022 Governors Outstanding Performance Award (as a member of the Children's Behavioral Health Initiative)

Autism Insurance Resource Center 2017 Champion Award

Commonwealth of Massachusetts 2012 Governors Outstanding Performance Award

Publications

Arienti, F., Sloane, L., Conrad, L., Gulley, J. (2025). *Scaling Medicaid-Funded Tenancy Sustaining Services in Affordable & Supportive Housing*. Washington, DC: Housing & Services Resource Center.

Boss, R., Chalk, M., Conrad, L., Croze, C., Polk, L. (2023). *Transforming the Role of Opioid Treatment Programs: Opportunities, Considerations, and Choices in a Time of Crisis*. Boston, MA: Technical Assistance Collaborative

Conrad, L. (2023, December 7). <https://www.commonwealthfund.org/blog/2023/expanding-services-meet-growing-needs-young-people-autism-spectrum-disorder> Expanding Services to Meet the Growing Needs of Young People with Autism Spectrum Disorder *To the Point (blog)*, The Commonwealth Fund.

Conrad, L., Lee, M., & Okolo, Z. (2024, April 10). [Using Medicaid to address young people's mental health needs in school settings](#) *To the Point* (blog). The Commonwealth Fund

Bipartisan Policy Center, Youth Mental Health and Substance Use Task Force: *Early Action for Youth and Mental health and Substance Use: Prevention, Identification and Support*, April 2025. Available at <https://bipartisanpolicy.org/report/early-action-for-youth-mental-health-substance-use-prevention-identification-support/>

Bipartisan Policy Center, Youth Mental Health and Substance Use Task Force: Redesigning the Health Care Delivery System to Better Meet the Needs of Youth, January 2025. Available at: <https://bipartisanpolicy.org/report/health-care-redesign-youth/>.

Bipartisan Policy Center, Youth Mental Health and Substance Use Task Force: *Safe and Secure Social Media Use*, September, 2024. Available at: <https://bipartisanpolicy.org/report/safe-and-secure-social-media-use/>

References

- 1) Aisha Elmquist, Minnesota Olmstead Implementation Office (formerly), 400 Wabasha St N Unit 400, St Paul, MN 55102, aisha.elmquist@gmail.com, (612) 405-4153
- 2) Rayan Orbom, Washington State Health Care Authority Division of Behavioral Health & Recovery Services, Rayan.Orbom@hca.wa.gov, (360) 643-6932
- 3) Jennifer Hallisey, MassHealth, Office of Behavioral Health, One Ashburton Place, 10th Floor, Boston, MA 02108, jennifer.hallisey@state.ma.us, (508) 277-0561

Megan Lee, M.A., L.P.C.

Senior Associate

Megan Lee has over 15 years of experience advancing behavioral health system reform, with a focus on crisis systems, outcomes-oriented data and evaluation, and implementation of community-based solutions in partnership with federal, state, and local governments, providers, and community stakeholders.

Technical Assistance Collaborative, Inc. (Boston, MA)

Senior Associate (July 2023 – Present)

Manages and provides consultation, training, support, and expertise on federal housing and homelessness programs. Works with state and local public entities on strategic planning and systems transformation initiatives.

Recent Projects

- Project manager for TAC's recent Olmstead engagement in Minnesota leading policy analysis, stakeholder engagement, and cross-agency coordination to support compliance and implementation planning.
- Provides support for Pennsylvania OMHSAS and counties in the development of a framework for their Olmstead Plans.
- Supports *Olmstead* planning and monitoring efforts in North Carolina, including community engagement and alignment with broader system reform initiatives to implement quality community-based services.
- Designed outcomes-oriented data infrastructure and evaluation frameworks for multiple communities, supporting system-level decision-making, accountability, and implementation planning across behavioral health crisis response and community-based services.
- Led system mapping, evaluation, and implementation support for Walla Walla County, WA, related to their behavioral health crisis continuum.
- Advanced crisis and criminal justice system interoperability, including analysis of emergency response pathways, 911 diversion, and role clarity across the crisis continuum in several communities.

Other Professional Experience

Colorado Behavioral Health Administration

2018 – 2023

Program Manager of Crisis Services

- Oversaw \$47.3 million multimodal statewide crisis system receiving regional, statewide, and national media and legislative attention; wrote RFPs, contracts, workplans; managed contracts; conducted program evaluation and quality assurance activities.
- Orchestrated change management through landscape analysis, strategic planning, stakeholder engagement, and TA and problem-solving to promote innovation and evidence-based practices.
- Directed collaboration efforts for public safety, criminal justice, and behavioral health interoperability, defining roles in the crisis continuum to promote appropriate response types.

Skills & Expertise

- Policy & program creation & implementation
- Training & curriculum development
- Community engagement
- Program evaluation & quality improvement

Education

- M.A. / 2013
(Counseling Psychology)
U. of Colorado, Denver
- B.A. / 2009
(Psychology)
U. of Colorado, Denver

- Strategized with stakeholders and community partners to drive operational improvements in equity and tailored service delivery.
- Spearheaded development of comprehensive training curriculum through extensive research and project solicitation.
- Spearheaded creation of Veteran Suicide Prevention Program, leveraging community expertise in program design to create a responsive program with flexible and innovative service delivery.
- Strategized through budget planning and fiscal prioritization to align spending with program vision and goals, engaging with utilization data and community partnerships to inform fiscal year strategy.
- Engaged with contractors, provider partners, and constituents to create positive, trusting relationships across the state and in underserved areas to reduce barriers and increase access to care.
- Orchestrated smooth and efficient program development by collaborating cross-functionally across teams and other state departments.

Jefferson Center for Mental Health (Lakewood, CO)

2014 – 2018

Primary Clinician/Outreach Coordinator; Intensive Case Manager

- Developed and implemented strategic plan for Colorado's original First Episode Psychosis (FEP) program, including researching and establishing best practices, staff recruitment and retention efforts, and ongoing analysis of program.
- Increased education and awareness of FEP program through community outreach and delivering evidence-informed strategies for engagement, resulting in a 150% increase in program participation.
- Supervised clinical interns through in-depth trainings, supervision, and other learning opportunities.
- Developed cross-agency relationships to enhance community awareness and promote services.
- Conferred with representatives of local governments to assess and meet community needs.
- Delivered trauma-informed individual, family, and group therapy to address symptoms using a recovery-focused approach.
- Advocated for education on client and personal rights in health care, education, and housing.
- Addressed social-economic needs of individuals and families.

U.S. Department of Veterans Affairs

2012 – 2013

Research Assistant

- Improved programs in the mental health department through data analysis and reporting, fidelity monitoring, and development of informational materials.

Certifications/Licenses

- Licensed Professional Counselor

References

- 1) Aisha Elmquist, Minnesota Olmstead Implementation Office (formerly), 400 Wabasha St N Unit 400, St Paul, MN 55102, aisha.elmquist@gmail.com, (612) 405-4153
- 2) Deb Goda, North Carolina Department of Health and Human Services, 1915 Health Services Way Raleigh, NC 27607, deborah.goda@dhhs.nc.gov, (919) 855-4800
- 3) Linn Torto, Massachusetts Executive Office of Health and Human Services (formerly), 1 Ashburton Pl 11th floor, Boston, MA 02108, linn.torto@gmail.com, (617) 974-4366

Amy Horton

Senior Associate

Ms. Horton (she, her, hers) has over 15 years of experience managing homelessness and behavioral health technical assistance (TA) and evaluation initiatives. She has specific expertise in implementing behavioral health redesign consistent with Children's System of Care (SOC) philosophy and practice.

Technical Assistance Collaborative, Inc. (Boston, MA)

Senior Associate (2022 – Present); Associate II (2021 – 2022); Associate (2016 – 2021); Program Assistant (2013 – 2016); Technical Assistance & Training Coordinator (2010 – 2013)

Manages and provides consultation, training, support, and expertise on behavioral health and supportive housing models for people experiencing homelessness; and best practices in addressing the treatment, housing, and recovery support needs of people with serious mental illness and substance use disorders (SUDs).

Recent Projects

- Developed logic model for coaching efforts in North Carolina's Community Support Team service. Co-designing a data study to track the impact of inputs and activities on member outcomes.
- Administers statewide implementation of the Document Assessment and Review Tool in MA to assess fidelity to Wraparound.
- Oversees Massachusetts Children's Behavioral Health Initiative (CBHI) coaching, training, and workforce development initiatives, including subcontractor management and supervision.
- Helped multidisciplinary team to create resources to support Olmstead Plan development in the state of Minnesota.
- Constructed systems/processes for tracking performance of a specialty behavioral health managed care organization responsible for implementation and delivery of statewide children's SOC services.
- Consulted on the development and implementation of state-level policy and children's SOC initiatives to transform behavioral health delivery in response to federal Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) litigation.
- Conducted data analysis and reporting for OR's Homeless Strategy and Solutions Initiative SUD system of care.
- Spearheaded a train-the-trainer initiative on risk assessment, safety planning, and de-escalation for CBHI providers.
- Created an interactive resource directory for the U.S. Department of Housing and Urban Development – Department of Veterans Affairs Supportive Housing program in Providence, RI.

Skills & Expertise

- TA management & coordination
- Administration of large state & federal contract budgets
- Behavioral health program evaluation
- Quality improvement & assurance, including Continuous Quality Improvement & Plan-Do-Study-Act
- EPSDT-related behavioral health redesign
- HIPAA Privacy & Security Rule policy implementation

Education

- B.A. / 2010
(International Development & Social Change)
Clark U. (Worcester, MA)

Other Professional Experience

Technical Assistance Collaborative, Inc. (Boston, MA)

2019 – Present

HIPAA Privacy & Security Officer

Ms. Horton oversees development, implementation, maintenance, and adherence of TAC's privacy policies and procedures regarding the safe use and handling of protected health information in compliance with federal and state HIPAA regulations. She also manages information security policies and procedures, working alongside TAC's IT Systems Administrator to ensure that all technical systems maintain the confidentiality, integrity, and availability of all organizational information systems.

Main South Community Development Corporation (Worcester, MA)

2009 – 2010

First-Time Homebuyer Coordinator

- Managed the First-Time Homebuyer Program using HUD HOME funding, overseeing outreach initiatives to potential homebuyers, and ensuring that applicants met stringent eligibility requirements
- Oversaw the production of lending agreements between banks and homebuyers and the execution of closing agreements.

Recent Publications

Post, R., Horton, A. (2023) *The role of employment in ending homelessness: A report to the Homeless Strategic Initiative on supported employment*. Boston, MA: Technical Assistance Collaborative.

Post, R., Boss, R., Horton, A. (2022) *Resolving homelessness: The critical need for a substance use disorder system of care*. Boston, MA: Technical Assistance Collaborative.

References

- 1) Aisha Elmquist, Minnesota Olmstead Implementation Office (formerly), 400 Wabasha St N Unit 400, St Paul, MN 55102, aisha.elmquist@gmail.com, (612) 405-4153
- 2) Jennifer Hallisey, MassHealth, Office of Behavioral Health, One Ashburton Place, 10th Floor, Boston, MA 02108, jennifer.hallisey@state.ma.us, (508) 277-0561
- 3) Kim Hammack, Alabama Department of Mental Health, 100 North Union Street, Suite 408, Montgomery, AL 36104, kim.hammack@mh.alabama.gov, (334) 242-3209.

Sara Burke

Communications Director

Ms. Burke has robust and diverse experience in nonprofit communications leadership roles, with specific expertise in the fields of public health, education, and social justice. She is well-versed in meeting the intersecting priorities of funders, constituents, and consumers, and is familiar with the unique communications requirements of federal, state, local, and philanthropic policy leaders.

Technical Assistance Collaborative, Inc. (Boston, MA)

Communications Director (2015 – Present)

Manages TAC's full array of outreach, marketing, and education projects; Edits proposals, reports, presentations, articles, and other deliverables for funders and clients; supervises TAC's Communications Team.

Recent Projects

- Created a complex template and assembled and edited a multi-author best practices report to support the state of Minnesota in a major update of its Olmstead Plan; also created a "plain language" version.
- Working with the MA Medicaid Children's Behavioral Health Initiative, edited the [*Family Partner Practice Profile*](#) for greater accessibility to the intended audience of peer support specialists.
- Edited and oversaw production of TAC policy brief [*Transforming the Role of Opioid Treatment Programs*](#).
- Edited a series of TAC-authored posts on public financing for children's behavioral health initiatives, published in the Commonwealth Fund's *To the Point* blog.

Skills & Expertise

- Project management, graphic design supervision
- Writing & editing
- Editorial support for content experts, including young people & "outsider" writers
- Social media, blogs, & outreach for public health & related policy efforts
- 508/WCAG accessibility compliance

Education

- B.A. / 1986 (English Literature)
Earlham College,
Richmond, IN

Other Professional Experience

Education Development Center (Waltham, MA)

2014 – 2015

Senior Editor/Writer, Suicide Prevention Resource Center

At EDC's Suicide Prevention Resource Center (a project of the U.S. Substance Abuse & Mental Health Services Administration), Ms. Burke oversaw social media production, developed and edited reports and educational materials, coordinated web writing projects, and produced a weekly electronic newsletter for the behavioral health community.

Technical Education Research Centers (Cambridge, MA)

2010 – 2014

Center Administrator

Coordinated daily operations of a 25-person team of educational researchers, including administration, communications, and grant proposal submissions.

American Friends Service Committee (Cambridge, MA)**1997 – 2009***Co-editor, Peacework Magazine*

As one of two co-editors leading the *Peacework* program, Ms. Burke handled all aspects of editing, designing, producing, and distributing an award-winning monthly print and online magazine for peace and justice organizers. She oversaw a major redesign, planned and executed successful fundraising campaigns, organized events, and launched an innovative and successful paid internship program for young activist writers of color.

AIDS Action Committee (Boston, MA)**1996 – 1998***Editor, Wellspring Magazine*

Ms. Burke handled all editorial aspects of an award-winning bilingual magazine for AIDS Action Committee's clients and others living with HIV/AIDS, oversaw design and layout, supervised teams of volunteers, and supported a team of teens and young adults in producing a newsletter for the organization's Youth Only AIDS hotline.

References

- 1) Aisha Elmquist, Minnesota Olmstead Implementation Office (formerly), 400 Wabasha St N Unit 400, St Paul, MN 55102, aisha.elmquist@gmail.com, (612) 405-4153
- 2) Deb Goda, North Carolina Department of Health and Human Services, 1915 Health Services Way Raleigh, NC 27607, deborah.goda@dhhs.nc.gov, (919) 855-4800
- 3) Linn Torto, Massachusetts Executive Office of Health and Human Services (formerly), 1 Ashburton Pl 11th floor, Boston, MA 02108, linn.torto@gmail.com, (617) 974-4366

Jeff Nguyen, M.A.

Communications Designer & Accessibility Manager

Mr. Nguyen has a decade of experience helping people and institutions clearly communicate their visions by designing with the mission in mind. Through his zeal for language and problem-solving to scale, he strategizes with stakeholders to determine efficient workflows and carry out design solutions that engage new audiences across the print and digital hypersphere while satisfying growing demands for maximal accessibility.

Technical Assistance Collaborative, Inc. (Boston, MA)

Communications Designer & Accessibility Manager (2023 – Present)

Communications Designer (2019 – 2023)

Manages design, production, and accessibility remediation of TAC's business-to-business deliverables for federal and state clients in accordance with Section 508 protocols.

Recent Projects and Responsibilities

- *Ensures 508-accessible design and remediation support* for TAC consultants working with federal and state partners towards the effective alignment of affordable housing and supportive services systems. *Oversees all phases of remediation workflow:* color correction, tagging, annotations, validation, training project support (2023–25), and coordination of outsourced jobs.
- *Executes standardized design identities across integrated product suites:* webinar decks, [guidebooks](#), [fact sheets](#), [success stories](#), and promotional literature for high-profile state and federal programs.
- *Consolidates annual reports, guides, and fillable forms* for HUD and VA like [2025–26 SSVF Program Guide](#).
- *Buttons up action plans for federal and state clients addressing their mental and behavioral health systems:* see North Carolina [Olmstead Plan](#) (2021) and [Strategic Housing Plan](#) (2023) and SAMHSA-sponsored [Optimizing Recovery Funding](#) (Vol. 2) with Peer Recovery Center of Excellence.
- *Co-manages website and implements digital strategy initiatives:* supervised responsive website redesign and integration with Mailchimp.
- *Boosts marketing and outreach efforts:* photography, social media, and QR coded display ads for City of Boston's Landlord Incentive Program.
- *Merges and scales up:* business cards, merchandise, conference programs.

Skills & Expertise

- Integrative information design & data visualization
- Accessible document creation, remediation, & validation
- Web content management, production, & front-end customization
- Multi-device marketing campaigns and cross-media standardization
- Template design & production, PDF fillables with calculations
- Internal brand control & execution of design identity systems

Education

M.A. / 2007 (English)

Harvard U. (Cambridge, MA)

B.A. / 2004 (English,

Music)

Stanford U. (Stanford, CA)

Other Professional Experience

Houghton Library (Harvard University)

2016 – 2019

Graphic Designer (2017 – 2019)

Assistant Graphic Designer (2016 – 2017)

Executed comprehensive identities for exhibitions and programs for Harvard University's chief repository of rare collections. Designed signage, object captions, exhibition catalogs, symposium booklets, door prizes, and environmental spaces for retrospectives on Shakespeare, John Ruskin, Marius Petipa, and Mary Shelley, among others. Assisted creating program literature, exhibition assets, and social media for exhibitions and programs for Harvard University's chief repository of rare collections.

Harvard University

2005 – 2014

Teaching Fellow, Department of English

Taught undergraduate seminars on literature, theater, and art history since 1890.

Academic Technology Group (Harvard University)

2008 – 2012

Website Developer

Developed the e-journal *Exposé* with interactive commentary and video from instructors and scholars; scripted plug-ins and platforms for Middle English and Chinese language courses.

Stanford University

2004 – 2006

Website Developer

Developed the e-journal *Exposé* with interactive commentary and video from instructors and scholars; scripted plug-ins and platforms for Middle English and Chinese language courses.

Certifications

Accessible Document Specialist — International Association of Accessibility Professionals, 2023

Publications

May 2017 Review of *When I Grow Up, I Want to be a List of Further Possibilities*, by Chen-Chen (BOA Editions, 2017). *Harvard Review*.

May 2017 Review of *Blackacre*, by Monica Youn (Graywolf Press, 2016), *The Critical Flame*.

May 2017 Review of *Sun and Urn*, by Christopher Salerno (University of Georgia Press, 2017). *Kenyon Review*.

April 2016 Review of *Night Sky with Exit Wounds*, by Ocean Vuong (Copper Canyon Press, 2015), *The Rumpus*.

Oct 2015 "The Scar Lit District of Jenny Zhang," review of *Hags* (Guillotine, 2014) and *Dear Jenny, We Are All Find*, by Jenny Zhang (Octopus Books, 2012), *Jacket2*.

References

- 1) Aisha Elmquist, Minnesota Olmstead Implementation Office (formerly), 400 Wabasha St N Unit 400, St Paul, MN 55102, aisha.elmquist@gmail.com, (612) 405-4153
- 2) Deb Goda, North Carolina Department of Health and Human Services, 1915 Health Services Way Raleigh, NC 27607, deborah.goda@dhhs.nc.gov, (919) 855-4800
- 3) Linn Torto, Massachusetts Executive Office of Health and Human Services (formerly), 1 Ashburton Pl 11th floor, Boston, MA 02108, linn.torto@gmail.com, (617) 974-4366

Jeff Nguyen, M.A., Communications Designer & Accessibility Manager



Bevin Croft, PhD

Director, Behavioral Health

bcroft@hsri.org | (617) 876-0426 | www.hsri.org

Profile

Dr. Croft has 20 years of experience in the behavioral health field, with expertise in person-centered practice, self-direction, peer-delivered crisis alternatives, and quality improvement. Bevin is highly skilled at mixed methods research rooted in community engagement, providing technical assistance, convening learning collaboratives, and managing complex projects.

Project Experience

Project Director, Forsyth County Behavioral Health Services Needs Gap Analysis

Funder: **Forsyth County, North Carolina** | Dates: **2025 – Present**

Contribution: HSRI is conducting a countywide behavioral health system needs assessment in Forsyth County, NC to evaluate the availability of mental health, substance use, and intellectual and developmental disability services, identify service gaps, and inform strategic planning and allocation of public funding. Bevin oversees all aspects of the project.

Co-Project Director, No Wrong Door Resource Center (NWDRC) Long Term Services and Supports (LTSS) and Technical Assistance

Funder: **Administration for Community Living** | Dates: **2025 – Present**

Contribution: HSRI is supporting the No Wrong Door Technical Assistance Resource Center to implement person-centered practices across the No Wrong Door network, with a specific focus on community care hubs. HSRI is developing competencies for person-centered practices along with training materials and resources to bolster workforce development and ensure people receive person-centered care. Bevin co-leads this project, overseeing all activities and deliverables, and providing subject matter expertise in person-centered practices.

Project Director, Certified Community Behavioral Health Clinic Community Needs Assessment Support

Funder: **North Dakota Dept of Health & Human Services** | Dates: **2024 – Present**

Contribution: HSRI is supporting North Dakota Health and Human Services (ND HHS) Behavioral Health Division to develop a standardized process for conducting community needs assessments as part of its Certified Community Behavioral Health Clinic (CCBHC) state certification program. Project activities will be designed so that ND HHS and its partners can conduct community needs assessments in each CCBHC region independently on an ongoing basis at the close of this three-year contract period. Bevin oversees all project activities and leads development of the needs assessment toolkit.

Education

PhD

Brandeis University
Waltham, MA
(Social Policy)

MA

Brandeis University
Waltham, MA
(Social Policy)

MPP

Brandeis University
Waltham, MA
(Behavioral Health Policy)

BA

Brandeis University
Waltham, MA
(English and American Literature and European Culture Studies)

Professional Experience

Senior Research Associate and Director, Behavioral Health

(2021 – Present)

Research Associate

(2014 – 2021)

Policy Analyst

(2013 – 2014)

Research Assistant

(2009 – 2013)

Human Services
Research Institute
Cambridge, MA

Quality Coordinator, Human Rights Coordinator

(2007 – 2009)

Cascap, Inc.
Cambridge, MA

Project Director, *Ulster County Behavioral Health Community Needs Assessment*

Funder: **State of New York, County of Ulster** | Dates: **2024 – 2026**

Contribution: HSRI is conducting a comprehensive needs assessment of the behavioral health system in Ulster County, New York, to support the county in its goal to improve the effectiveness, efficiency, and equity of its behavioral health system for all residents. The scope encompasses needs related to mental health, addiction, and intellectual/developmental disabilities. Bevin leads this project and oversees all aspects of the work.

Co-Principal Investigator, *Community Living Equity Center (CLEC)*

Funder: **Administration for Community Living (ACL)** | Dates: **2022 – Present**

Contribution: HSRI is partnering with Brandeis University to conduct research on race and equity in self-direction as part of its CLEC. The overall goal of the CLEC is to understand experiences and outcomes for disabled people of color. Bevin co-leads the project, and oversees project design and focus groups with organizations that support disabled people of color to self-direct.

Project Director, *North Dakota System Change Initiatives*

Funder: **North Dakota Department of Human Services (ND DHS)** | Dates: **2019 – Present**

Contribution: HSRI is supporting the ND DHS in the statewide Person-Centered Practices project and system change initiative by assisting the State in achieving the goals and objectives outlined its National Center on Advancing Person-Centered Practices and Systems (NCAPPS) Technical Assistance plan. Bevin oversees the technical assistance and supports the project manager and subject matter experts to ensure the process is responsive to ND DHS and its system change goals.

Co-Director, *National Center on Advancing Person-Centered Practices and Systems (NCAPPS)*

Funder: **Administration for Community Living (ACL)** | Dates: **2019 – 2025**

Contribution: HSRI led a Center that provided actionable technical assistance to assist states, tribes, and territories in transforming their LTSS systems by implementing U.S. Department of Health and Human Services policy on person-centered thinking, planning, and practice. Bevin was responsible for managing and overseeing all personnel and project activities.

Consultant, *North Dakota Brain Injury System of Care Study*

Funder: **University of North Dakota** | Dates: **2023 – 2024**

Contribution: HSRI is supporting the National Association of State Head Injury Administrators (NASHIA) to conduct a study of North Dakota's Brain Injury System of Care to consider whether the services provided in the state relating to the care and treatment of individuals with brain injury are adequate. Bevin provided consultation and guidance for the project leads.

Project Director, *Texas Health and Human Services Person-Centered Recovery Planning Technical Assistance*

Funder: **University of Texas at Austin** | Dates: **2023**

Contribution: Texas Health and Human Services (HHS) wanted to strengthen its policy and practice supporting person-centered recovery planning (PCRP). HSRI supported that aim through developing a better understanding of how providers interpret PCRP requirements and implementation, and through recommendations for improved guidance, communications, and quality monitoring. Bevin led this project and co-authored the final report.

Principal Investigator, *National Demonstration of Self-Direction in Behavioral Health*

Funder: **Robert Wood Johnson Foundation** | Dates: **2016 – 2021**

Contribution: Funded by the Robert Wood Johnson Foundation and the New York State Health Foundation with support from Substance Abuse and Mental Health Services Administration (SAMHSA), HSRI led an evaluation of mental health self-direction in six states, charting best practices and exploring its impacts at the individual and system level. As part of the project, HSRI developed mentalhealthselfdirection.org, a resource that features participant stories and serves as a clearinghouse for all things mental health self-direction. As project director of the evaluation component, Bevin led all aspects of the process and outcomes evaluation. She assumed the role of principal investigator in 2017 and was responsible for overseeing all project activities.

Project Director, *Evaluation of the Santa Cruz Peer Respite*

Funder: **Substance Abuse and Mental Health Services Administration (SAMHSA)** | Dates: **2010 – 2015**

Contribution: The 2nd Story program is a peer-staffed crisis residential program that is an alternative to existing emergency psychiatric services. The program was funded by a five-year SAMHSA Mental Health Transformation Grant. The evaluation examined both process and outcome questions related to the program objectives, including issues related to the program's implementation. The goal of the peer respite is to provide recovery-oriented, trauma-informed peer support in a crisis respite using the Intentional Peer Support model. Bevin served as the local evaluator for this SAMHSA grantee.

Honors, Awards, and Memberships

Co-Chair, Self-Directed Support Network (2023-present)
 Friend of NASHIA Award for work with the NCAPPS Brain Injury Learning Collaborative (2021)
 Brandeis University Heller School Commencement Speaker representing the PhD Program (2017)
 Provost's Dissertation Support Award (2014)
 Heller Fund Dissertation Support Award (2013)
 Wyatt Jones Fund Dissertation Fellowship (2013)
 National Institutes on Alcohol Abuse and Alcoholism (NIAAA) Traineeship (2010 – 2013)
 Brandeis University Heller School Commencement Speaker representing the MPP Program (2010)
 Brandeis University Heller School MPP Program Leadership Award (2010)
 Brandeis University National Committee Scholar (2008 – 2010)
 Washington Family Horatio Alger Scholarship of Excellence (2008 – 2010)
 Brandeis University Walter H. and Lee Annenberg Scholar (1999 – 2003)
 Brandeis University Justice Brandeis Scholar (1999 – 2003)
 Horatio Alger National Scholar (1999 – 2003)

References

1. North Dakota Health & Human Services, Behavioral Health Division

Laura Anderson, Policy Director
 (701) 328-8918 600 East Boulevard Ave., Bismark, ND 58505

2. Ulster County Department of Mental Health

Joleen Darby, Special Projects Director
 (845) 340-8629 368 Broadway, Suite 401, Kingston, NY 12401

3. Forsyth County Behavioral Health Services

Annie Vazquez, Substance Use Services Coordinator
 (336) 703-3175 650 Highland Ave., Winston Salem, NC 27101



Rachael Gerber, MPH

Director of Operations

rgerber@hsri.org | (617) 876-0426 | www.hsri.org

Profile

Rachael has over 15 years of experience in behavioral health program evaluation, needs assessment, and system planning. Her expertise is in collection and analysis of data to assist policymakers in system transformation efforts. She is experienced working with Medicaid and other administrative claims data as well as data from national and state surveys and surveillance systems. In her role as director of operations for HSRI's behavioral health team, she develops and oversees standard operating procedures for quality assurance and production of high-quality deliverables.

Project Experience

Project Manager, Forsyth County Behavioral Health Services Needs Gap Analysis

Funder: **Forsyth County, North Carolina** | Dates: **2025 – Present**

Contribution: HSRI is conducting a countywide behavioral health system needs assessment in Forsyth County, NC to evaluate the availability of mental health, substance use, and intellectual and developmental disability services, identify service gaps, and inform strategic planning and allocation of public funding. Rachael oversees the project workplan and timeline, conducts interviews and focus groups with community members, gathers and analyzes quantitative and qualitative data, and develops recommendations for system improvements.

Project Manager, Ulster County Behavioral Health Community Needs Assessment

Funder: **State of New York, County of Ulster** | Dates: **2024 – 2026**

Contribution: HSRI conducted a comprehensive needs assessment of the behavioral health system in Ulster County, New York, to support the county in its goal to improve the effectiveness, efficiency, and equity of its behavioral health system for all residents. The scope encompassed needs related to mental health, addiction, and intellectual/developmental disabilities. Rachael developed and oversaw the project workplan, conducted quantitative and qualitative data collection and analysis, planned and coordinated community engagement activities, and contributed to report writing and development of recommendations.

Consultant, Idaho Supports Budget Methodology

Funder: **The Idaho Department of Health and Welfare** | Dates: **2025 – Present**

Contribution: HSRI is aiding the Idaho Department of Health and Welfare (DHW) in development of a new personal supports budget methodology for adults with intellectual and developmental disabilities (IDD) receiving Medicaid Home and Community-Based Services (HCBS). Rachael supports the project team in developing community engagement strategies, drafts

Education

MPH

Yale School of Public Health
New Haven, CT
(Social and Behavioral Science)

BA

Boston University
Boston, MA
(History)

Professional Experience

Director of Operations for Behavioral Health Team

(2022 – Present)

Research Associate

(2013 – Present)
Human Services Research Institute
Cambridge, MA

Sr. Research Associate

(2012 – 2013)
New England Research Institutes, Inc.
Watertown, MA

Research Analyst

(2009 – 2012)
Human Services Research Institute
Cambridge, MA

Research Assistant

(2007 – 2009)
Center for Interdisciplinary Research on AIDS
New Haven, CT

engagement plans and action steps, and develops pilot testing protocols for assessment tools and evaluation of the supports budget model.

Data Analyst, North Dakota Behavioral Health Needs Assessment and North Dakota Behavioral Health Strategic Planning

Funder: **ND Department of Human Services Behavioral Health** | Dates: **2017 – Present**

Contribution: In 2017 and 2018, HSRI conducted an in-depth review of North Dakota's behavioral health system and produced recommendations and strategies for implementing changes to address the needs of the community. Beginning in 2018, HSRI is working with the State's Behavioral Health Planning Council to facilitate an in-depth strategic planning process to implement the recommendations for behavioral health systems transformation. Populations of focus include individuals with mental health conditions, substance use disorders, and brain injury. Rachael coordinates data transfers and analyzes data from Medicaid and other secondary sources.

Data Analyst, Delaware Community Needs Assessment

Funder: **Delaware Health and Social Services** | Dates: **2024 – 2025**

Contribution: HSRI conducted a community needs assessment to support successful community tenure for people with disabilities and to inform repurposing of state institutional properties. HSRI collected and analyzed qualitative data from facility residents, people receiving services in the community, and other key informants, as well as analyzed quantitative demographic, assessment, and utilization data. HSRI provided recommendations to the state on enhancing community capacity and addressing system gaps. Rachael led development of the data analysis plan for Medicaid claims data, drafted and coordinated data requests, conducted quantitative and qualitative analyses and quality control, and developed data visualizations.

Project Manager and Data Analyst, New Hampshire System Assessment and Gap Analysis

Funder: **New Hampshire Dept. of Health & Human Services** | Dates: **2023 – 2025**

Contribution: HSRI conducted comprehensive system assessment and gap analysis of New Hampshire's Long-Term Services and Supports (LTSS). Based on the findings, the project team provided data-driven recommendations to direct policy and action, and support long-term strategic planning in NH. Rachael was responsible for developing and overseeing the workplan, ensuring timely and high-quality deliverables across community engagement, data analysis, and reporting tasks, drafting monthly progress reports to DHHS, and conducting qualitative, quantitative, and mixed methods analysis.

Project Director, Behavioral Health Service Gap Analysis

Funder: **Colorado Department of Health Care Policy & Financing** | Dates: **2023 – 2024**

Contribution: HSRI conducted an analysis of the Regional Accountable Entities (RAE) and Managed Care Organizations (MCO) in Colorado, collectively referred to as Managed Care Entities (MCE), for the purpose of testing the reasonable access to behavioral health providers in the state. Rachael led an environmental scan of methods for assessing network adequacy, developed methodologies to examine network access and gaps using claims data, and developed reports and presentations to HCPF.

Project Manager/Data Lead, Wake County Behavioral Health Crisis System Assessment

Funder: **Wake County, North Carolina** | Dates: **2022 – 2025**

Contribution: Wake County contracted HSRI to assess the county's behavioral health crisis service system. This included an assessment of services across the crisis continuum in comparison to national best practices for crisis care. Using qualitative and quantitative methods, the team identified strengths and gaps in the county's crisis system and made recommendations for improvements. Rachael developed and oversaw the work plan and timeline, collected and analyzed quantitative and qualitative data, conducted key informant interviews, drafted reports and recommendations, and presented key findings to county leadership and community partners.

Data Analyst, Louisiana Olmstead Evaluation Project

Funder: **Louisiana Department of Justice** | Dates: **2022 – 2023**

Contribution: HSRI assisted Louisiana in successfully meeting the requirements of Olmstead-related settlement agreements and court decisions. HSRI provided data analysis for utilization of case management for the at-risk population and of claims data for review of service utilization. Rachael developed analytic methods and conducted analysis of Medicaid claims and data from the state's case management system.

Data Analyst, South Dakota Behavioral Health Service System Needs Assessment

Funder: **SD Department of Social Services** | Dates: **2020 – 2021**

Contribution: HSRI conducted a comprehensive assessment of South Dakota's public behavioral health system and provided recommendations to the state for addressing gaps in services. Rachael analyzed data from Medicaid- and state-funded services and other secondary sources to identify service use patterns and gaps to inform recommendations for systems improvement.

Data Analyst, North Carolina Olmstead Planning

Funder: **North Carolina Department of Health and Human Services** | Dates: **2020 – 2021**

Contribution: NC DHHS contracted the Technical Assistance Collaborative (TAC), in partnership with HSRI, to conduct a comprehensive system analysis and provide recommendations to assist NC in developing its Olmstead Plan. Rachael analyzed data from Medicaid, state-operated health care facilities, and other state agencies to inform development of recommendations.

Data Analyst, Louisiana Department of Justice

Funder: **Technical Assistance Collaborative (TAC)** | Dates: **2019 – 2021**

Contribution: HSRI worked with TAC to help the state of Louisiana to develop a Population Health Strategic Plan aligned with the Louisiana Medicaid Managed Care Quality Strategy. Rachael analyzed data from Medicaid, transition assessments, and other survey instruments, collaborating in drafting the final report, and presented findings to the state, DOJ, and other community partners.

Senior Data Analyst, North Carolina Olmstead Evaluation Project

Funder: **Independent Reviewer, US DOJ Settlement with NC** | Dates: **2017 – 2018**

Contribution: HSRI was contracted to conduct an analysis of the services provided to the covered target population in the Olmstead Settlement Agreement, informing the court monitor's determination of compliance with the agreement. Rachael coordinated with state agencies to obtain data from numerous sources, cleaned and linked data on individuals' housing status with claims Medicaid claims, analyzed data, drafted reports, and produced data summaries to facilitate community partner discussions.

References

1. **North Dakota Health & Human Services, Behavioral Health Division**
Laura Anderson, Policy Director, Behavioral Health Division
(701) 328-8918 600 East Boulevard Ave., Bismark, ND 58505
2. **Ulster County Department of Mental Health**
Joleen Darby, Special Projects Director
(845) 340-8629 368 Broadway, Suite 401, Kingston, NY 12401
3. **Forsyth County Behavioral Health Services**
Annie Vazquez, Substance Use Services Coordinator
(336) 703-3175 650 Highland Ave., Winston Salem, NC 27101



Kristin Battis, MPH

Data Scientist

kbattis@hsri.org | (617) 876-0426 | www.hsri.org

Profile

Kristin has been working in health research, with a focus on behavioral health, since 2008. She has extensive experience developing data collection materials, managing and analyzing quantitative data using SQL, SPSS, and SAS, and disseminating information through written reports and data visualizations. Since 2016, Kristin has specialized in working with commercial, Medicare, and Medicaid health insurance claims data to fulfill clients' data extract, analytic, and reporting needs. Additionally, she supports the development and maintenance of health care transparency websites.

Project Experience

Research Analyst, *Evaluation of the New York State Assisted Outpatient Treatment (AOT) Program*

Funder: **New York State Office of Mental Health** | Dates: **2024 – 2026**

Contribution: HSRI conducted an independent evaluation of the New York State AOT program to 1) assess the implementation status and operations of AOT programs as they vary across localities across New York State; and 2) to understand the experiences of people with current and past AOT court orders, their families and loved ones, and communities through a mixed-methods approach. Kristin was responsible for the management and analysis of Medicaid claims data for people with behavioral health diagnoses to examine service utilization patterns.

Research Analyst, *Pathways Vermont Peer Respite Evaluation*

Funder: **Pathways Vermont** | Dates: **2024 – Present**

Contribution: The Pathways Vermont Peer Respite Evaluation will use a mix of qualitative and quantitative methods to understand its impact on individuals and the local behavioral health system and to chart implementation factors that may influence effectiveness. Kristin is responsible for the data management and analysis of participant entry and exit surveys to explore outcomes related to quality of life and wellbeing among those who use the respite.

Health Data Analyst, *Maine Health Data Organization (MHDO) Data Warehouse Project*

Funder: **MHDO** | Dates: **2018 – Present**

Contribution: As a part of this ten-year contract with the State of Maine, HSRI and its partners are building a highly secure and robust data warehouse to collect and house health care claims, encounter and eligibility data, hospital financial data and other related information. We continue to maintain and enhance the CompareMaine work started on the CMS grants. Kristin is responsible for the research of health care cost transparency, the analysis of medical claims data for reporting purposes, the development of the

Education

MPH

Boston University
School of Public Health
Boston, MA
(Social and Behavioral Sciences)

BA

Northeastern University
Boston, MA
(Sociology)

Professional Experience

Data Scientist

(2021 – Present)

Research Associate

(2018 – 2021)

Research Analyst

(2016 – 2018)

Human Services Research Institute
Cambridge, MA

Programmer/Analyst

(2012 – 2016)

Brigham and Women's Hospital
Boston, MA

Research Analyst

(2009 – 2012)

Research Assistant

(2008 – 2009)

Human Services Research Institute
Cambridge, MA

methodology for calculating the average cost of common medical procedures, and supporting the development and maintenance of Maine's health care transparency website.

Research Analyst, *Delaware Community Needs Assessment*

Funder: **Delaware Health and Social Services** | Dates: **2024 – 2025**

Contribution: HSRI conducted a community needs assessment to support successful community tenure for people with disabilities and to inform repurposing of state institutional properties. HSRI collected and analyzed qualitative data from facility residents, people receiving services in the community, and other key informants, as well as analyzed quantitative demographic, assessment, and utilization data. HSRI provided recommendations to the state on enhancing community capacity and addressing system gaps. Kristin was responsible for the management and analysis of Medicaid claims of long-term care facility residents.

Health Data Analyst, *Behavioral Health Service Gap Analysis*

Funder: **Colorado Department of Health Care Policy and Financing (HCPF)** | Dates: **2023 – 2024**

Contribution: HSRI conducted an analysis of the Regional Accountable Entities (RAE) and Managed Care Organizations (MCO) in Colorado, collectively referred to as Managed Care Entities (MCE), for the purpose of testing the reasonable access to behavioral health providers in the state. Kristin was responsible for the management and analysis of all administrative data, including managed care encounter data, fee-for-service medical and pharmacy claims, and member and provider enrollment data. Kristin was involved in the development of reports, including tables and graphs, related to examining Health First Colorado member demographic characteristics, behavioral health diagnoses, and behavioral health service utilization including telehealth utilization, and assessing behavioral health provider network adequacy.

Research Analyst, *New Hampshire State Youth Treatment – Planning and Implementation Evaluation (SYT-P/I)*

Funder: **NH DHHS** | Dates: **2017 – 2024**

Contribution: HSRI evaluated New Hampshire's initiative to develop and pilot a continuum of care model for adolescents and transitional aged youth with substance use disorders and co-occurring substance use and mental health disorders, integrating evidence-based screening, assessment, treatment, recovery, and peer support services. During the planning phase of the initiative, HSRI developed an evaluation plan, designed tools to track the planning process, attended all planning meetings, administered surveys to Interagency Council members, supported the state in fulfilling its federal reporting requirements, and developed annual evaluation reports. HSRI continued to evaluate the initiative in its implementation phase. Kristin was responsible for collecting, managing, analyzing, and reporting on process and outcome data.

Research Analyst, *Louisiana Olmstead Evaluation Project*

Funder: **Louisiana Department of Justice** | Dates: **2022 – 2023**

Contribution: HSRI assisted Louisiana in successfully meeting the requirements of Olmstead-related settlement agreements and court decisions. HSRI provided data analysis for utilization of case management for the at-risk population and of claims data for review of service utilization. Kristin was responsible for creating analytic spreadsheets for Louisiana case management data and conducting quality control processes on reporting summaries. She was also responsible for analyzing and summarizing Medicaid claims data for the purpose of a service review.

Research Analyst, *Massachusetts Commission for the Blind (MCB) Assistive Technology Survey*

Funder: MCB | Dates: 2022

Contribution: HRSI designed and conducted a random sample survey of MCB's consumer population to gain insight regarding assistive technology usage and need for support in this area. Participants were given the option to respond online, via a large-print survey instrument mailed to them, or a phone interview. Kristin collaborated in designing and piloting the survey and accompanying materials and was responsible for monitoring recruitment, mailing out large print surveys and manually entering responses from returned surveys, and communicating with the phone interview vendor to request phone interviews for participants and resolve data issues. She performed data management and analysis on the survey data and contributed to the writing of the report, including populating tables and graphs.

Research Analyst, *North Carolina Olmstead Planning*

Funder: North Carolina Department of Health and Human Services | Dates: 2020 – 2021

Contribution: NC DHHS contracted the Technical Assistance Collaborative (TAC), in partnership with HSRI, to conduct a comprehensive system analysis and provide recommendations to assist NC in developing its Olmstead Plan. Kristin was responsible for the data management and analysis of quantitative data from Medicaid and other state agencies to guide the development of the recommendations.

Research Analyst, *National Demonstration of Self-Direction in Behavioral Health*

Funder: Robert Wood Johnson Foundation | Dates: 2016 – 2021

Contribution: Funded by the Robert Wood Johnson Foundation and the New York State Health Foundation with support from Substance Abuse and Mental Health Services Administration (SAMHSA), HSRI led an evaluation of mental health self-direction in six states, charting best practices and exploring its impacts at the individual and system level. As part of the project, HSRI developed mentalhealthselfdirection.org, a resource that features participant stories and serves as a clearinghouse for all things mental health self-direction. Kristin was responsible for cleaning, managing, and analyzing participant-level service utilization data and Government Performance and Results Act (GPRA) outcome data.

Research Analyst, *North Carolina Olmstead Evaluation Project*

Funder: Independent Reviewer, U.S. DOJ Settlement with North Carolina | Dates: 2018

Contribution: HSRI was contracted to conduct an analysis of the services provided to the covered target population in the Olmstead Settlement Agreement, informing the court monitor's determination of compliance with the agreement. Kristin was responsible for analyzing Medicaid data.

References

- 1. Colorado Department of Health Care Policy and Financing (HCPF)**
Sandi Wetenkamp, Health Network Accountability Specialist
(303) 866-2993 303 East 17th Avenue, Denver, CO 80203
- 2. North Dakota Health & Human Services, Behavioral Health Division**
Laura Anderson, Policy Director, Behavioral Health Division
(701) 328-8918 600 East Boulevard Ave., Bismark, ND 58505
- 3. Ulster County Department of Mental Health**
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Education

Ph.D. (Counseling Psychology), Northwestern University School of Education and Social Policy 1987
M.S. (Rehabilitation Counseling), Southern Illinois University 1973
B.A. (English, minor Education), Southern Illinois University 1970

Professional Work Experience

2026-present **Subject Matter Expert** in multiple states via EconSys NEON project or Department of Labor, Office of Disability Employment Programs

2025- (Summer) **Subject Matter Expert** for the National Council for Mental Wellbeing's "Office Hours" series regarding implementing IPS in **CCBHC's** for five states.

2025-present: **Subject Matter Expert** for Boston University Technical Assistance project in Illinois: Implementing **IPS for youth**.

2024-Present; Manatt **Subject Matter Expert** regarding standing up Individual Placement and Support (IPS) as a Medicaid benefit in California.

2023-2024: **Subject Matter Expert**. State of New Hampshire. Evaluated Assertive Community Treatment team adequacy under the DOJ settlement

2021-2024: **Subject Matter Expert** via WESTAT ASPIRE (Advancing State Policy Integration for Recovery and Employment) for Department of Labor, Office of Disability Employment Programs. This initiative seeks to support and expand competitive integrated employment people with mental health conditions.

2021: **Subject Matter Expert** Colorado Office of Employment First.

2017-present: **Subject Matter Expert** for the Technical Assistance Collaborative working currently with Louisiana on Department of Justice Agreement; Recent work in WA included cross departmental collaboration among workforce (DOL), VR, and behavioral health to enhance **WIOA** accessibility and inclusion goals for people with behavioral health conditions.

10/16-2/20: **Consultant**, Health Care Homes and Certified Community Behavioral Health Centers (**CCBHC**) Practice Coach, Missouri Coalition of Community Behavioral Health Programs;

2014-present: **Subject Matter Expert in multiple states** via Econsys for Department of Labor, Office of Disability Employment Programs (2020 states: IN, IA, CO, WI); These projects included strategic planning and policy work. Vision Quest in MO in previous years created a toolkit to enhance collaboration among workforce (DOL), VR, and behavioral health to enhance **WIOA** accessibility and inclusion goals for people with behavioral health conditions.

2014-2018: **Subject Matter Expert** for GAINS PRA for Substance Abuse and Mental Health Services Administration Seven state Implementation of IPS Supported Employment; 2019 assist with series of 4 webinars concerning barriers and opportunities around employment for people with behavioral health conditions. Session 1 included cross departmental work including DOL/Workforce/ **WIOA**.

- 7/12-1/16 **Chief Clinical Officer**, Places for People, St. Louis, MO.
Direct the clinical activities of this comprehensive community mental health agency in urban St. Louis. Services include diverse clinical teams, using Evidence Based and emerging best practices, under contract with the Department of Mental Health.
- 2006-2012 **Clinical Director** - Division of Comprehensive Psychiatric Services, Missouri Department of Mental Health;
Director, Missouri's SAMHSA 5 year Transformation Grant
Provide clinical leadership for the Comprehensive Psychiatric Services Division. Create policies, practices and technical assistance methods with Division staff that will lead to enhanced recovery outcomes for people with serious mental illness.

Align policy and practice to support Transformation outcomes, and the use of Evidence Based Practices.
- 1999-2006 **Supervisor**, Minnesota Department of Human Services, Mental Health Division, Adult Mental Health
Supervise a team of ten staff. The team's essential function is to provide policy direction, technical assistance, mental health grants management, and diverse liaison services between the counties, provider organizations, and the state. Major projects included: 1) Restructuring the adult mental health system in order to provide a more robust local community service system; 2) Implementation of four Evidence Based Practices (EBP), Supported Employment, Assertive Community Treatment, Integrated Dual Disorders Treatment, and Illness Management and Recovery; 3) Continuing the development of the Medicaid and other funding Infrastructure to appropriately support EBP and Best Practices;

Liaison to the Minnesota TANF Division, on steering committee for Integrated Services Projects, an initiative to provide coordinated care to TANF recipients with mental illness, chemical health, and other barriers to employment;

Supervise the Tribal Mental Health Specialist; Represent Minnesota on the Adult Services Division of the National Association of State Mental Health Program Directors.
- 1993-1999 **Program Consultant**, Minnesota Department of Human Services, Mental Health Division

Responsible for providing technical assistance, policy direction and liaison services for twenty-two counties in SW Minnesota; Federal Block Grant writer;

Contract management for Consumer Survivor Network (a primary consumer advocacy organization); Supported Employment specialist and liaison with MN Vocational Rehabilitation Division.
- 1975-1994 Thresholds, 2700 North Lakeview Avenue, Chicago, Illinois 60614

Thresholds is a Psychosocial Rehabilitation Program providing comprehensive mental health services in the areas of prevention of unnecessary hospitalization, employment, housing, education, socialization, health and wellbeing. Roles during my tenure:
Consultant (a telecommuting arrangement after I moved to Minnesota). Thresholds Research and Training Center on Mental Illness, May, 1992 to September, 1993.
Associate Director, Thresholds and Supervisor, Thresholds National Research and

Training Center, October, 1990 to May, 1992. **Program Director**, Thresholds North, August, 1986 to October, 1990.

Director, Training and Quality Assurance, May, 1985 to August, 1986.

Team Leader, Rehabilitation Program, August, 1979 to May, 1985.

SELECT PUBLICATIONS:

Selleck, V., Knight, E., Migas, N., Terrell, S. Consumers at the center: True transformation or more reform without change. Proceedings, National Consensus Conference on Person/Family – Centered Planning. Substance Abuse and Mental Health Services Administration, Washington, DC, December, 2005.

Simmons, T.J., Selleck, V., Steele R., & Sepetac, F. Psychiatric Vocational Rehabilitation: Supports and Rehabilitation for Employment. In P. Solomon and R.W. Flexer (Eds), Psychiatric Rehabilitation in Practice. Andover, 1993.

PROFESSIONAL TRAINING AND CONSULTING ACTIVITIES: (partial list)

Consulted (separately) in 2013 with states of Nebraska, South Dakota on employment and related system change efforts, again in Nebraska in 2018-19. The latter work included **WIOA** partners and goals.

Consulted with CMS; Prepared draft documents concerning Supported Employment and Medicaid, 2013

University of Alaska, Alaska Works Initiative, Financing Supported Employment, November, 2006

Missouri Mental Health Employment Program, Summer and Fall, 2006

Panelist, Forum on Effective Employment for People with Mental Illness Using Community Services, Institute for Community Inclusion, Peoria, Illinois, September, 2005

Panelist, Mental Health Employment Summit, Governors Council on Disability and Special Education, Anchorage, Alaska, August, 2004

Keynote, Seattle Recovery Symposium, United Behavioral Health, Seattle, Washington, September, 2002

Panelist, Presidential Task Force on Employment of Adults with Disabilities Summit: "Real Choice, Real Jobs, Real Pay: Employment for the 21st Century, Washington DC, April, 2000

Consultant, Kansas Department of Social and Rehabilitation Services. Presented two day training for all Community Mental Health Center Executive Directors on "Supported Employment in a Mental Health Setting: Creating Opportunities for Success." Salina, Kansas, October, 1994

Consultant, Goodwill Industries of Nebraska. Design assessments for persons with serious mental illness, February, 1994

REFERENCES

- 1) John O'Brien, 187 Desert Lakes Drive, Rancho Mirage, CA, jpob1009@gmail.com, (781) 971-3210
- 2) Joe Marrone, UMASS BOSTON- ICI (retired), 4517 NE Cesar E. Chavez Blvd., Portland, OR 97211-8125, joseph.marrone@gmail.com, (334) 235-0011
- 3) Denise Bern, Individual Placement and Support – Coordinator and Trainer, RSA Union Building, 100 North Union Street, Suite 554, Montgomery, AL 36104, Denise.Bern@mh.alabama.gov

KELLY NYE-LENGERMAN, PH.D., MSW, FAAIDD

KMNYE@UMD.EDU

KNYE@KINDWORKSCONSULTING.NET

Education

Doctor of Philosophy (Ph.D.) Social Work, 2015 University of Minnesota-Twin Cities, Minneapolis, MN

Disability Policy and Services Certificate, 2015 University of Minnesota-Twin Cities, Minneapolis, MN

Master of Social Work (MSW), 2008 University of Minnesota-Twin Cities, Minneapolis, MN

Bachelor of Arts (BA) Social Work and Psychology, ~~200~~Luther College, Decorah, Iowa

Experience

University of Maryland, College of Education, College Park, MD

Appointment: Visiting Research Professor, Department of Counseling, Higher Education, & Special Education (Research Professor appointment under review)

09/2025-Present Center for Transition & Career Innovation

Kind Works Consulting LLC, Dover, NH

05/2025-Present Owner & Principal

Mathematica, Princeton, NJ

09/2024-04/2025 Principal Researcher

University of New Hampshire, Institute on Disability, Durham, NH

Appointment: Academic Administrator & Research Professor, Social Work

06/2020-09/2024 Director, Institute on Disability

07/2022-01/2023 Interim Director, National Center for START Services

University of Minnesota, Institute on Community Integration, Minneapolis, MN

01/2019-05/2020 Director, Community Living & Employment

01/2016-05/2020 Research Associate

06/2009-01/2016 Project Coordinator

Select Publications

Henly, M., Paul, S., Brucker, D.L., Houtenville, A., **Nye-Lengerman, K.**, & Kingsbury, S. (2026) Barriers to Program Information for Populations Underrepresented in Social Security Disability Programs: A Scoping Review. *Journal of Disability Policy Studies*.

doi: 10.1177/10442073261430839

Grosso, B., Caoili, A., Klein, A., & **Nye-Lengerman, K.** (2025). Exploring the Impact of Training on the Mental Health Aspects of Intellectual and Developmental Disabilities for Direct Support Professional. *Inclusion*, 13(1), 1-12. DOI: 10.1352/2326-6988-13.1.1

McCabe, M. & **Nye-Lengerman, K.** (2021). Putting Policy into Practice: Impact of the Every Student Succeeds Act (ESSA) on Speech-Language Pathologists and Students with Disabilities. *Language, Speech, and Hearing Services in Schools*. [doi:10.1044/2021_LSHSS-20-00139](https://doi.org/10.1044/2021_LSHSS-20-00139)

Stancliffe, R. J., **Nye-Lengerman, K. M.**, & Kramme, J. E. (2019). Aging, community-based employment, mobility impairment, and retirement: National core indicators–Adult Consumer Survey Data. *Research and Practice for Persons with Severe Disabilities*, 44(4), 251-266. doi.org/10.1177/1540796919882921

Larson, S.A., Neidorf, J., Pettingell, S., & **Nye-Lengerman, K.**, & Vegas, L. (2026). *Long-term supports and services for persons with intellectual or developmental disabilities: Status and trends through 2021*. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

Selleck, V., & **Nye-Lengerman, K.** (2025). Best and Promising Practices in Employment to Support Olmstead Plan Development for Minnesota. Technical Assistance Collaborative.

Conrad, L., & **Nye-Lengerman, K.** (2025). Best and Promising Practices in Education to Support Olmstead Plan Development for Minnesota. Technical Assistance Collaborative.

Hewitt, A. **Nye-Lengerman, K.** & (Ed.) (2019). *Community Living and Participation for Individuals with Intellectual and Developmental Disabilities*. Washington, DC: Association of Intellectual and Developmental Disabilities.

Research Experience

Grants and Contracts Awarded

2025-2029	Leveraging Interagency Networks for Knowledge-sharing (LINK) to Develop a 21st Workforce of Youth with Disabilities. Rehabilitation Services Administration, subcontract from Maryland Department of Disabilities. Co-Principal Investigator.
2024-2025	Research Support Services for Employment of Young Adults on the Autism Spectrum (REYAAS). Office of Disability Employment Policy. Principal Investigator.
2024-2025	Barriers and Facilitators of Using ABLE Accounts and Characteristics of Newly Eligible ABLE Users. Retirement & Disability Research Consortium- Social Security Administration. Co-Principal Investigator.
2024-2025	Rehabilitation Research and Training Center on Disability Statistics and Demographics. National Institute on Disability, Independent Living and Rehabilitation Research. Task Lead.
2023-2028	University Center for Excellence in Developmental Disabilities. U.S Department of Health and Human Services, Administration on Community Living. (\$3,000,000). Principal Investigator.

Consulting Experience

2025-2026	American Association on Intellectual and Developmental Disabilities (AAIDD). Publication consultant.
2025	Technical Assistance Collaborative (TAC). MN Olmstead Project. Project consultant.
2025-2026	University of Minnesota, Institute on Community Integration. MN Transformation Initiative, Residential Systems Information Project, Direct Care Workforce Strategies Center. Project consultant.
2022-2025	Mathematica. Best Practices in Case Management. Consultant.

Teaching Experience

- 2021-2024 University of New Hampshire, Durham, NH. Lecturer
NH Leadership Series & NH-ME LEND
- 2019-2020 University of Minnesota, Minneapolis, MN. Instructor
Department: Organizational Leadership and Policy Development (OLPD)
Course: Disability policy and services

Professional Certifications/License

- 2026 Fellow of the American Association on Intellectual and Developmental Disabilities
- 2000-2024 Licensed Graduate Social Worker, State of Minnesota #14994
- 2022 Advancing Academic Leaders, University of New Hampshire

National Advisory & Board Appointments

- 2020-2024 Retirement and Disability Research Consortium. Social Security Administration
- 2022-2024 National Research Consortium on Mental Health and Intellectual and Developmental Disabilities (MH-IDD), Board Member
- 2022-2024 PCORI IDD-MH Telehealth Advisory Council, National Center for START Services
- 2019-2023 Access to Integrated Employment Advisory Committee (UMass/AIDD)
- 2018-2021 Association of People Supporting Employment First (APSE). National board member (Elected)

Awards

- 2016 Association of University Centers on Disability Young Professional Award
- 2016 National APSE "Got Mike" Educational Leadership Award
- 2015 National APSE Public Policy Advocate of the Year (Member of MN EF Coalition Team)
- 2014 Institute on Community Integration- Future Leader Award
- 2011 Rosene Doctoral Fellowship, School of Social Work

Other Professional Direct Service Experience

- 2007-2009 Program Director. PossAbilities of Southern Minnesota, Rochester, MN
- 2000-2009 Quality Assurance Team Member. Region10 Quality Assurance, Rochester, MN
- 2001-2007 Program Manager & Coordinator. Ability Building Center, Rochester, MN
- 2000-2001 Social Worker. Catholic Charities, Rochester, MN
- 1997-2000 Direct Support Professional. REM, Hiawatha Homes, and Spectrum Industries: Rochester, MN & Decorah, IA

References

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Appendix C - Work Examples

2024 MA Olmstead Update Report

2025 MN Best Practices Report

NC Olmstead Plan Implementation 2025 Quarter 3 Summary Report

NC Olmstead Plan Implementation 2025 Quarter 4 Summary Report

Services for People with Disabilities in North Carolina Survey



COMMONWEALTH OF MASSACHUSETTS

2024 Olmstead Update Report

Celebrating the 25th Anniversary of Olmstead and Charting
Pathways for Continued Progress

Contents

Executive Summary	1
Olmstead Overview	3
What is an Olmstead Plan?	3
Massachusetts' Olmstead Goals — The Four Pillars	3
What Have We Accomplished? Progress Since 2018	5
Expansion of Access to Affordable, Accessible Housing	5
Enhancements to Community-Based Services and Supports	15
Promotion of Community-Integrated Employment of People with Disabilities	28
Investments in Accessible Transportation for Individuals with Disabilities	31
Where Are We Now? State Snapshot	35
Overall Progress	35
Community Feedback	39
Where Are We Going? Current Initiatives to Achieve Continued Progress	41
Massachusetts' Community Living Initiative	41
Expanding Access to Affordable, Accessible Housing	42
Enhancing Community-Based Services and Supports	44
Promoting Community-Integrated Employment of People with Disabilities	47
Investing in Accessible Transportation for Individuals with Disabilities	49
Conclusion	50

Executive Summary

This year marks the 25th anniversary of the Supreme Court’s landmark *Olmstead* decision, which elevated the rights of people with disabilities to live fully integrated in their communities of choice. This year also marks 16 years since Massachusetts released its initial *Olmstead* Plan charting a path towards improved community integration. Over that time, Massachusetts’ long-term care system has evolved considerably. In this 25th anniversary year, the Executive Office of Health and Human Services (EOHHS),¹ in collaboration with the Executive Office of Housing and Livable Communities (EOHLC),² is issuing this report to track Massachusetts’ *Olmstead* progress, provide a snapshot of the current state, and identify new initiatives and opportunities for continued development.

This report provides both a macro-level overview, as well as a person-centered focus, on Massachusetts’ Olmstead efforts to improve community integration for persons with disabilities.

Looking back over the years, the prioritization of community integration has long been a focus of Massachusetts government, as evidenced by the lengthy arc of its successful initiatives in this area. This includes participation in the federal Balancing Incentive Program (BIP) in the years 2012–2015 to increase the use of community-based services over facility-based services; the successful implementation of a Money Follows the Person (MFP) Rebalancing Demonstration in the years 2012–2018 to move individuals from facility settings to the community; and the development and implementation of multiple Medicaid Home and Community-Based Services (HCBS) waivers that enable persons with complex needs to live in the community as an alternative to facility-based care.

In 2018, Massachusetts issued an update to its original 2008 *Olmstead* Plan. The update introduced a framework for measuring progress with actions. The focus of this report is measuring Massachusetts’ progress as a result of its actions. Recognizing that *Olmstead* is about real lives and real people — our neighbors, our friends, our families — this report provides an overview of Massachusetts’ evolving system of services and supports, and includes personal stories that provide a close-up view into the real-world importance of *Olmstead*. In doing so, this report provides both a macro-level overview, as well as a person-centered focus, on the state’s *Olmstead* efforts.

Highlighted in this report are projects and initiatives that expand access to affordable housing, historic investments in community-based services, and unique initiatives that solidify and exemplify Massachusetts as a health care and housing innovator and national leader. This report also identifies new developments and initiatives currently underway that chart a path towards continued evolution of the state’s community integration

-
1. EOHHS is the largest secretariat of Massachusetts and comprises 11 agencies, including the Department of Mental Health and the Department of Developmental Services. In addition, EOHHS is the single state agency responsible for administering Massachusetts’ Medicaid program and its Children’s Health Insurance Program (CHIP) (together, MassHealth).
 2. EOHLC is the executive office of Massachusetts tasked with creating housing policy and advancing innovative solutions to provide safe, accessible, affordable, and livable communities throughout Massachusetts.

efforts. Among these is the [Massachusetts Community Living Initiative](#), through which the state seeks to assist a minimum of 2,400 MassHealth-eligible individuals interested in community living to transition from nursing facilities to the community over eight years.

In this 25th anniversary year, Massachusetts remains committed to implementing Olmstead principles to promote inclusive and supportive community living, ensuring that individuals with disabilities have greater opportunities to thrive in their community of choice. We aim to leverage technological innovations to enhance independence, improve safety, and create solutions tailored to an individual's unique needs. Additionally, we recognize the importance of flexibility and remain focused on adapting to meet the evolving needs of Massachusetts residents who could benefit from our support. By taking these steps, we strive to empower individuals with disabilities to lead fulfilling and self-directed lives.

Finally, in reporting on the state's progress, this Report serves to elevate and acknowledge Massachusetts' Olmstead vision. In this manner — as our society continues its work towards becoming a fully accessible and inclusive community — measuring progress as a way to deepen focus, raise awareness, and re-affirm the state's commitment to the principles of Olmstead.

Olmstead Overview

What is an Olmstead Plan?

The term “Olmstead Plan” derives from the Supreme Court’s opinion in *Olmstead v. L.C.*, 527 U.S. 581 (1999), in which the Court held that the Americans with Disabilities Act, as well as the regulations promulgated under that statute, prohibit the unjustified institutional isolation of individuals with disabilities. Specifically, the Court concluded that public entities must make community-based services — as opposed to facility-based services — available to persons with disabilities when:

1. Such services are appropriate;
2. The affected persons do not oppose the community-based services; and
3. The community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others with disabilities.

The court also signaled that states should develop “a comprehensive, effective working plan” for expanding access to community-based services for qualified persons with disabilities in long-term care facilities or at risk of entering a long-term care facility. In the years since the Supreme Court’s *Olmstead* decision, 24 states have issued Olmstead Plans setting a national path towards community integration. Massachusetts is one of these 24 states.

Massachusetts issued its initial Olmstead Plan in 2008. This initial plan served as a guide for advancing community integration for individuals with disabilities across all age groups—children, youth, adults, and seniors. In 2018, Massachusetts issued an update to its Olmstead Plan that established a strategic framework built around four goals, or pillars, necessary for persons with disabilities to live fully integrated in the community and identified actions to help achieve progress towards those goals.

Massachusetts’ Olmstead Goals — The Four Pillars

Recognizing that a state’s Olmstead Plan should reflect the whole person, Massachusetts structured its 2018 Olmstead Plan around four Olmstead-related goals, each representing a core facet necessary for building a successful foundation for community integration. These are:

Expanding Access to Affordable Accessible Housing with Supports

Massachusetts recognizes that a robust system of affordable, accessible housing is essential to helping individuals with disabilities transition to, and remain in, the community. Many people with disabilities need affordable housing that is accessible. They may also need services to help them find community-based

housing to move out of a facility, like a shelter or nursing home, or avoid having to move into one.

Enhancing Community-Based Long-Term Services and Supports

Massachusetts recognizes that it is important for persons with disabilities to have access to a broad range of community-based services. Community-based services help people move into, and stay in, community-based settings. Persons should be able to choose the services they need and have ready access to those services. People need access to services like medical, mental health, substance use disorder treatment, personal care, and other services to thrive in their homes and communities.

Promoting Community-Integrated Employment of People with Disabilities

Massachusetts recognizes that to be fully integrated in community living, persons with disabilities need to have access to competitive job opportunities that are not segregated. This means they should be able to get the same opportunities and benefits, in the same work setting, as people without disabilities.

Investing in Accessible Transportation for Individuals with Disabilities

Massachusetts recognizes that many people with disabilities rely on local or regional transportation systems and need access to a robust and accessible transportation system. Transportation allows individuals with disabilities to live independently within their communities. It connects individuals to employment, education, healthcare, and community life.

Figure 1: The Four Olmstead Pillars



What Have We Accomplished?

Progress Since 2018

In its 2018 Olmstead Plan, Massachusetts set an ambitious agenda with specific goals that would improve community living efforts across the four pillars of Housing, Services, Employment, and Transportation. While substantial progress has been made towards community integration, implementation of a state's Olmstead Plan does not occur in a vacuum, but often in the context of a system or systems already faced with competing priorities, finite resources, and a myriad of challenging circumstances.

Since 2018, Massachusetts has experienced growing demands and complexities within its system, largely driven by the global COVID-19 pandemic and its ongoing effects. While the pandemic brought unique challenges, it also highlighted the need for strategies to address workforce shortages in the community-based system and the importance of flexible service delivery. In needing to adapt to changing circumstances, Massachusetts has been guided at every step by individuals with lived experience, their families, and a diverse group of stakeholders.

Below are specific initiatives focused around the four pillars of [Housing](#), [Services](#), [Employment](#), and [Transportation](#) that Massachusetts has undertaken since 2018 that have advanced the cause of community living and the principles of Olmstead.



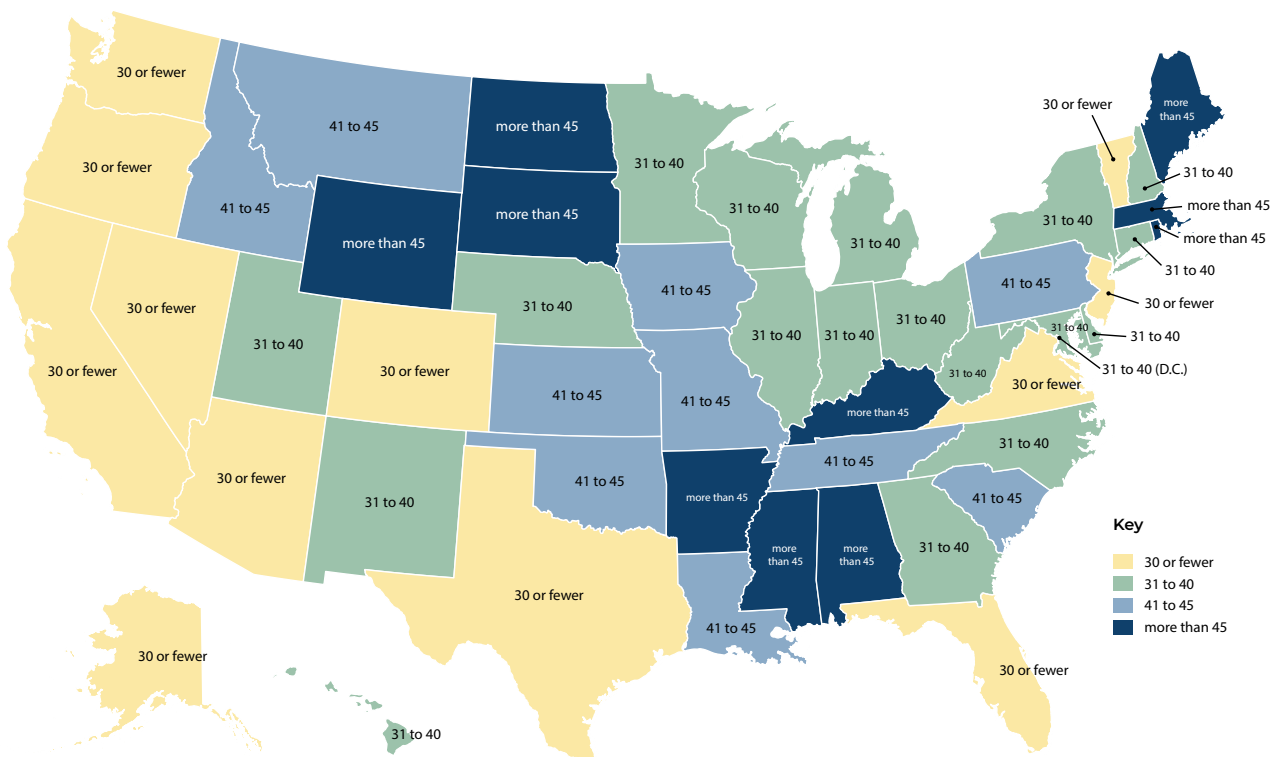
Expansion of Access to Affordable, Accessible Housing

Massachusetts has a high-cost housing market. In response to this challenge, Massachusetts has established multiple state-funded housing production and rental assistance programs specifically targeted to support people with disabilities to live in their community of choice. Today, Massachusetts is a leader in providing integrated, affordable, accessible housing. While no state has an adequate supply of affordable rental housing, as shown in [Figure 2](#), the National Low Income Housing Coalition data shows that Massachusetts ranks in the top tier.

Nationally, Massachusetts ranks 11th in adequacy of housing supply among states and has the 10th highest number of units, with 46 affordable rental units per 100 extremely low-income renter households.

Since the release of its 2018 Olmstead Plan, Massachusetts has continued to invest substantial resources in making housing more affordable and accessible for people with disabilities. These investments include: new production, increased supply of integrated housing, increasing investments in rental assistance programs, supporting the modification of existing homes, and housing search and transitional assistance.

Figure 2: No state has an adequate supply of affordable rental housing for the lowest-income renters. Affordable and available rental homes per 100 extremely low-income renter households.³



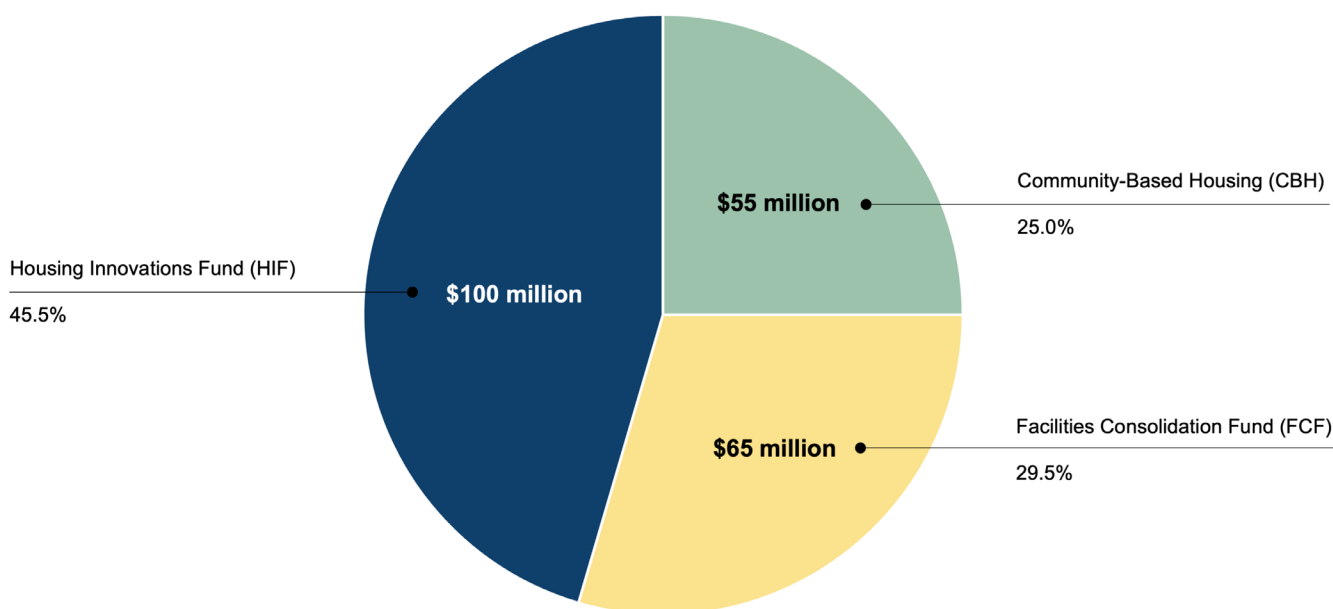
Source: Map based on [The Gap: A Shortage of Affordable Homes](#), National Low Income Housing Coalition

NEW PRODUCTION

Massachusetts continually invests in new housing to increase the supply of affordable and accessible housing. Specific housing capital programs that fund housing for people with disabilities include the Facilities Consolidation Fund (FCF) and the Community Based Housing (CBH) program fund, as well as the Housing Innovation Fund (HIF). FCF was created in response to an advocate-driven effort to close institutions serving Department of Mental Health (DMH) or Department of Developmental Services (DDS) consumers. The fund provides capital for the development of community-based housing for clients of DMH and DDS. The CBH program funds the development of integrated housing for people with disabilities, including older adults, with priority for individuals who are in institutions, nursing facilities, or at risk of entering an institution or nursing facility. HIF funds affordable rental housing for special needs populations; EOHLC currently gives preference to projects that provide transitional and permanent housing for individuals and families experiencing homelessness. Since the release of the 2018 Olmstead Plan, Massachusetts has invested over \$220 million through these programs in building housing for people with disabilities and those experiencing homelessness.

3. National Low Income Housing Coalition, "The Gap: A Shortage of Affordable Homes," <https://nlihc.org/gap>

Figure 3: Investments in building housing for people with disabilities since 2018



Between fiscal year (FY) 2018 and FY2023, over 10,000 affordable units were funded. As these and other EOHLC investments are generally in new construction or substantial rehabilitation, most of these properties include accessible units as required under state and federal fair housing laws. Among the 10,000 affordable units, Massachusetts funded the development of 3,897 units of permanent supportive housing (PSH) across multiple funding sources. PSH refers to affordable housing combined with voluntary supportive services, prioritized for people with disabilities and/or who have experienced homelessness or housing instability.

INCREASED SUPPLY OF INTEGRATED HOUSING

Towards that same end, Massachusetts has shifted policy to increase the supply of integrated housing for people with disabilities. The Massachusetts 3% Priority Program, for example, supports the state's efforts to help people with disabilities and older adults live in the least restrictive and most integrated setting possible of their choosing. Through this program, the state provides priority access for people with disabilities and older adults to community-based housing coupled with the services they need to be successful members of the community. Since 2018, Massachusetts has refined the program to better target low-income individuals with disabilities referred by DMH, DDS, MassAbility⁴, and the Executive Office of Elder Affairs (EOEA). As of September 2020, owners of publicly supported rental developments⁵ with at least 17 affordable units are required to prioritize referrals from these state agencies for 3% of the subsidized units.

INCREASING INVESTMENTS IN RENTAL ASSISTANCE PROGRAMS

In addition to increasing the supply of affordable units, Massachusetts has committed to funding programs that provide housing assistance to persons with disabilities. EOHLC administers numerous rental assistance programs consisting of flexible subsidies that assist individuals and households in affording the housing costs

4. MassAbility, formerly the Massachusetts Rehabilitation Commission.

5. Publicly supported rental developments are defined as receiving state or federal capital subsidies, tax credits, or project-based rental assistance through state housing agencies.

of market-rate units. Rental assistance program participants typically pay 30% of their income for rent and EOHLC pays the landlord the remaining cost, up to the applicable rental standard. Tenants are generally able to choose the type and location of their unit. Some vouchers are mobile and allow the participants to take the vouchers with them if they move to another property or community. Other vouchers are attached to specific units and are not mobile.

EOHLC administers over 23,000 federally funded Section 8 Housing Choice Voucher Program (HCVP) vouchers and over 10,000 state-funded Massachusetts Rental Voucher Program (MRVP) vouchers. People with disabilities have access to both of these programs. EOHLC reports that an estimated 40% of MRVP vouchers are used by households with a head of household who has a disability and that 49% of HCVP vouchers are used by households with a head of household who has a disability and/or is an older adult. EOHLC often project-bases HCVP and MRVP vouchers in projects funded with FCF, CBH, and HIF in order to make them affordable to extremely low-income people with disabilities.

EOLHC Administered Vouchers

Massachusetts residents with disabilities have access to housing vouchers through these federally- or state-funded programs.

Through Section 8 HCV Program (federal):	23,000
<i>Head of Household has a disability or is an older adult</i>	49%
Through MA Rental Voucher Program (state):	10,000
<i>Head of Household has a disability</i>	40%

Importantly, the state also administers vouchers that are specifically targeted and available only to people with disabilities. Federally funded targeted programs include Mainstream vouchers, a component of the HCVP program for which the only eligible households are those that include at least one person between the ages of 18 and 62 who has a disability. Since 2018, the state has been awarded 127 additional Mainstream vouchers for a total of 291. EOHLC also administers the Section 811 Project Rental Assistance (PRA) program, a federally funded partnership between EOHLC and EOHHS that provides integrated housing for extremely low-income adults with disabilities under the age of 62 including individuals transitioning from long-term care facilities into the community and those who are at risk of entering such facilities. The program is designed to support persons with disabilities who need affordable housing and access to community-based supports and services, such as case management, housekeeping, and daily living assistance, to successfully live independently in the community. The state has applied to and been successful in every 811 PRA competitive funding round beginning in 2012. Since 2018, the state has applied for and been awarded funding for 72 units in 2020 and funding for 62 units in 2023, bringing the current total to 272 units.

State-funded rental assistance programs targeted to people with disabilities include DMH's Rental Subsidy Program and the Alternative Housing Voucher Program (AHVP). Only DMH clients are eligible for the DMH Rental Subsidy Program, which provides sponsor-based and tenant-based vouchers; this rental assistance is paired with services funded by DMH. AHVP provides rental assistance to non-elderly persons with disabilities, and is administered by local housing authorities and regional administering agencies. Since 2018, the DMH Rental Subsidy Program has increased by more than 50%, from serving 1,430 clients in FY2019 to 2,451 in FY2024. The AHVP program has increased by over 85% from 425 leased vouchers in FY2019 to 798 in FY2024.

[Figure 4](#) below shows the overall growth in housing vouchers for persons with disabilities from 2019 to 2023, and indicates a 11.1% increase from 17,502 vouchers in 2019 to 19,444 vouchers in 2023.

Figure 4: Housing Vouchers for People with Disabilities in Massachusetts

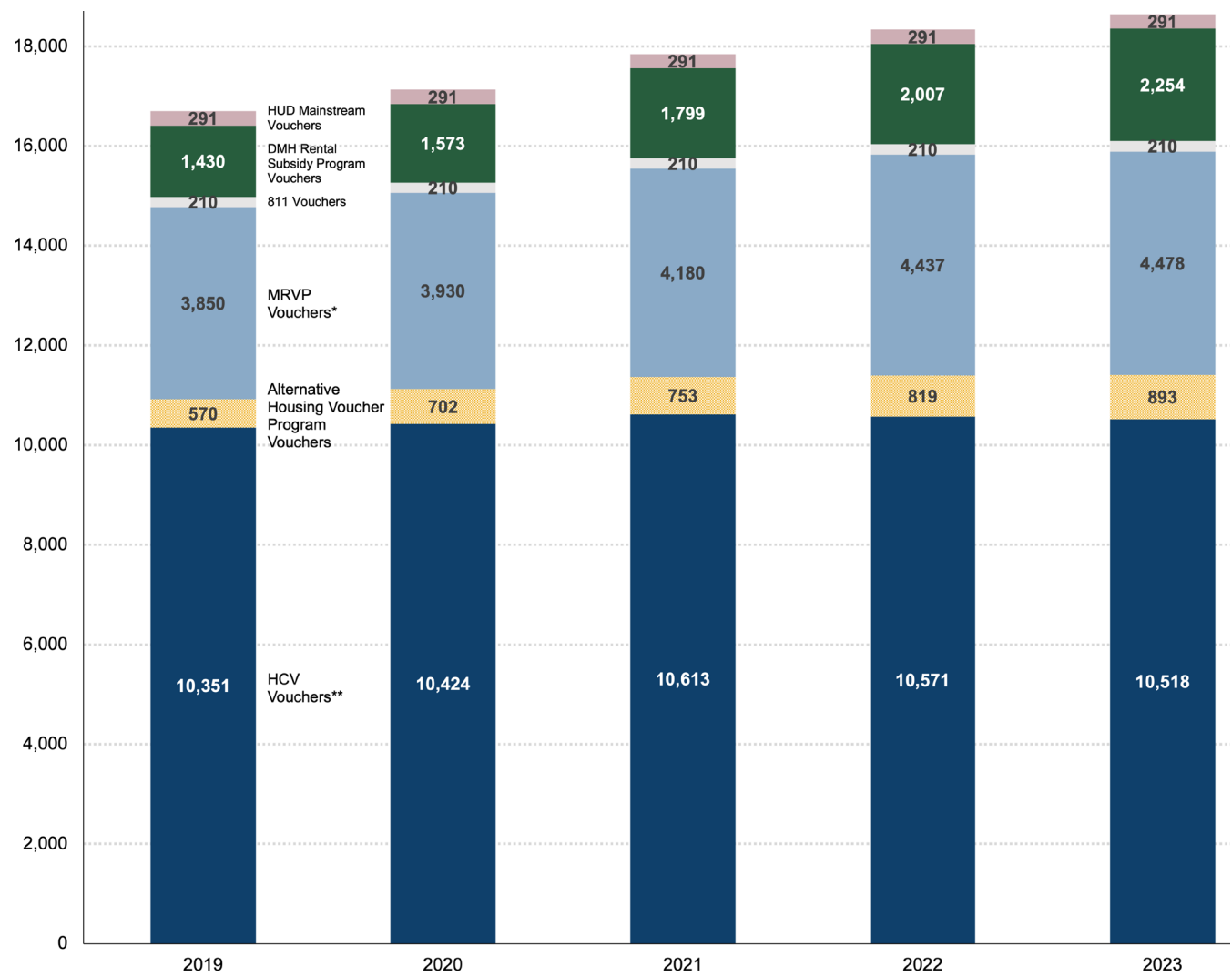


Table 1: Housing Vouchers for People with Disabilities in Massachusetts

Housing Vouchers for Persons with Disabilities in MA	2019	2020	2021	2022	2023
811 Vouchers	210	210	210	210	210
Alternative Housing Voucher Program Vouchers	570	702	753	819	893
DMH Rental Subsidy Program Vouchers	1,430	1,573	1,799	2,007	2,254
Housing Choice Vouchers (HCV)**	10,351	10,424	10,613	10,571	10,518
HUD Mainstream Vouchers	291	291	291	291	291
MA Rental Voucher Program Vouchers (MRVP)*	3,850	3,930	4,180	4,437	4,478

*This data series represents the 40% of the MRVP vouchers held by households with a disabled head of household.

**This data series represents the 49% of HCV held by households with a disabled and/or elder head of household.

SUPPORTING THE MODIFICATION OF EXISTING HOMES

Another strategy Massachusetts has used to increase accessible, affordable housing is to fund the modification of existing homes or properties to accommodate residents or their family members with disabilities.

The Home Modification Loan Program (HMLP), administered by the Community Economic Development Assistance Corporation (CEDAC), helps individuals to remain in their own homes by making changes such as installing wheelchair ramps, bathroom adaptations, and other accessibility modifications. HMLP provides low- and no-interest loans for home modifications to older adults, individuals with disabilities, the families of children with disabilities, and qualified landlords who rent homes to individuals with disabilities. Since FY2019, Massachusetts has issued 1,140 home modification loans, totaling an investment of over \$34 million, through this program.

Figure 5: Home Modification Loans (FY19 – FY23)

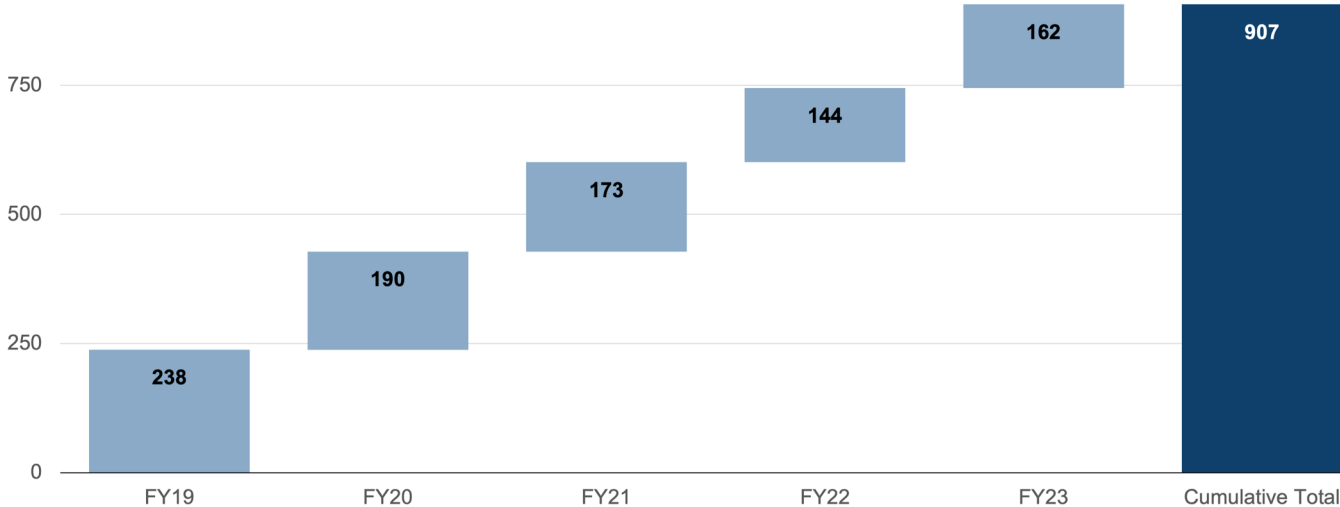


Table 2: Statewide Fiscal Year Summary for Home Modification Loans (FY2019 – FY2024)

State Fiscal Year	Number of Households	Number of Loans	Total Amount Deployed	Average Loan amount
2024	212	233	\$7,209,635	\$34,000
2023	149	162	\$5,074,189	\$34,055
2022	131	144	\$4,436,280	\$33,864
2021	157	173	\$5,319,427	\$33,881
2020	172	190	\$5,411,610	\$31,462
2019	205	238	\$6,552,144	\$31,961

MassAbility also provides home modifications through its community living division. MassAbility covers the cost of home modifications up to \$50,000 when needed to help a person transition from a nursing facility to the community under the Moving Forward Plan-Community Living waiver or the MFP Demonstration. Examples of home modifications funded through MassAbility under these two programs include the installation of wheelchair ramps, the widening of doorways to enable wheelchair ingress/egress, and the remodeling of homes to create accessible bathrooms. Homeownership is not required, and modifications are available for individuals transitioning to both rental apartments and privately owned homes.

Since 2018, MassAbility has completed 995 home modifications that were necessary to enable an individual to move from a facility to the community, with an average cost of approximately \$19,700 per home modification. [Table 2](#) on the next page provides the total number of home modifications provided by MassAbility from FY2018 through FY2024.

Olmstead Voices: Cathy

Program: MFP-CL Waiver

Cathy was married and working full time when she woke up one morning unable to walk. In her mid-fifties, she was hospitalized and received rehabilitative services and was able to return home. She became sick again in her early sixties and eventually needed to enter a nursing home. In 2019, now divorced and unable to work, Cathy found herself alone with little hope of resuming life in the community. MassAbility conducts outreach in nursing facilities in an effort to identify eligible individuals who may wish to return to the community with supports through one of the Home and Community Based Services Waivers. With encouragement from Alison, a MassAbility case manager who told her she was “too young to stay in a nursing home her whole life,” Cathy agreed to pursue options for community living. Alison and a representative from the Southeast Center for Independent Living assisted Cathy with an application for the Moving Forward Plan – Community Living (MFP-CL) waiver. She was found

eligible for the waiver and in August 2020, Cathy was supported to move into her own furnished apartment, with essential services in place. She now has a home health aide who assists with cooking and cleaning, among other things. She receives quarterly visits from her nurse practitioner who helps her to manage her multiple sclerosis, high blood pressure, and diabetes. Cathy praises Alison’s assistance in supporting her move to the community. Living on her own, Cathy appreciates all of the services she receives that support her independence. Alison remains involved in her care and reported that “Cathy was and remains a very sharp, independent woman and we felt she could do well with a return to the community. She was eager to try and has been such a delight to work with and support over the years.



Table 3: Home Modifications by MassAbility from FY2018–FY2024

State Fiscal Year	Major Home Mods (>\$5,000)	Minor Home Mods (<\$5,000)	Total	Average Home mods cost
2024	116	32	148	\$ 21,634.65
2023	121	37	158	\$ 16,952.94
2022	96	47	149	\$ 17,115.19
2021	103	25	128	\$ 20,325.22
2020	120	8	128	\$ 24,752.56
2019	137	12	149	\$ 17,419.22
2018	115	20	135	\$ 19,715.54

HOUSING SEARCH AND TRANSITIONAL ASSISTANCE

In addition to increasing the supply of affordable and accessible housing and supporting residents’ ability to afford existing housing, Massachusetts has made significant advances in supporting individuals throughout the housing-seeking process. These improvements focus on enhancing access to housing by refining housing search and application procedures and tools. In April 2019, Massachusetts introduced the [Common Housing Application for Massachusetts Programs](#) (“CHAMP”) portal, allowing applicants to access state-funded subsidized housing resources online, including state-aided public housing, MRVP, and AHVP.

Furthermore, the state facilitated the development of the [Housing Navigator](#) in 2021, an online search tool encompassing all affordable housing options. Housing Navigator is the official online listing and search tool for accessible and affordable rental homes in Massachusetts, and includes filters for various accessibility features of listed units. As of mid-2024, 40,000 people use the Housing Navigator search tool every month — more than 400,000 unique users a year.⁶

Beyond having sufficient affordable and accessible housing, and assistance with locating such housing, persons seeking to transition to the community from an institution may have other unique housing related barriers to transition. These barriers may manifest as lack of funds to cover a security deposit, a lack of resources to cover costs associated with furnishing a home in the community, or need for assistance with setting up utilities and coordinating a move to the community. Massachusetts has sought to address these unique barriers to transition through the following initiatives.

6. Housing Navigator Massachusetts (n.d.). About us. Housing Navigator Massachusetts. Retrieved September 9, 2024 from <https://housingnavigatorma.org/about-us/>

Mitigating the Costs of Housing (MATCH) Program

With federal funds available through the American Rescue Plan Act (ARPA), EOHHS developed the MATCH program in 2023 to help MassHealth members pay for move-in costs and buy the items they need to make a new home livable. MATCH funds were available to pay for one-time costs for those moving out of institutions — including nursing homes and correctional facilities — or moving from homelessness into housing. Flexible funds were used for a variety of services including the following one-time transition costs: move-in assistance (e.g., moving costs, security deposits, costs related to starting utilities, first month's rent); furniture; basic furnishings and supplies to set up a bathroom and bedroom (e.g., bedding, towels, toiletries); basic kitchen supplies (e.g., dishware, silverware, cooking supplies, appliances not supplied by the property owner); environmental modifications necessary to install necessary accommodations but not covered by insurance; pest eradication or onetime cleaning; and other one-time expenses required for the transition from an institution to community housing. Through the MATCH program, Massachusetts helped approximately 2,600 individuals to find, secure, and transition to community housing.

While MATCH was a standalone program funded with one-time funds available through ARPA, Massachusetts currently operates multiple programs that cover similar transition costs to assist individuals in overcoming housing-related barriers and moving from facilities to the community. These programs include multiple MassHealth HCBS waivers that provide transitional assistance services; the state's current MFP Demonstration, launched in 2023; and the Executive Office of Elder Affairs' Community Transition Liaison Program (CTLP). Details on these programs are provided in the next section of this report, covering enhancements to community-based services and supports since 2018.

Homeless Initiatives Serving People with Disabilities

Despite efforts to increase housing supply and affordability and decrease barriers to finding housing, homelessness persists among the disability population. The U.S. Department of Housing and Urban Development's (HUD) 2023 HUD Homeless Populations and Subpopulations report for Massachusetts indicates that many homeless individuals self-report as having a mental illness and/or a substance use disorder.⁷ As many of these individuals with disabilities are not only experiencing homelessness but are also at risk of entering an institution or nursing facility, Massachusetts' Olmstead-related housing initiatives have also sought to address homelessness.

Olmstead Voices: Anonymous Participant

Program: MATCH

"Before the MATCH program existed, I had been through detox several times and completed a few residential programs, but transitioning from the house to living on my own was incredibly challenging. Every time I graduated, I built a strong recovery support network, but I couldn't sustain it on my own, so I'd end up back in my old environment and, inevitably, relapsed. This cycle of addiction, detox, CSS, TSS, and Residential Programs seemed endless—until the MATCH program stepped in.

This time, with their help, I was able to move into my first place on my own, giving me the stability and support I needed to stay grounded in my recovery. Now, I'm living in a beautiful apartment in downtown Salem, Massachusetts, and I work as a case manager for the very program that saved my life. My goal is to be a source of hope and inspiration for others facing the same struggles I went through.

The MATCH program truly gave me a fighting chance, and I will always be indebted to it."

7. Report available at: https://files.hudexchange.info/reports/published/CoC_PopSub_State_MA_2023.pdf

One way Massachusetts has worked to address homelessness among individuals with disabilities is by participating in the federally funded Continuum of Care (CoC) program. Through this program, regional organizations coordinate housing programs and services to assist individuals and families experiencing homelessness. There are 11 CoCs in Massachusetts that collectively fund 8,881 units of PSH. PSH provides long-term housing subsidies and support services to eligible individuals who are homeless and have a disability. Additionally, the Balance of State CoC, managed by EOHLC, anticipates increasing the number of households in PSH during 2024 by 35 households with children. In EOHLC's October 2024 submission to HUD for additional funding, EOHLC is seeking to add 37 units for medically fragile homeless individuals and 30 units for homeless individuals with a substance use disorder.

The Safe Haven program is another Massachusetts initiative that seeks to address homelessness among individuals with disabilities. This program provides supportive housing for hard-to-reach individuals with serious mental illness, primarily those who have been living on the streets and are unable or unwilling to engage in traditional housing or support services. Safe Havens use a [Housing First](#) supportive housing model, offering an alternative to shelter placement. While many Safe Haven clients choose to participate in behavioral health treatment, it is not required to access Safe Haven housing. Since 2018, DMH has added 39 Safe Haven beds, with 35 more in development, which will bring the total to 140 beds.

Additionally, in 2022, EOHLC developed the Sponsor Based Permanent Supportive Housing Program, creating 200 units of service-rich housing for very vulnerable homeless persons. The project was expanded in 2023 to sustain low-threshold sponsor-based leasing. The program was designed to mitigate overcrowding in homeless shelters and leverage existing Medicaid supportive services to ensure individuals have the necessary supports to remain housed. In 2024, the program received \$8.9 million in legislative appropriations to support 329 adults in PSH.

Another innovative program to help prevent homelessness and promote long-term housing stabilization for individuals with high health care needs is Massachusetts' Medical Respite pilot program. In 2023, Massachusetts awarded \$5.2 million in grants for partnerships between health care agencies and community-based organizations under a new medical respite pilot program that provides individuals experiencing homelessness a safe space to recover after a hospital visit. Medical Respite locations currently offer 40 beds of temporary housing with clinical supports while program participants receive assistance in finding suitable long-term housing. The Medical Respite Program aims to improve hospital discharge rates, reduce hospital lengths of stay, and decrease the total cost of care for patients experiencing homelessness. It also seeks to strengthen the relationship between providers of homelessness services and health care agencies. Medical respite locations serve individuals experiencing homelessness who meet specific criteria, such as being discharged from a hospital with no housing option, requiring a safe place to prepare for a medical procedure, and not needing hospital-level care or 24/7 support. Studies have shown that medical respite programs significantly reduce health care costs and improve health outcomes by reducing hospital inpatient lengths of stay and readmissions. They have also proven instrumental in helping individuals achieve long-term housing stabilization.



Enhancements to Community-Based Services and Supports

Since 2018, Massachusetts has made substantial investments to improve access to and quality of communitybased care, expand community-based service options, and support choice in services and providers. Most notably, via one-time ARPA funds, Massachusetts invested more than \$650 million in a range of initiatives designed to support the strengthening of Medicaid-related home and community-based services.⁸

The following section captures progress across two main Olmstead-related themes: 1) new and existing programs and initiatives designed to support diversion and discharge from facility-based settings to the community and 2) new and existing programs and initiatives to enhance and expand Massachusetts' infrastructure of communitybased services and supports.

PROGRAMS AND INITIATIVES THAT SUPPORT DIVERSION

In the 25 years since the Supreme Court's Olmstead decision, Massachusetts has developed and implemented numerous programs that are designed to help reduce reliance on facility-based settings for the delivery of long-term services and supports. This includes programs that provide options counseling for individuals living in the community to help them understand their care options. This also includes programs that screen individuals prior to an admission to a nursing facility to determine whether they have an intellectual disability or serious mental illness and to assess whether community-based services are more appropriate. Additionally, this includes innovative diversion programs for persons with mental illness that seek to help maintain community tenure, as well as programs that evaluate hospital patients at the point of discharge to a nursing facility for post-acute care to determine whether discharge home is a possible alternative.

For individuals who have been residing long-term in facility-based settings, there are programs and initiatives to help them understand their options for discharge and return to the community. Additionally, because individuals who have resided long-term in a facility-based setting frequently do not have access to community housing, these programs include support in locating and accessing community-based housing. This support may include assistance with the housing search process, completion of housing related paperwork, and funding for one-time setup costs for the individual's new home in the community (e.g., the purchase of kitchen supplies and bedroom furnishings).

Options Counseling to Promote Informed Choice for Long-Term Care

Often times individuals and their caregivers are unaware of their options for long-term care and presume that admission to a nursing facility is the only path. Massachusetts recognizes the importance of informed choice and operates multiple programs to help ensure that individuals and their families are informed of the options to receive long-term care services in the community and as an alternative to receiving services in a facility-based setting. One manner in which outreach is performed is through EOE's Options Counseling program. The Options Counseling program serves both individuals in community settings who are at risk of admission to a nursing facility, as well as individuals residing in facilities who express a wish to return to the community, and is

8. Massachusetts' full ARPA 9817 spending plan is available at <https://www.medicaid.gov/medicaid/home-community-based-services/downloads/ma-spend-pln-july2023-amend.pdf>. The spending plan outlines over 70 projects and initiatives across three key areas: 'HCBS Workforce,' 'HCBS Technology and Infrastructure,' and 'Access to and Promotion of HCBS.' All of the projects and initiatives in the state's ARPA spending plan are designed to enhance, expand, and strengthen Medicaid-covered HCBS in Massachusetts.

available to all individuals regardless of insurance type.

In state fiscal year (SFY) 2023, EOEa provided options counseling to 4,785 individuals.⁹ Review of available data indicates that 96% of individuals who received options counseling in the community with an initial goal of staying in the community were able to achieve that goal.¹⁰ More importantly, 65% of individuals who received options counseling in the community with an initial goal of entering a nursing facility opted for community-based services instead.¹¹

Pre-Admission Screening and Resident Review (PASRR) Enhancements

For persons with an intellectual disability (ID) or Serious Mental Illness (SMI),¹² or suspected of having an ID or SMI, EOHHS operates a PASRR program pursuant to federal requirements. Through PASRR, EOHHS is able to ensure that persons seeking admission to a nursing facility are screened for ID/SMI and that persons suspected of having ID/SMI receive a comprehensive evaluation prior to admission and upon any significant change in condition. The comprehensive evaluation includes an assessment, recommendation, and determination as to whether the person's total care needs can be met in a nursing facility or whether community-based services would be more appropriate.

In 2023, EOHHS, in collaboration with DMH and DDS, launched an online PASRR portal to digitize and streamline the PASRR process. Introduced in late August 2023, this portal enables the state to track PASRR screenings and PASRR evaluations more effectively. The portal also enhances DDS's and DMH's ability to analyze PASRR outcomes on a broader scale, helping to identify patterns and detect potential biases. Additionally, the portal assists nursing facilities in monitoring PASRR status for their residents and supports EOHHS enforcement of nursing facility compliance with PASRR regulations. In FY2023, 84,585 PASRR Level I screenings were completed, and 5,802 PASRR Level II evaluations were conducted.

Table 4: PASRR Screening Data

PASRR Screening Completed	Metrics
Number of PASRR Level I screens completed 8/28/23 – 6/30/24* <i>The PASRR Level I screen assesses whether a person may have SMI and/or ID. If the screening indicates the assessed person may have SMI and/or ID, a PASRR Level II evaluation is performed.</i>	Total Screenings: 84,585 May have SMI: 10,611 May have ID: 817 May have SMI and ID: 243 No SMI: 73,974 No ID: 73,157
Number of PASRR Level II evaluations completed 7/1/23 – 6/30/24* <i>The PASRR Level II evaluation determines whether a person has SMI and/or ID.</i>	Total Evaluations: 5,802 SMI Positive: 670 SMI Negative: 5,132 ID Positive: 523 ID Negative: 147

*Data is by total number of screenings/evaluations, not total number of individuals screened/evaluated

9. SFY 2023 Options Counseling Legislative Report

10. Id.

11. Id.

12. SMI as defined under federal PASRR regulations at 42 CFR 483.102 (b)(1).

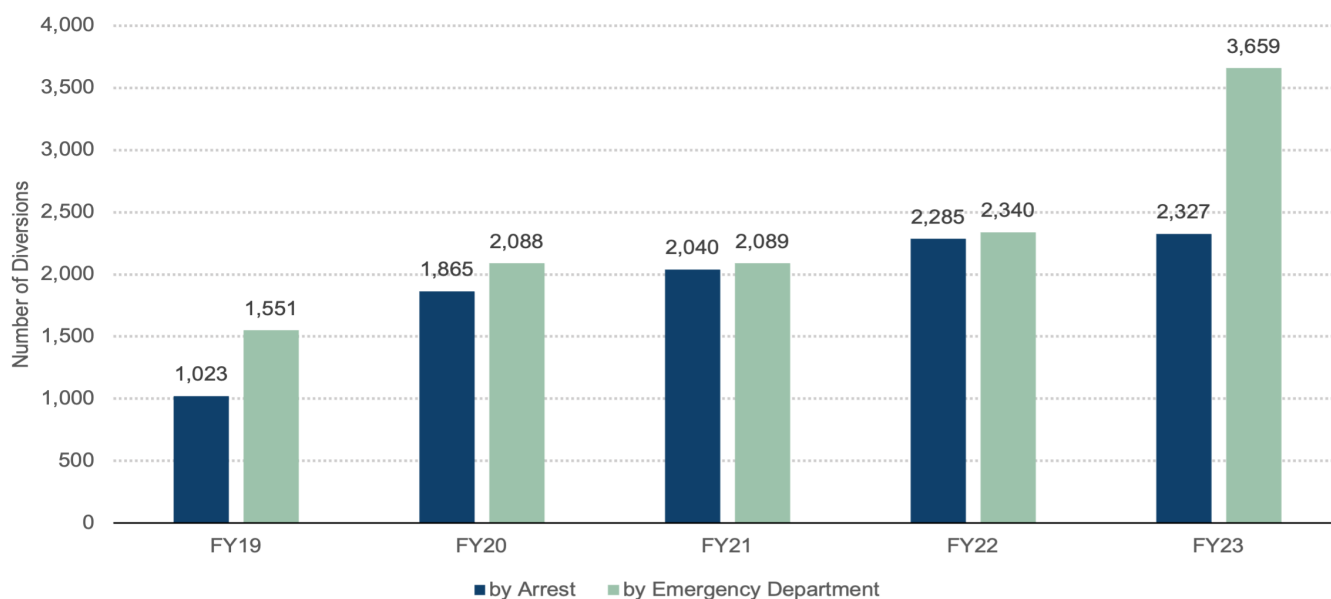
Hospital to Home Partnership Program (HHPP)

To further promote diversion from nursing facility admission and towards community-based services, EOHHS launched a grant program in 2024 to embed a Hospital to Home Liaison in hospitals to provide enhanced discharge planning. The grant funds support HCBS Hospital Liaisons, employed by local area Aging Services Access Points (ASAPs), who partner with hospital case managers to connect patients with home and community-based services before discharge. This initiative aims to reduce hospital-to-nursing-facility discharges by fostering partnerships between hospitals and local ASAPs, improving communication and coordination with community-based services providers and with the goal of promoting discharges directly to home settings. Massachusetts awarded an initial 10 grants of \$300,000 each followed by an additional 5 grants totaling approximately \$850,000. While this is a new program, some hospitals have already reported that this program has been an invaluable resource for improving discharges to home and other hospitals have expressed interest in participating.

DMH Jail Diversion Program

The DMH Jail Diversion Program has aimed to keep individuals with mental illness or other behavioral health conditions who are experiencing a crisis out of prisons, jails, and emergency departments. Studies note that nationally, jails have become the nation's largest psychiatric institutions, and emergency departments can be the gateway to long-term institutional care. The DMH Jail Diversion Program has provided grant funding directly to municipalities and behavioral health providers to help support diversion projects, while also supporting technical assistance for law enforcement and their behavioral health partners statewide. Data gathered by DMH to evaluate the success of these grants has demonstrated positive outcomes.

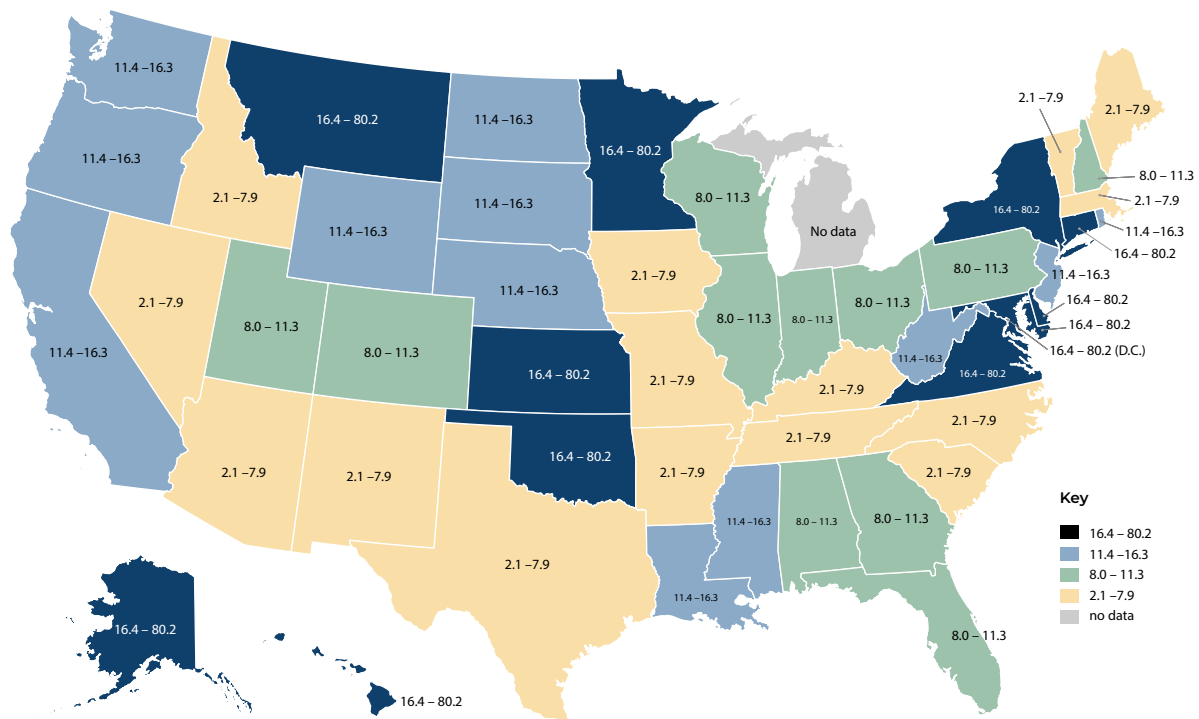
Figure 6: *Diversion Outcomes by Grantees (FY19–FY23). The following chart shows the FY19–FY23 recorded number of diversions from arrests and emergency department visits by year.*



Further evidence to support the success of DMH's efforts to reduce unnecessary hospitalizations can be found in an NRI State Profiles report which identifies Massachusetts among states with the lowest percentage of population

in state psychiatric hospitals.

Figure 7: State Psychiatric Hospital Patients on First Day of Fiscal Year 2022, per 100,000 State Population



PROGRAMS AND INITIATIVES THAT SUPPORT DISCHARGE FROM LONG-TERM CARE FACILITIES

Since implementation of the 2018 Olmstead Plan, Massachusetts has made substantial investments in a number of innovative programs to identify and assist individuals residing in long-term care facilities to transition to the community with supports. This includes:

The Community Transition Liaison Program (CTLTP)

CTLTP was created by EOEA to assist nursing facility residents in exploring community service options and transitioning back to community living. The program began operation in July 2023 and is available to all nursing facility residents aged 22 and older, regardless of diagnosis or insurance type. The program operates through EOEA contracts with local area ASAPs. CTLTP teams are assigned to specific nursing facilities and visit each nursing facility at least once a week. CTLTP teams offer education about community living options, support informed choice, and for residents interested in transitioning to the community, CTLTP teams provide transition support and help arranging community-based services and supports. Each team includes a full-time Community Transition Liaison and a Case Assistant supported by a part-time supervisor. In 2024, there are 45 CTLTP teams providing statewide coverage. Since implementation of this new program, CTLTP teams have helped over 1,200 individuals transition from nursing facility to community settings. The chart below provides the total number of individuals that enrolled in CTLTP and who completed a transition to the community with CTLTP supports in SFY 2024.

Table 5: Community Transition Liaison Program Enrollments and Assisted Transitions for State FY23

State Fiscal Year	CTLP Enrollment	CTLP Assisted Transitions
2024	3,763	1,201

Implementation of a Renewed Money Follows the Person Demonstration (MFP Demo)

In April 2023, EOHHS successfully negotiated funding for a renewed MFP Demo with the federal government. This initiative supports EOHHS's goal of promoting community-based care as an alternative to receiving care in an institutional setting. The MFP Demo seeks to identify Medicaid-eligible individuals residing in a nursing facility for at least 60 days who wish to transition to community living, with a focus on identifying older adults, individuals with ID/DD, individuals with mental illness, and individuals with physical disabilities. Participants in the program receive specialized services beyond those covered by MassHealth, including housing search assistance, transitional assistance services to help cover initial home set up costs such as the purchase of kitchen supplies and bedroom furnishings, as well as medically necessary home modifications such as the installation of ramps for ingress and egress.

Massachusetts' MFP Demo began enrolling individuals in July, 2023 and currently there are 710 individuals enrolled in the program, while 173 individuals have successfully transitioned from a facility to the community under the program.

Table 6: Money Follows the Person (MFP) Demonstration Chart: Number enrolled to date and number of transitions to date

Calendar Year	MFP Demo Enrollment	MFP Demo Participants (transitioned to the community)
2023	381	71
2024	710	173

Behavioral Health Community Partners in Nursing Facilities (BH CPs in NFs)

In July 2023, EOHHS and DMH launched the Behavioral Health Community Partners (BH CP) program in nursing facilities to provide enhanced coordination of behavioral health and specialized services for nursing facility residents identified as having SMI pursuant to a PASRR evaluation. The overall goal of the BH CP program is to improve care coordination and delivery of behavioral health and specialized services for nursing facility residents with SMI, with an emphasis on facilitating transitions to community-based living.

Through this program, EOHHS partners with BH CPs — organizations specializing in behavioral health care — to coordinate recommended behavioral health and specialized services. This care coordination helps ensure that nursing facility residents with SMI receive the essential behavioral health services and supports they need. Since implementation of this program, more than 840 individuals residing in nursing facilities have received BH CP care coordination.

In combination with this program, in December 2022, DMH updated its regulations to extend DMH eligibility to all nursing facility residents identified as having SMI through a PASRR evaluation. As part of this expansion,

DMH now offers transition case management services to nursing facility residents identified as having SMI who are expected to be discharged within 90 days. The DMH transition case managers facilitate the transition process and coordination for supports and services in the community. Since implementation of this program, DMH has provided nursing facility transition case management to over 92 individuals to assist with transition to a community-setting with supports.

Table 7: Department of Mental Health (DMH) and Behavioral Health Community Partners (CP) Outcomes

DMH Nursing Facility Transition Team and BH CP	No. of Persons
Number of persons enrolled with DMH transition case management	164
Number of persons with DMH transition case management who transitioned to community	92
Number of persons enrolled with BH CP	804

Olmstead Voices: Jillian

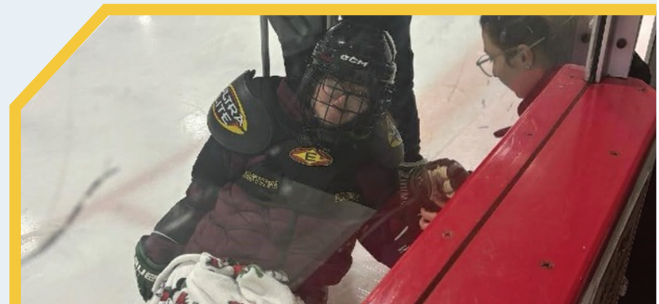
Program: MFP-RS Waiver

Jillian is a young woman living with complex medical needs. In 2023, through the Moving Forward Plan – Residential Supports Waiver (MFP-RS) operated by the Department of Developmental Services (DDS), Jillian received support to transition from Tewksbury Hospital to a group home where she has been living for almost one year.

Now Jillian states she has more freedom, she has goals and people to help her achieve those goals. With the help of DDS, the MFP-RS waiver, and the Edinburgh Center, Jillian has choices of activities to participate in; her favorite is adaptive sled hockey. As a woman who requires a wheelchair to move around, Jillian never imagined she could ever play a sport like hockey — and she absolutely loves it! She volunteers at Strongwater Farm, a therapeutic equestrian center in Tewksbury where she gets to spend time with horses and helps clean stalls. Jillian loves animals and enjoys weekly visits from a therapy dog in her home.

Although her life isn't without challenges, Jillian views her struggles as similar to those faced by anyone else. She continues to work with a psychiatrist and

counselor to stabilize her mental health and aspires to one day attend college to study psychology or train as a peer counselor. Jillian dreams of helping others in similar situations, showing them that it is possible to “make it to the other side and feel good about life.” She sees herself as “living proof” that there can be light at the end of the tunnel and hopes her story will inspire others. She emphasizes that her life has greatly improved with access to choices, transportation, and the ability to engage in meaningful activities, such as attending church. Jillian is an advocate for individuals with disabilities. Her message is that the services in Massachusetts are really making a difference.



For individuals who transition to the community with DMH supports, DMH offers community-based supports through its Adult Clinical Community Services (ACCS) program, which is a comprehensive, clinically focused service model anchored by a multidisciplinary team that provides clinical coverage 24 hours a day, 7 days a week, 365 days a year. Specifically, ACCS provides clinical assessment of symptoms and risk factors and develops treatment plans to treat symptoms and mitigate risk in order to promote community tenure, improve symptom stabilization, promote self-sufficiency, and maximize functioning, safety, and health for persons with complex behavioral health issues living in the community.

ACCS encompasses two primary components: ACCS Group Living Environments (GLEs) and ACCS Integrated Teams (ITs). ACCS GLEs provide a range of housing with services options, which serve as treatment settings to assist individuals in developing skills and establishing natural supports and resources to live successfully in the community. ACCS ITs provide clinical interventions and peer and family support to individuals residing in the community, and support individuals as they develop the skills to move toward independence. Specific supports include providing assistance with securing affordable housing, including ongoing engagement with clinical teams, and continued treatment interventions to promote successful community living.

To further support individuals who are transitioning or diverting from skilled nursing facilities to the community, DMH has established a new intensive ACCS model — Enhanced Medical Group Living Environment (EMGLE) — that provides 24/7 nursing and related supports in a community-based setting for individuals who require a higher level of nursing care than available under a GLE.

GROWTH IN MASSACHUSETTS' COMMUNITY-BASED SERVICES INFRASTRUCTURE

Since 2018, Massachusetts has continued to invest, innovate and expand its community-based services infrastructure. This includes the continued expansion and growth in the state's Medicaid Home and Community-based services waivers, as well as the continued investment and expansion in options to self-direct services. The overall result of these efforts has been a continual decline in the number of Massachusetts residents residing in nursing facilities. While there have been numerous initiatives across EOHHS agencies, the following seeks to provide a brief overview of growth in this area.

ENHANCEMENTS TO MASSHEALTH HOME AND COMMUNITY-BASED SERVICES WAIVERS

EOHHS, through its MassHealth program, operates ten Medicaid 1915(c) HCBS waivers, offering eligible individuals community-based services as an alternative to facility-based care. Together, these waivers support approximately 32,000 individuals—who would otherwise require services in a facility-based setting—to live integrated within their communities of choice.

MassHealth's HCBS waivers are administered by different EOHHS agencies to leverage each agency's specialized expertise in serving older adults and individuals with specific disabilities. Below is an overview of MassHealth's ten HCBS waivers and the populations they serve.

Frail Elder Waiver

This waiver is operated by EOEA and is designed to help eligible older adults (60+) remain in their communities instead of moving to facility-based care as well as assist those seeking to transition from a facility to a community residence. Available services in the Frail Elder Waiver include services designed to assist frail older adults to maintain community residency and include services such as homemaking, assistance with personal care, grocery shopping and delivery, certified older adult peer supports, homemade meals, Alzheimer's/dementia coaching, supportive day program services, transitional assistance, environmental accessibility

adaptations, as well as a range of other services. Approximately 15,000 individuals are enrolled in the waiver at this time. In 2019, EOHHS renewed the waiver for an additional five years. In renewing the waiver, EOHHS increased capacity in the waiver by 800 slots and added self-direction as a mode of service delivery.

Intellectual Disability (ID) Waivers

These are three waivers operated by DDS — the Adult Supports waiver, the Community Living waiver, and the Intensive Supports waiver— that are designed to assist adults with intellectual disabilities to reside in the community as an alternative to residing in an Intermediate Care Facility for Intellectual Disability (ICF-ID). The three ID waivers each contain a unique set of services targeted to different acuity levels. All three waivers offer the ability for self-direction of certain services. Currently, there are approximately 16,500 individuals with ID enrolled in these waivers.

Moving Forward Plan (MFP) Waivers

These are two waivers designed to assist adults with disabilities transition from a nursing facility or a psychiatric, chronic disease, or rehabilitation hospital back to the community. The MFP Community Living waiver is operated by MassAbility and supports those seeking to live independently in their own home or apartment, while the MFP Residential Supports waiver is operated by DDS and serves those needing 24/7 supervision and support in a provider-operated residence. Together, these two waivers serve approximately 1,527 individuals. The [Massachusetts Community Living Initiative](#), described later in this report, includes an expansion of capacity in these two waivers.

Children's Autism Waiver

This waiver supports children with autism, from birth to age 10, to live in the community. The waiver is operated by DDS and includes a range of services including expanded habilitation, education, and in-home services and supports. In 2022, the waiver was amended to add capacity to serve an additional 225 individuals, bringing the total capacity to 665.

Acquired Brain Injury (ABI) Waivers

These are two waivers designed to assist individuals aged 22+ with brain injuries transition from a nursing facility or a psychiatric, chronic disease, or rehabilitation hospital back to the community. The ABI Non-Residential waiver is operated by MassAbility and is designed for those seeking to live independently in their own home or apartment, while the ABI Residential waiver is operated by DDS and serves those needing 24/7 supervision and support in a provider-operated residence. Combined, these two waivers serve over 700 individuals. In 2019 EOHHS renewed the waivers for an additional 5-year term and as part of the renewal process, added services to the waivers to align with services available in the MFP waivers including Community-Behavioral Support and Navigation Services, Community-Based Day Supports, assistive technology, home delivered meals, and laundry services.

Traumatic Brain Injury (TBI) Waiver

Operated by MassAbility, this waiver supports adults aged 18+ with TBI who wish to live in the community instead of a facility. The waiver includes residential support services, habilitation services, and other services designed to enable participants to reside safely in the community. This waiver currently serves 78 waiver participants. In 2023, EOHHS amended the waiver to include assistive technology as an additional available waiver service.

EXPANSION OF MASSHEALTH'S INTEGRATED CARE PROGRAMS

MassHealth, in conjunction with Medicare, administers three different integrated care programs to provide comprehensive, person-centered, coordinated care for MassHealth members with disabilities. These programs are the Senior Care Options (SCO) Program, the One Care Program, and the Program of All-Inclusive Care for the Elderly (PACE).

Since 2004, Massachusetts has offered the Senior Care Options (SCO) Program, which provides a comprehensive suite of services for MassHealth members aged 65 and older. The program combines all Medicare and Medicaid benefits into one, with access to additional services aimed at helping SCO enrollees remain in their communities of choice and to age in place. Each SCO enrollee receives case management support, including a geriatric support services coordinator. Innovative services available through SCO that support community tenure include home safety evaluations, environmental accessibility adaptations, and Alzheimer's/dementia coaching, among other services. As of 2024, there are six SCO plans that collectively serve approximately 79,000 MassHealth members.

Similar to SCO, the One Care program (One Care) provides a comprehensive suite of services for disabled MassHealth members aged 21 to 64, aimed at helping One Care enrollees to live independently in their communities of choice. The program combines all Medicare and Medicaid benefits into one, with access to additional services. Each One Care enrollee receives care coordination of their services, which includes the option to receive additional care coordination for long-term services through a long-term services and supports coordinator. One Care also includes innovative services that promote community integration, such as coverage for social transportation, among other services. Massachusetts has offered the One Care program since 2013. As of 2024, there are three One Care plans that collectively serve approximately 42,000 MassHealth Members.

Olmstead Voices: Rhonda

Program: MFP-CL Waiver

Rhonda entered a nursing facility after experiencing a stroke that left her with right-sided weakness and an inability to speak. Initially, she and her daughter were eager for her to move into her daughter's home and rejoin the community. However, a lack of necessary home modifications and support services made the arrangement unsustainable, and Rhonda had to return to a nursing facility. In April 2022, as Rhonda prepared for discharge again, she was enrolled in the Moving Forward Plan – Community Living (MFP-CL) waiver and connected with a MassAbility case manager, Becca. Together, they tackled challenges such as installing a ramp on her daughter's historic home, obtaining an electronic Hoyer lift through transitional assistance, and modifying the bathroom to accommodate Rhonda's needs.

By July 2022, Rhonda was ready to return home with a comprehensive support system provided through the MFP-CL Waiver. This included a home health aide to assist with medical and personal care needs, homemaking services to help maintain her household,

and a companion to offer emotional support and reduce isolation. These services were tailored to ensure Rhonda could live safely and independently while enjoying an improved quality of life. Additionally, Rhonda and her daughter were able to take advantage of the waiver's self-directed services, which allowed her daughter to be actively involved in her care. Under this arrangement, Rhonda's daughter is compensated for providing some of her care, reducing the need to rely solely on agency-based services.

Today, Rhonda thrives in social settings. She enjoys attending her waiver-funded day program, where she actively participates and engages with others. With the robust support system in place, Rhonda has successfully remained at home and has not needed to return to a rehabilitation or nursing facility since her discharge in 2022.



The PACE program is for eligible individuals age 55 + who require a nursing facility level of care. The program combines all Medicare and Medicaid benefits into one, and service delivery is centered around a PACE day program that provides access to community services and socialization in addition to medical services and care coordination. The primary goal of the PACE program is to provide PACE enrollees with the services they need to remain in their communities of choice and to age in place. Massachusetts has offered the PACE program through MassHealth for over 30 years. In the last several years, there has been a focus on expanding the service areas of existing PACE organizations to allow PACE to be offered to all eligible Massachusetts residents. As of 2024, Massachusetts has eight PACE organizations with over 5,000 enrollees. Nationally, Massachusetts ranks 2nd for PACE enrollment.¹³

Figure 8: Enrollment Growth for SCO (July 2018 – July 2024)

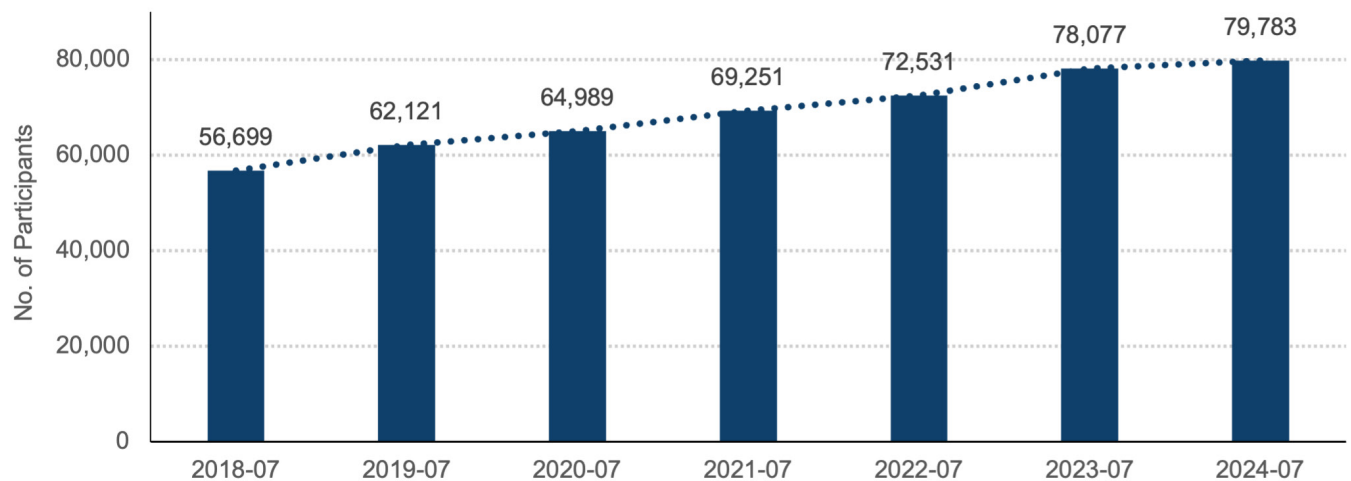
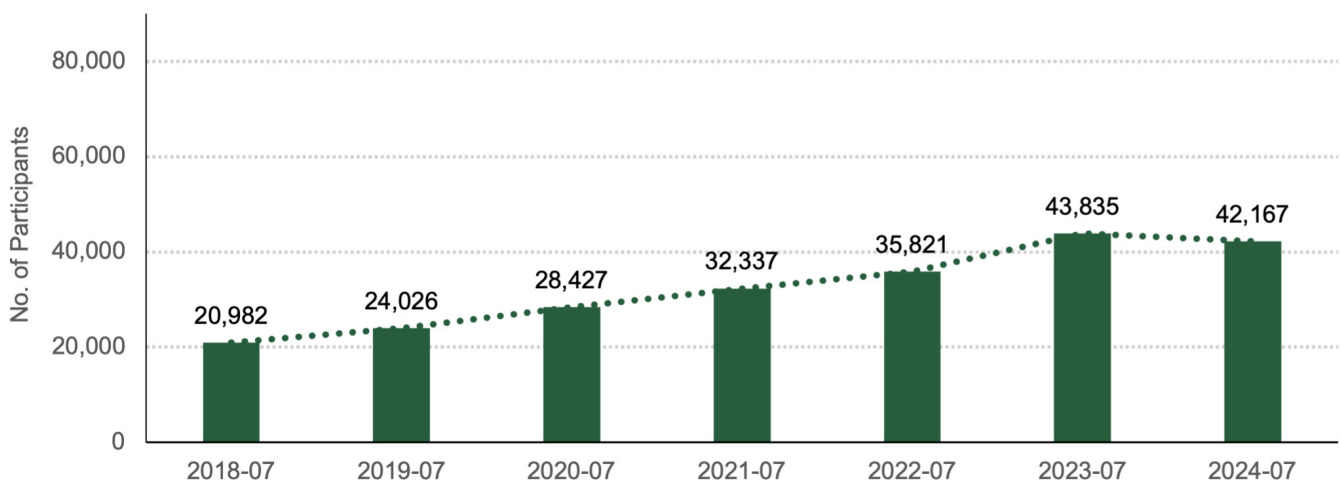
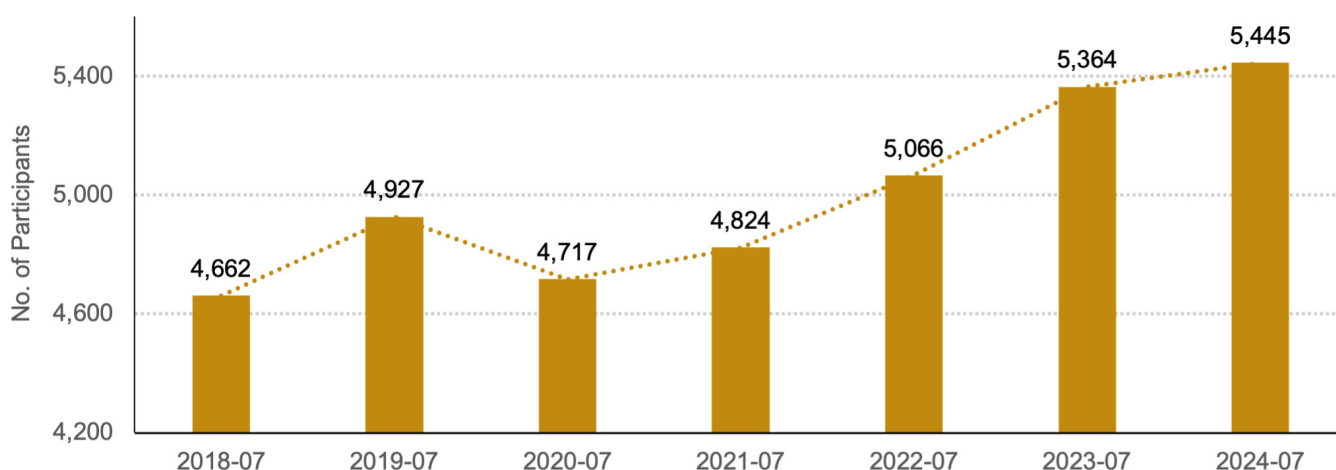


Figure 9: Enrollment Growth for One Care (July 2018 – July 2024)



13. 2023 Long-Term Services & Supports State Scorecard: Indicator: Pace Enrollment, <https://ltsschoices.aarp.org/scorecard-report/2023/dimensions-and-indicators/pace-enrollment>

Figure 10: Enrollment Growth for PACE (July 2018 – July 2024)



EXPANSION OF OPPORTUNITIES FOR SELF-DIRECTION

Massachusetts has a significant dedication to, and long history of promoting, self-direction of publicly funded services. The state's dedication to self-direction is grounded in the Independent Living philosophy, which emphasizes consumer control, recognizing that individuals with disabilities are the best experts on their own needs. The philosophy recognizes that individuals with disabilities have agency, that their perspectives are crucial and valuable, and that they deserve equal opportunities to decide how they live, work, and participate in their communities — especially when it comes to services that significantly impact their daily lives and independence.

Self-direction service delivery models provide individuals and their families direct control over services, enabling them to tailor services to their specific needs and preferences. These models may include authority over decisions on hiring or firing providers, setting service schedules, defining tasks, choosing service locations, and may include authority over managing a budget. Through the inclusion of autonomy in the decision-making process, self-directed services help individuals maintain independence and dignity in the community.

Massachusetts ranks 4th in the nation for the number of individuals who choose to self-direct services.¹⁴ Since 2018 Massachusetts has expanded self-direction opportunities in multiple programs and continues to invest and expand self-directed services through MassHealth, DDS, EOEa and other state agency programs.

Under Massachusetts Real Lives law, DDS provides the option for individuals with developmental or intellectual disabilities and their families to self-direct their services. In 2024, DDS introduced regulations establishing two options for self-directing services: 1) the Participant-Directed Program, and 2) Agency with Choice. The Participant-Directed Program allows individuals to manage their budgets and customize services and tasks based on their activities, interests, and needs. The Agency with Choice option provides agency support for employment functions and other activities, while still allowing individuals a degree of personal control. DDS's recently promulgated self-direction regulations aim to further promote and enable DDS clients and their families to self-direct DDS-covered services and supports. As shown in the table below, utilization of self-direction in DDS programs has grown significantly since 2018.

14. 2023 Long-Term Services & Supports State Scorecard: Indicator: Self-Directed Program Enrollment, <https://ltsschoices.aarp.org/scorecard-report/2023/dimensions-and-indicators/self-directed-program-enrollment>

Table 8: Growth in DDS self-direction numbers

State Fiscal Year	Number Enrolled in DDS Self-Direction Programs	State Spend
2019	1,279	\$11,628,852
2024	2,475	\$25,734,937

Massachusetts demonstrates its commitment to self-direction not only through DDS and the Real Lives law, but also through the MassHealth Personal Care Attendant (PCA) Program, which enables eligible MassHealth members to self-direct their personal care services. Established in the 1970s, the program has empowered thousands of disabled individuals to live independently in their communities. Figure 11 shows unduplicated member counts, the number of active PCAs, and program funding by state fiscal year. The data reflects the state's substantial investment in self-direction, with PCA service utilization increasing by approximately 71% and state spending on PCA services more than doubling since 2018.

Figure 11: Growth in PCA program (SFY 2018 – SFY 2024)

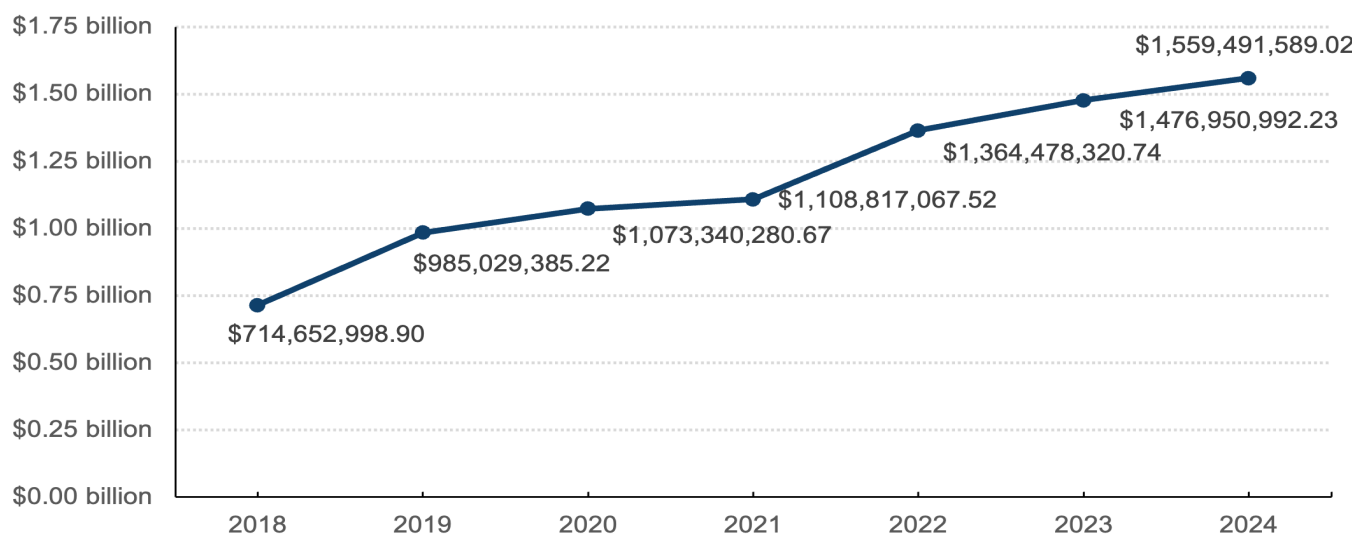


Table 9: Growth in PCA program (SFY 2018 – SFY 2024)

State Fiscal Year	MassHealth Members Receiving PCA services	Number of PCAs	State Spend
2018	31,863	47,664	\$714,652,998.90
2019	47,609	49,762	\$985,029,385.22

Table 9: Growth in PCA program (SFY 2018 – SFY 2024), continued

State Fiscal Year	MassHealth Members Receiving PCA services	Number of PCAs	State Spend
2020	48,585	47,871	\$1,073,340,280.67
2021	49,285	49,395	\$1,108,817,067.52
2022	51,168	51,010	\$1,364,478,320.74
2023	50,233	53,502	\$1,476,950,992.23
2024	51,649	53,570	\$1,559,491,589.02

Other MassHealth programs that offer the opportunity to self-direct services include the three Adult ID HCBS waivers, the Children’s Autism HCBS waiver, and the two Moving Forward Plan HCBS waivers. These six MassHealth HCBS waivers offer the opportunity to self-direct numerous services, including personal care, homemaking, adult companion, peer support, chore, and individual supports and community habilitation. Recognizing the importance of self-direction, EOHHS is currently working to operationalize self-direction in three other MassHealth HCBS Waivers, specifically the two Acquired Brain Injury Waivers and the Frail Elder Waiver.

The Massachusetts commitment to self-direction exists in other state programs as well. The state’s Home Care program, administered by EOEA, allows participants to self-direct personal care, homemaking, and companion services through the Consumer-Directed Care (CDC) model. Since 2018, the use of self-direction in the Home Care program has increased by approximately 45% and state spending on these services has doubled, as shown in Table 10.

Table 10: Growth in Home Care Program self-direction numbers

State Fiscal Year	Home Care Program Participants Utilizing CDC Self Directed Services	State Spend
2018	2,471	\$10,000,494.56
2024	3,854	\$20,545,326.91

Massachusetts continues to receive broad stakeholder support for its self-directed programs. The opportunities to self-direct in Massachusetts programs are likely to continue to grow in importance as a means of ensuring services meet individuals’ needs while promoting individuals’ dignity and ability to live integrated in their communities of choice.

DECLINING NURSING FACILITY OCCUPANCY

Parallel to Massachusetts' successful operation and expansion of community-based services and diversion and transition efforts, nursing facility occupancy in Massachusetts had been declining in recent years. The right-sizing of the nursing facility industry and the prioritization of community-based care wherever possible was a central theme of Massachusetts' 2019 Nursing Facility Task Force established by the legislature. Since 2018, Massachusetts has seen 36 nursing homes close, and nursing facility occupancy in the state has declined from approximately 37,000 in April 2018 to approximately 33,000 in April 2024.¹⁵ Further, EOHHS and the Department of Public Health have both implemented higher staffing level requirements and set maximum room occupancy standards to promote higher standards of care and living for those residing in nursing facilities. In sum, since 2018, EOHHS and its agencies have taken a multifaceted approach to ensure high-quality long-term care, continue to support and increase access to and utilization of community-based services and supports, and promote, improve, and sustain successful community transitions.



Promotion of Community-Integrated Employment of People with Disabilities

A commitment to support individuals living with disabilities in the community of their choice includes more than just supporting accessible housing and the delivery of community-based services. Fully inclusive lives demand equal opportunity to engage in community alongside nondisabled peers. In Massachusetts, ensuring that individuals living with disabilities have integrated and competitive employment opportunities requires a coordinated approach across multiple state agencies, with primary responsibilities belonging to MassAbility, DDS, and the Executive Office of Labor and Workforce Development (EOLWD).

VOCATIONAL REHABILITATION CAREER SERVICES

MassAbility provides Career Services (also known as vocational rehabilitation) for individuals with disabilities. This includes a range of highly individualized supports for individuals seeking competitive integrated employment. This may include connecting individuals with services to obtain a GED or post-secondary education, and can include coverage of tuition and fees, uniforms, and tools necessary for job-seeking, job placement, and training. Career Service counselors meet with individuals in the community, develop an individualized plan, and make robust connections to help the individual forge a path to their vocational goals. Additionally, Career Services can provide home and vehicle modifications to support an individual's vocational goals.

MassAbility's Career Services staff works with public colleges and universities, professional training programs, and employers to break down barriers for individuals living with disabilities and expand possibilities in modern career and work life. Program participants can explore many industries and sectors to find what is best for them and their situation. MassAbility also provides guidance and support to employers to create the accessible and inclusive environment service recipients deserve. [Success of these efforts for FY 2023](#) are highlighted on the next page.

15. These numbers include all nursing facility residents regardless of payer and include residents receiving short-term benefits (e.g., a short term post-acute stay covered under Medicare or commercial insurance).

NEXTGEN CAREERS

In 2022, MassAbility received a competitive \$17 million Innovation Grant from the federal Rehabilitation Services Administration (RSA), which it used to launch NextGen Careers — a program that helps young adults ages 18–30 with disabilities who want to make a change in their life. Dedicated experts in counseling, benefits, and peer support help “NextGen-ers” learn to advocate for themselves, gain self-confidence, and become self-sufficient on their career path. Program participants are encouraged to pursue careers on their terms, understanding that it is their choice, their career, and their life. With offices in Lawrence, Lowell, Downtown Boston, Roxbury, Braintree, Springfield, and Worcester, 328 young adults were served in the first year.

CROSS-AGENCY COORDINATION EFFORTS

MassAbility recognizes that meeting the needs of individuals with disabilities requires a coordinated approach that combines the strengths of various agencies. MassAbility has established a memorandum of understanding with DDS for blending and braiding funding, recognizing that many people in Pre-employment Transition Services come from DDS. In addition, MassAbility coordinates funding with DMH to provide specialty Mental Health Vocational Rehabilitation counselors. A team of 26 counselors provide support to individuals receiving community-based services through DMH. This integrated resource team has reduced the Individualized Plan for Employment time by almost half.

These partnerships allow MassAbility’s Career Services program to offer services above and beyond what traditional vocational rehabilitation programs provide. By collaborating with other state agencies, MassAbility is able to leverage the other agency’s expertise to provide career resources tailored to the specific needs of different populations, improving service effectiveness. In line with the principles of Olmstead, this cross-agency coordination not only enhances that quality of MassAbility’s career services but also promotes community integration by supporting individuals with disabilities to live and work in the settings of their choice.

Without Walls Initiative

Consistent with the theme of a coordinated approach, MassAbility and DDS have partnered to support the Without Walls Initiative, a DDS service delivery approach for Community Based Day Supports (CBDS) that provides services exclusively in the community for small groups of individuals and does not use a day program center as a base, but instead uses small satellites or program hubs/storefronts located in community centers accessible to transportation and a variety of community resources, businesses, and activities. This innovative CBDS initiative leverages MassAbility’s Career Services expertise for participating individuals who are on a path to employment through engaging in community activities.

MassAbility FY2023 Vocational Rehabilitation

Career Services Accomplishments

2,823 job seekers with disabilities have been successfully placed into competitive employment based on their choices, interests, needs, and skills. The earnings of successfully placed employees in MA in the first year were **\$75.6 million**.

Average Hourly Wage:	\$18.73
Average Work Hours Weekly:	27.5
New referrals:	10,213
Applicants:	7,783
Job seekers actively receiving services:	21,704
Participants enrolled in training/education programs:	16,026
Placements leading to successful employment outcomes:	86.5%
Participants employed with medical insurance:	99.4%

DDS Blueprint for Success 2.0, Moving Forward Together

DDS has utilized an employment first model for many years and supports individuals with disabilities in competitive integrated employment through strong partnerships. Since the end of the federal COVID-19 public health emergency, DDS has convened various community partners with the goal of increasing and enhancing employment and/or meaningful engagement opportunities for individuals served by DDS to be productive and contributing members of their communities. These community engagements culminated in the development of a roadmap that provides a path forward to “reset” following the end of the federal COVID-19 public health emergency and build on the momentum of the Employment First initiatives and the changes and outcomes that occurred as a result of the 2013–2018 *Blueprint for Success: Employing Individuals with Intellectual Disabilities in Massachusetts*. In commitment to competitive, integrated employment, DDS recently adopted the position that it will no longer support subminimum wages. As of October 1, 2024, all DDS-funded programs in Massachusetts pay persons with disabilities at least the state minimum wage.

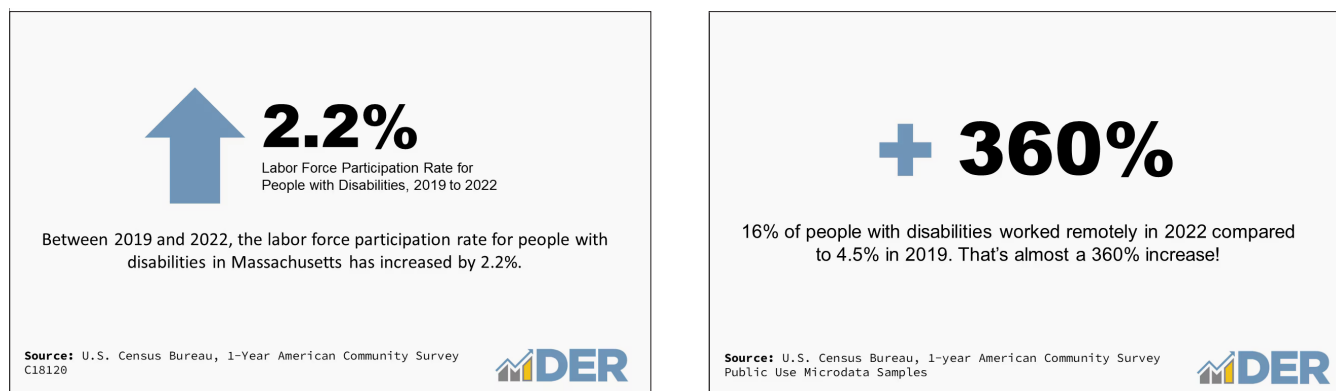
MassHire

EOWLD operates a number of programs and initiatives dedicated to employment opportunities for individuals with disabilities offered in coordination with other agencies such as MassAbility, the Massachusetts Commission for the Blind, and the Massachusetts Commission for the Deaf and Hard of Hearing. The MassHire Department of Career Services under EOLWD provides assistance to job seekers and employers. Statewide Career Centers offer a range of services including job search assistance and short-term training. In 2021, 5,859 people with disabilities were served through MassHire.

People With Disabilities Workforce Data Dashboard

EOLWD also created [the People with Disabilities Workforce Data Dashboard](#), which provides a comprehensive view of employment-related insights across a number of variables. This public-facing dashboard, developed with the input of state and community partners, enables Massachusetts to use data on barriers and opportunities to inform strategy. In addition, this dashboard can highlight areas of success such as overall improvement in employment rates for individuals with disabilities and the increase in the number of individuals with disabilities who work remotely.

Figure 12: People with Disabilities Workforce Dashboard, U.S. Census Bureau



Source: U.S. Census Bureau, 1-Year American Community Survey

Disability Employment Tax Credit

In addition to these efforts, Massachusetts established a tax incentive program — the Disability Employment Tax Credit (DETC) — for employers, aimed at increasing employment opportunities for individuals with a disability in Massachusetts. After a minimum of 12 months of continuous employment, employers are eligible for a state tax credit equal to \$5,000 or 30% of the wages paid to each qualified employee with a disability in the first taxable year of employment, whichever is less. In each subsequent tax year, employers are allowed a credit equal to \$2,000 or 30% of the wages paid to each qualified employee with a disability, whichever is less. To promote utilization of the employer tax credit, MassAbility has created an online form that may be used by individuals seeking employment to explain that they qualify for employment with a disability under this employer tax credit.



Investments in Accessible Transportation for Individuals with Disabilities

Recognizing that many individuals with disabilities rely on public transportation, the Massachusetts Department of Transportation (MassDOT), the Massachusetts Bay Transportation Authority (MBTA), and Regional Transit Authorities (RTAs) have prioritized improving accessibility in line with Olmstead objectives. This effort includes: investments and innovations, MBTA improvements, and growth in on-demand microtransit.

INVESTMENTS AND INNOVATIONS

Every new capital project in MassDOT's Capital Investment Plan (CIP) has accessibility components, ensuring that new infrastructure is accessible. More specifically, MassDOT has made increasing investments through the Accessibility Improvement Program under the agency's modernization efforts to implement projects in areas with the greatest programmatic need. The program evolved from a focus on ADA retrofits to a much broader one that includes all elements of the pedestrian infrastructure network at various phases of their life cycle to achieve an accessible and connected network. Investments under this program have more than doubled in the past seven years, from just under \$20 million in the 2018–2022 CIP, to \$41.7 million in the current 2025–2029 CIP.

Additional MassDOT initiatives include the Community Transit Grant Program (CTGP), which awards funds to help meet the transportation and mobility needs of older adults and people with disabilities. The program is an important means of support for transportation partners who work to ensure access to destinations for those with limited mobility options, including RTAs, municipalities, Councils on Aging, non-profit organizations, and private operators of public transit (ride-share) services. The FY2024 and FY2025 state budgets both included \$4 million to expand the CTGP.

MBTA IMPROVEMENTS

Over the last 15 years, the MBTA has invested heavily in improving its policies and services in order to achieve the vision of a 100% accessible MBTA. [Highlights of these efforts](#) are summarized on the next page.

Additionally, most major MBTA projects now include input from the [Riders Transportation Access Group \(RTAG\)](#), a community-based group that advises the MBTA on transportation matters impacting people with disabilities and older adults. The group's goal is to ensure that all people with disabilities and older adults have every opportunity to be fully participating members of their community. Additionally, an RTAG paratransit subcommittee was established to focus specifically on paratransit services. This subcommittee meets monthly with The RIDE to provide advice and recommendations on service delivery and emerging technologies.

MBTA Improvements

Highlights

- Full-scale renovations of dozens of MBTA stations in order to enhance accessibility, with over 35 stations that are either in the design or construction phase for major accessibility upgrades.
- Comprehensive updated training for all frontline employees on delivering accessible services.
- Development and implementation of policies and procedures to ensure transit information is provided in accessible formats — both audibly and visually — throughout the transit system.
- Increased staffing levels of RIDE drivers to improve on-time performance.
- The creation of RIDE Flex, a first-of-its-kind partnership between the RIDE and ride sharing companies, offering expanded mobility options to RIDE customers including same-day on-demand trip booking.
- The MBTA provision of a \$3 million annual subsidy to ensure an adequate number of wheelchair accessible vehicles are available for RIDE Flex users.
- The creation of the Mobility Center, launched in 2020, which serves as a one-stop resource for customers seeking accessible transportation options. Available both in-person and virtually, the center offers services such as travel training, trip planning, and support with technology tools. Staff also assist customers in connecting with additional community transportation resources.
- The September 2023 launch of a marketing campaign, Access in Motion, aimed at promoting awareness of accessibility and its benefits for all MBTA riders.

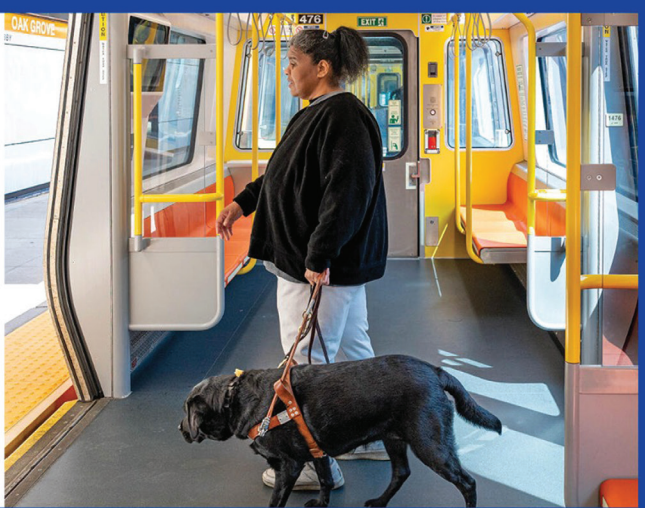
Figure 13: Sample Access in Motion Advertisement

Riders with service animals are always welcome.

It's our policy and the law.



Access In Motion



GROWTH IN ON-DEMAND MICROTRANSIT

Over the past five years, on-demand microtransit has redefined public transportation outside dense urban areas by offering flexible, affordable, and accessible services. Operating within specific areas and hours, these shared rides have become increasingly popular, especially in regions where traditional bus routes struggle with low ridership or are non-existent. On-demand microtransit is designed to deliver the kind of service that people love about ride-hailing apps like Uber and Lyft, but with key advantages: it is much more affordable and accessible, and drivers are trained in wheelchair securement. This makes it an appealing choice for those seeking the convenience of ride-hailing without the associated costs or accessibility barriers.

A prime example of this success is the Franklin Regional Transit Authority's (FRTA) pilot of on-demand service in rural areas, including weekend coverage. This pilot, which began in 2019, has since become a permanent feature, with plans for expansion. The FRTA's success highlights the growing demand for on-demand microtransit options across the region. Similarly, the Quaboag Connector, which serves ten towns between Worcester and Springfield, is an example of the utility of microtransit. Launched in 2017 through a collaboration of various human service agencies and the town of Ware, it has become a model for how organizations can work together to meet the transportation needs of rural communities. Though not on-demand, the Quaboag Connector uses a demand-response model with passengers reserving services in advance.

TRANSPORTATION IS A HEALTH ISSUE

MassHealth recognizes that transportation is more than just a logistical concern — it is a critical health issue, especially for individuals with disabilities. Social isolation can have serious medical consequences, and to address this MassHealth's integrated care plans now include social transportation services to help maintain essential community connections that promote overall well-being.

In 2023, EOHHS launched two grant programs to improve access to MassHealth day programs by expanding transportation services. The first, the Adult Day Health and Day Habilitation Community Inclusion Transportation Grant Program, is a \$2 million initiative aimed at increasing transportation to MassHealth-funded day programs. The second, the Day Habilitation Transportation Grant Program, allocates \$3 million to enhance transportation for day habilitation services. Since these grant programs were implemented, EOHHS has awarded grants of up to \$150,000 each to 55 day program providers. These funds are being used to purchase, maintain, or modify vehicles, or to explore alternative transportation solutions. The goal of both grant programs is to help eliminate transportation barriers and ensure that individuals with disabilities are able to fully access day program services.

Where Are We Now?

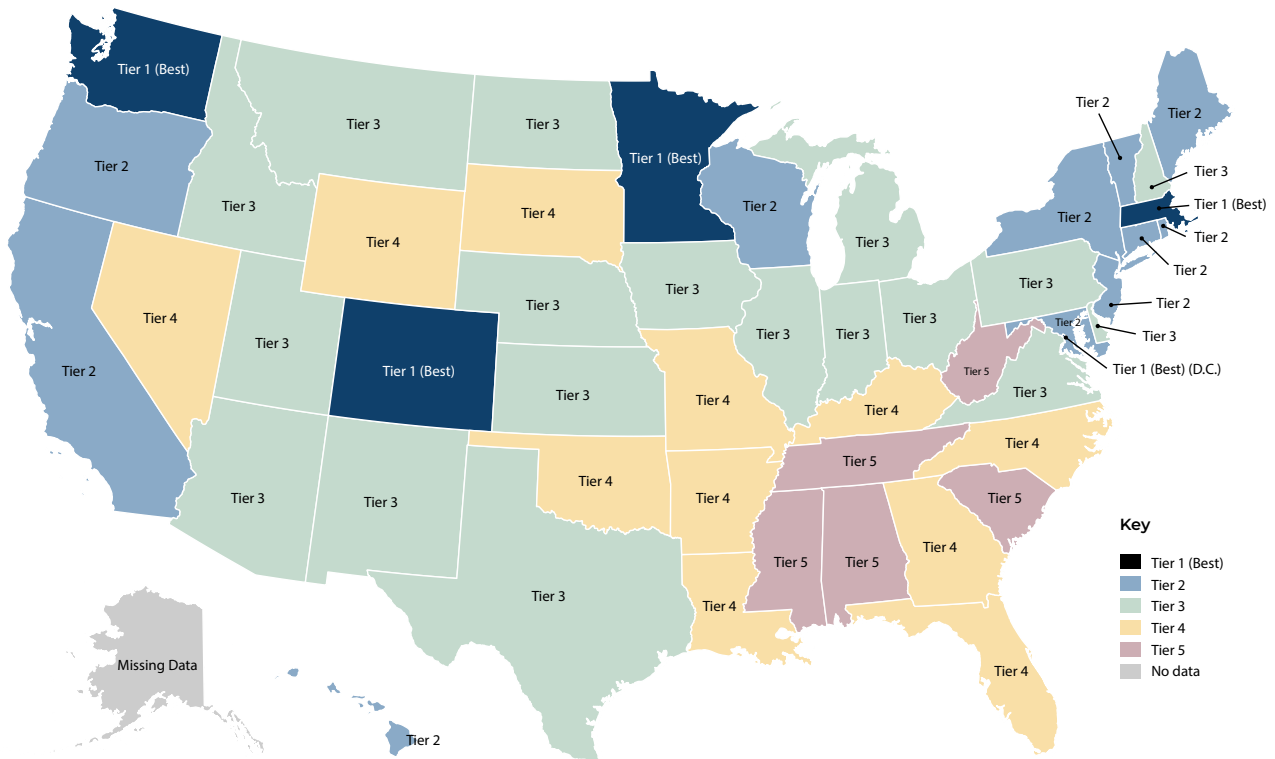
State Snapshot

Overall Progress

With a strong commitment to the principles of Olmstead, Massachusetts has significantly transformed its long-term care system to promote greater community integration. Data that supports the results of these significant investments and efforts include the following.

In AARP's 2023 Long Term Services and Supports (LTSS) Scorecard, Massachusetts was ranked in the top tier for all states for overall LTSS performance.¹⁶ The AARP LTSS Scorecard measures a state's LTSS services across five dimensions: affordability and access, choice of setting and provider, safety and quality, support for family caregivers, and community integration. States are ranked from 1 to 50, with Tier 1 being the top performing states.

Figure 14: Overall Performance Across Five Dimensions of LTSS



Source: [AARP Long-Term Services and Supports State Scorecard 2023 Edition](#), p. 9

16. AARP 2023 LTSS Scorecard is available at: <https://ltsschoices.aarp.org/scorecard-report/2023>

Massachusetts was also ranked 4th in the nation overall for LTSS performance.

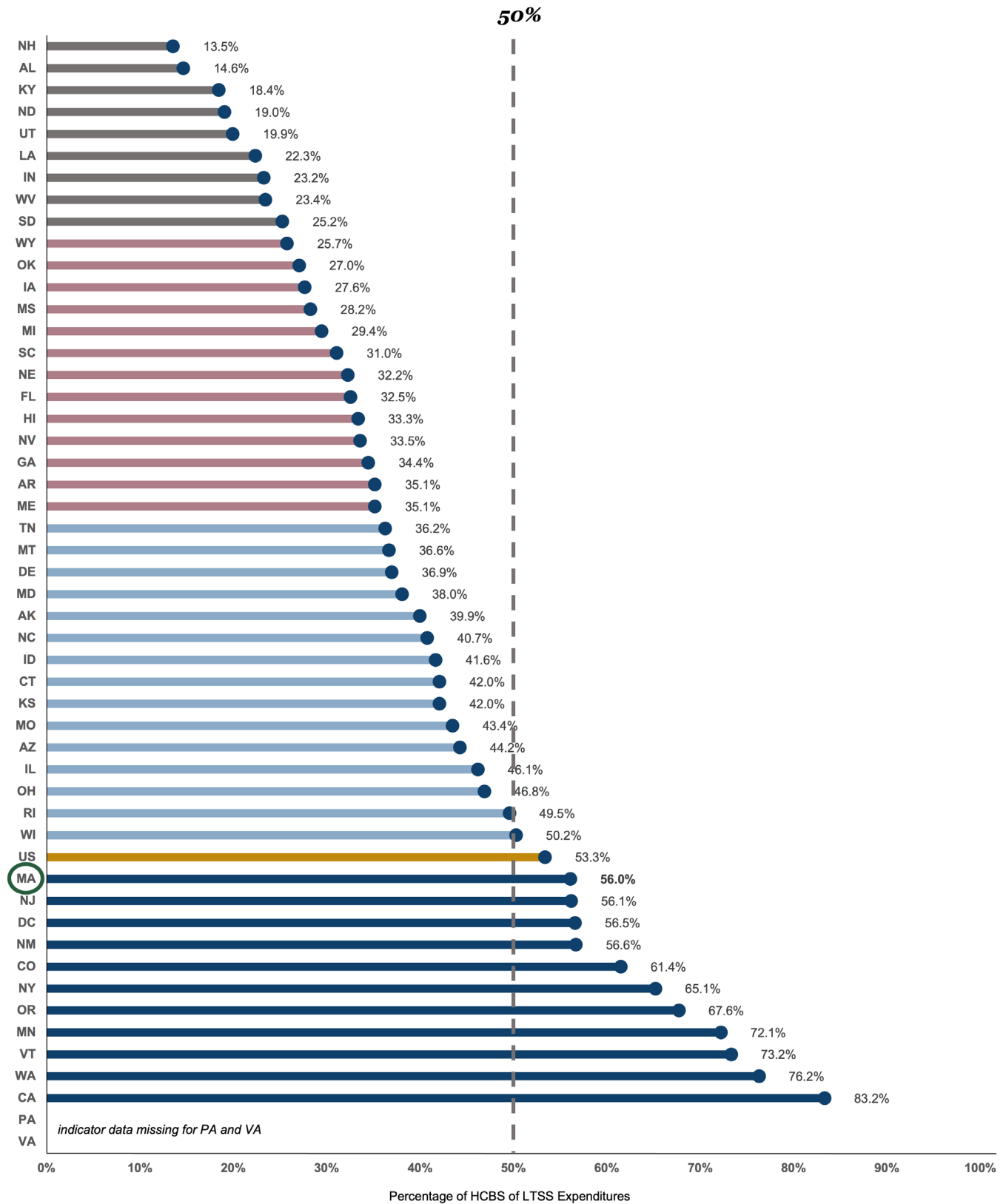
Table 11: LTSS Performance by Dimension – Massachusetts

Performance Dimension	2023 Rank	Performance Tier
Overall	4	 Tier 1
Affordability and Access	4	 Tier 2
Choice of Setting and Provider	2	 Tier 1
Safety and Quality	14	 Tier 2
Support for Family Caregivers	13	 Tier 2
Community Integration	9	 Tier 2

Key:  1st Tier (Best)  2nd Tier  3rd Tier  4th Tier  5th Tier (Worst)

Additional data in the Scorecard indicates that Massachusetts was ranked 11th in the nation for the balance of Medicaid spending on community-based LTSS compared to facility-based LTSS.

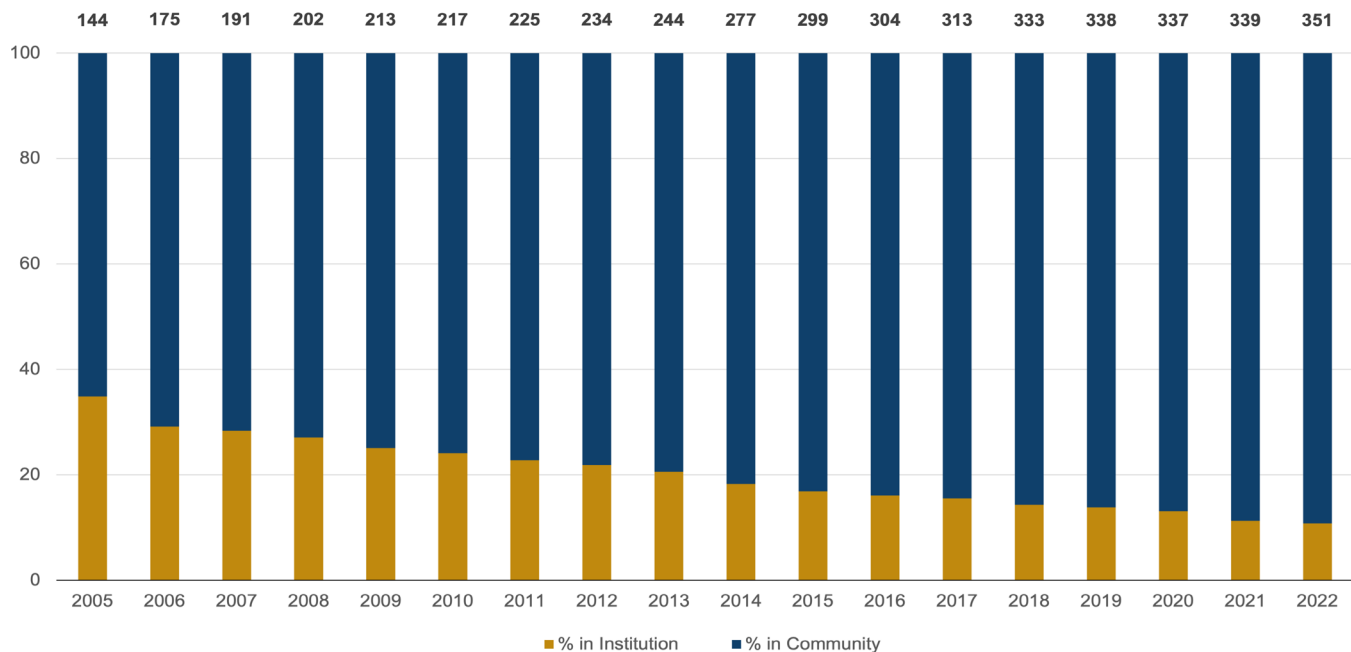
Figure 15: Percentage of Medicaid LTSS spending going to HCBS for older people and adults with physical disabilities for FY 2020



Source: Based on AARP, Appendix K: Indicator Data: Choice of Setting and Provider, [Long-Term Services and Supports State Scorecard 2023 Edition](#), p. 167

At the individual level, for Massachusetts residents, this ranking correlates with MassHealth data that indicates a longstanding trend of increasing MassHealth member reliance on community-based LTSS while the use of facility-based LTSS has declined as a percentage of overall LTSS utilization.

Figure 16: Percentages and total number of MassHealth members receiving LTSS in the community in thousands (2005–2022). In Massachusetts, approximately 90% of members receiving LTSS in the community today, vs. approximately 65% in 2005. The percentage of members receiving LTSS in the community has steadily increased over the past decade....



....Representing approximately 10,000 members diverted over time.

- Diversion estimate calculated as (% of people who would have been institutionalized in FY22 given split community vs. institutional) vs. (%) that are today given current split community vs. institutional)
- Potential reasons for diversion include:
 - creation of new community-based programs that fit in the needs of these individuals
 - Re-evaluation or change of needs leads to transitioning into the community.

Source: MassHealth program data. Members in community includes FFS HCBS utilization and Community Rating Categories for Integrated Care Members in institutional include SNF utilization and nursing facility Rating Categories for Integrated Care

Although Massachusetts ranks among the top states in the nation for LTSS performance, there is still room for improvement. In the national measures related to nursing facility transitions in AARP’s 2023 Scorecard, Massachusetts did not place in the top 10. Specifically, the state ranked 11th in successful community discharges and 31st for nursing facility residents with low care needs. This suggests that more can be done to help ensure individuals in nursing facilities are informed of their options to receive community-based services as an alternative to nursing facility care and that individuals interested in transitioning to the community have access to transition supports to promote their successful discharge to the community. The [Massachusetts Community Living Initiative](#), described in the next chapter, is an effort to improve the state’s performance in these areas.

Community Feedback

In developing this report, EOHHS and EOHLC issued a Request for Information (RFI) to solicit feedback on areas for improvement across the four pillars of Housing, Services, Employment, and Transportation.

EOHHS and EOHLC received responses from individuals, family and other caregivers, advocates, and organizations/providers. The following provides a high-level summary of their comments.

Improve Awareness of Services



Respondents identified a significant “knowledge gap” in awareness of and access to services, highlighting that existing systems are often complicated, fragmented, and opaque. Many felt that assistance is needed not only to access information and education but also to help navigate application processes to gain access to services. Additionally, respondents emphasized the importance of increasing and enhancing community engagement, suggesting that more efforts be made to connect with the public about available services.

Grow Accessible Affordable Housing



Many respondents identified the lack of affordable housing as a significant challenge, citing limited access to housing vouchers and the need for more vouchers specifically targeted to people with disabilities. They also highlighted a shortage of accessible housing units and emphasized the importance of developing units that exceed minimum accessibility requirements. Additionally, respondents expressed a desire for a wider variety of housing options, including support for accessory dwelling units (ADUs) as a viable alternative and an increase in different types of community-based provider settings, such as shared living arrangements.

Strengthen Community-Based Services and Supports



Respondents overwhelmingly pointed to challenges within the workforce and provider networks for community-based services, particularly high turnover and vacancy rates. Suggestions for improvement included expanding person-centered programming and self-directed services, providing more support for family caregivers (including respite and daytime assistance), and increasing opportunities for individuals with disabilities to engage with peers and natural supports in areas such as living, working, and socializing. There was also a call for greater use of assistive technology.

Increase Community-Integrated Employment for People with Disabilities



Employment challenges were a common theme, with respondents frequently citing the need for more accessible job opportunities that offer competitive wages. Many respondents advocated for increased technical job skills training, better support for work in competitive environments, and enhanced incentives for employers to hire individuals with disabilities. Additionally, there were concerns about how employment might impact public benefits, such as MassHealth and federal Supplemental Security Income, and a desire for improved technology use in the workplace for people with disabilities.

Improve Accessible Transportation



Transportation was another area of concern, with respondents noting the need for reliable, well-funded, and accessible transportation services. Public transportation was described as unreliable, though The RIDE and ride-sharing options were viewed as potential solutions. Respondents also highlighted a lack of coordination across geographic regions, the need for door-to-door and through-the-door services, and a lack of public transportation options in rural areas.

Increase Community Collaboration



Many respondents identified EOHHS' recent proposal to procure an independent assessment entity for MassHealth community-based LTSS that would replace the current structure in which assessments are performed by providers and community-based entities. In raising this procurement, respondents advocated for a different approach.

The feedback received from the RFI provides Massachusetts with valuable insights into its progress on community integration. Responses help assess whether current efforts align with public interest and highlight areas for improvement. One immediate change resulting from this input has been to reconsider MassHealth's approach to establishing an independent assessor entity. Overall, while highlighting some new areas for attention, the feedback reveals a strong alignment between the priorities identified by respondents and Massachusetts' current initiatives aimed at driving progress, as detailed in the following section on Massachusetts' ongoing efforts.

Where Are We Going?

Current Initiatives to Achieve Continued Progress

With unprecedented investments in funding and innovation in recent years, Massachusetts has launched several key initiatives to further advance progress around the four pillars of its Olmstead goals. These efforts include new investments in accessible housing and strategies to build and strengthen the future direct care workforce. Massachusetts is also funding studies on innovative approaches to delivering post-acute care in home-based settings, new ways for promoting community-integrated employment, and making additional investments in accessible transportation.

While many of the initiatives described in this section are still in development, the Healey-Driscoll administration is excited about the opportunities ahead and remains committed to their continued progress and implementation.

Massachusetts' Community Living Initiative

Massachusetts' Community Living Initiative grew out of a class action settlement, *Marsters v. Healey*, and is an ambitious commitment to further grow the state's ability to serve people with disabilities in the community and as an alternative to receiving services in a nursing facility setting. Through this initiative Massachusetts will assist a minimum of 2,400 MassHealth eligible individuals interested in community living to transition from nursing facilities to the community over eight years, while also expanding the state's capacity to provide residential services and supports.

The initiative is built on the foundation of in-reach, informed choice, and transition support provided through EOE's CLTP and MassHealth's MFP Demonstration, described previously, and that are designed to inform nursing facility residents about the option to receive community-based services and assist them in transitioning to the community.

For nursing facility residents with PASRR SMI, the initiative leverages the expertise of DMH and the support of MassHealth's Behavioral Health Community Partner program to provide enhanced behavioral health care coordination and case management during the transition to community-based living.

Growth targets for this initiative include expanding MassHealth's Moving Forward Plan – Residential Supports (MFP-RS) waiver to accommodate 400 more individuals over the next eight years and increasing capacity in the Moving Forward Plan – Community Living (MFP-CL) waiver to serve an additional 595 individuals over the same time period. Under the initiative, DMH will also expand its capacity to serve individuals in DMH provider-operated group living environments by 200 individuals, with a goal of further increasing capacity by another 200 individuals over the initiative's eight-year period.

The initiative also includes a commitment by EOHHS in coordination with EOHLC to expand subsidized housing capacity targeted to elder and disabled MassHealth members with disabilities transitioning from nursing facilities to the community by adding 800 new subsidized housing opportunities over eight years. This will be achieved through a combination of mobile and project-based vouchers, as well as increased funding for the development

of new housing units. Finally, through this initiative DMH will expand its rental subsidy program to support 320 more individuals over the course of the initiative and MassAbility will complete a minimum of 120 home modifications that enable a person to transition from a nursing facility to the community.



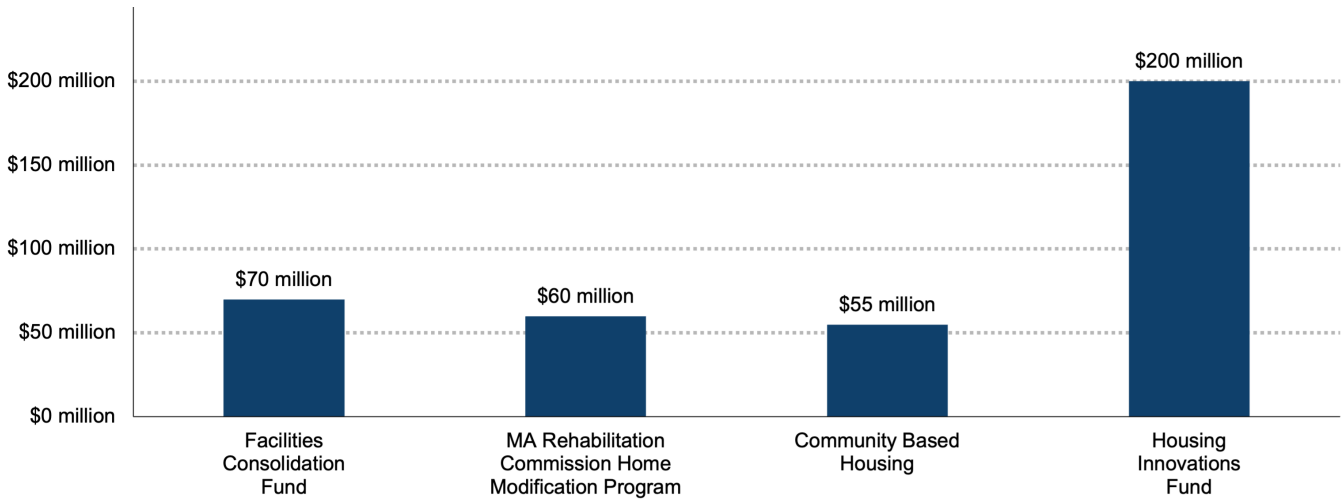
Expanding Access to Affordable, Accessible Housing

Looking toward the horizon, the expansion of affordable, accessible housing continues to be a priority for Massachusetts as described below.

HOUSING INVESTMENTS

Passed by the legislature and signed into law by Governor Healey in July 2024, the Affordable Homes Act and related initiatives will support the production, preservation, and rehabilitation of more than 65,000 homes statewide over the next five years. This is the largest housing bond bill ever filed and signed in Massachusetts, at more than triple the spending authorizations of the last housing bill passed in 2018. The historic legislation authorizes \$5.16 billion in spending over the next five years along with 49 policy initiatives to counter rising housing costs caused by high demand and limited supply. Key spending authorizations and policy changes include ADUs; an unprecedented investment in modernizing the state’s public housing system, including \$15 million dedicated to accessibility improvements; and incentives to build more housing for low- to moderate-income residents.

Figure 17: Affordable Homes Act Investments



The increased investment in FCF and CBH supports the development of community-based housing specifically for people with disabilities, including clients of DMH, DDS, and MassAbility. The Affordable Homes Act doubled the investment for HIF supports to \$200 million. The fund supports innovative and alternative forms of rental housing including single person occupancy (SPO) units, transitional and permanent housing for people experiencing homelessness, housing for seniors and veterans, and transitional units for persons recovering from substance use disorders. A \$60 million investment was made in the MassAbility Home Modification Program, which provides funding to modify homes for individuals and families with disabilities. These modifications enable residents to stay in their homes or return home from institutional settings.

In addition to the unprecedented level of spending authorizations, the Affordable Homes Act creates key policy initiatives, including allowing ADUs under 900 square feet by right on single-family lots. Often referred to as in-law apartments, ADUs can be attached to or detached from a single-family home and often take shape as a basement or attic conversion, a cottage in a backyard, or a bump-out addition to a home. Though ADUs are important to address the state's housing shortage, they also offer affordable living arrangements for older adults and people with disabilities to live independently while being near family, caregivers, or other supports.

Figure 18: *An Accessory Dwelling Unit as Home Modification*



Source: [Home Modification Loan Program Cape Accessory Dwelling Unit Testimonial](#), YouTube

As an example, above is a picture of an ADU built as a Home Modification for an individual with a mental health disability. He now lives next door to his parents in his own home (unit on the left).¹⁷ The autonomy and proximity to family supports has improved the health outcomes and housing stability for this individual.

The new statutory specifications for ADUs replace a patchwork of zoning regulations across the state with a uniform law that allows homeowners on single-family lots to add these small units without needing a special permit or variance unless they want to add more than one. The Healey-Driscoll administration estimates that between 8,000 and 10,000 ADUs will be built across the state over the next five years due to passage of the law, significantly increasing much needed housing supply.

The Affordable Homes Act also established three new commissions to study and recommend new policy to address housing disparities for older adults, households needing accessible housing, and extremely low-income households. The recommendations set forth by these commissions will further inform the Commonwealth's efforts to meet the housing needs of Massachusetts residents, including older adults and persons with disabilities.

17. For more information on this individual's story, visit: <https://youtu.be/9oc1RmMn-Ek>

Another critical policy initiative for people with disabilities exiting homelessness is the Supportive Housing Pool Fund. This fund creates a flexible supportive housing pool program to provide critical assistance for supportive housing by funding staffing, case management, service coordination, and other tenancy-related services not funded through other sources. By investing in PSH resources, the state will be able to increase the pipeline of service-enhanced subsidized housing for people with disabilities who have experienced long-term homelessness.

Beyond capital investments through the historic Affordable Homes Act housing bond bill, Massachusetts is making a significant commitment to additional housing investments. Specifically, through the Community Living Initiative discussed previously, Massachusetts is committed to further increasing subsidized housing solutions, including residential services, non-residential services with housing supports, and home modifications, ensuring that individuals with disabilities can live independently within their communities.



Enhancing Community-Based Services and Supports

Massachusetts continues to be a health care innovator. Beyond the community-based services and supports previously discussed, the state is actively working to enhance, expand, and improve access to community-based services and further promote community tenure for older adults and people with disabilities. Among these efforts includes an innovative expansion of behavioral health and community-based services under the MassHealth program; a first-of-its-kind clinical research trial to explore the efficacy of intensive in-home post-acute care as an alternative to post-acute care in a nursing facility, as well as historic investments in the state's PCA workforce. This also includes substantial investments in efforts and initiatives to grow the direct care workforce in order to expand access to services and to enable providers to innovate and further increase service offerings.

MASSHEALTH 1115 WAIVER INITIATIVES

Approved by the Centers for Medicare and Medicaid Services (CMS) in June 2024, MassHealth's new 1115 Waiver includes several key provisions to help prevent long-term institutionalization and support transitions to community-based living. Starting in January 2025, the waiver will cover Homeless Medical Respite Services, building upon the existing pilot program that provides pre-procedure or post-hospitalization short-term housing for individuals experiencing homelessness for up to 183 days, in collaboration with medical and homeless service providers. It also expands Behavioral Health Diversionary Services, offering community-based options to help individuals return to their communities after acute placements, with the goal of stabilizing individuals in the community. Additionally, the new 1115 waiver provides authorization for MassHealth to cover nonclinical services that impact health outcomes and community tenure through Health-Related Social Needs (HRSN) initiatives. By leveraging federal flexibility available under the 1115 waiver, Massachusetts will be able to fund innovative supports through Accountable Care Organizations (ACOs), seeking to address food insecurity and housing-related needs.

HOME FIRST CLINICAL RESEARCH TRIAL

Massachusetts has launched a first of its kind clinical research trial to test the efficacy of a new post-acute care model, where a patient gets post-acute care delivered in their home instead of in a skilled nursing facility. Post-acute care involves a combination of medical direction by an attending physician, and often includes skilled nursing, physical and occupational therapy, administration of medications and functional support for personal care and assistance with basic and instrumental activities of daily living. Approximately 40% of older

adults require post-acute care and rehabilitation when discharged from a hospital. Currently, most hospitalized individuals who require facility-based post-acute care are discharged to a skilled nursing facility. While currently post-acute care is typically delivered in nursing facilities, the study seeks to evaluate whether discharge to the home with intensive, time-limited post-acute care supports trends toward lower cost, greater functional status improvement, and better patient experience.

Through the Home First clinical research trial, two hospitals will enroll 900+ participants over the next 18 months, to ascertain whether a 'home first' model has the potential to help individuals retain community tenure by diverting nursing facility admissions intended for short term rehabilitation that can lead to long-term institutionalization.



Olmstead Voices: Maria and Meylin

Programs: MassHealth Continuous Skilled Nursing program, Complex Care Assistant program

Maria is the mother of two daughters living with disabilities. Her 16-year-old daughter Meylin is nonverbal and has complex medical needs that require skilled nursing. Meylin receives services through the MassHealth Continuous Skilled Nursing (CSN) program which provide the support she needs to stay in her home and out of an institution.

Taking care of her daughters meant that Maria was unable to work and contribute to the family income. Her husband's job was not enough to cover their expenses and for some time, they struggled to pay the bills, choosing between housing, food, and other necessities. Even with the support of the CSN program, their unstable housing combined with Meylin's complex needs resulted in frequent hospital admissions.

In 2023, when Massachusetts developed the Complex Care Assistant (CCA) program, one of Meylin's

nurses, Cathy Costa, suggested Maria consider this option for her family. Through CCA, Maria underwent training to provide enhanced care for her daughter's complex medical needs. Employed by a CSN agency and under the supervision of an RN, Maria can now provide oxygen therapy and other enhanced care services that her daughter needs.

This program has resulted in reduced hospital admissions for Meylin as Maria now has the knowledge and skills to respond to medical issues that arise. Maria's income as a CCA has resulted in financial stability, stable housing, and food security. Meylin is living in her family home, receiving the care she needs. Maria considers Cathy Costa to be an "angel sent to her family" and is extremely grateful for the services and support they receive.

The study will include data collection at 90 days and 180 days post discharge from an acute care hospital. Depending on the outcomes of this research trial, the findings have the potential to lead to future delivery innovations and the reimagining of how our society delivers post-acute care, not just in Massachusetts, but nationally.

PCA PROGRAM INVESTMENT

In 2023, Massachusetts negotiated the largest PCA program collective bargaining agreement in state history, significantly raising base wages paid for providing MassHealth-covered PCA services and introducing seniority-based wage steps, effective in 2025, with an aim to incentivize the retention of the longest serving and most experienced PCA providers. Additionally, the collective bargaining agreement allows for a complex care differential, which will provide for a significant rise in payments for PCA services provided to individuals who are designated by the MassHealth PCA Program as “Complex Care” consumers. The complex care differential will both incentivize PCAs to provide services to consumers who have more complex needs who may otherwise struggle to find the necessary PCAs to do this difficult and crucial work, as well as provide for an increased rate of pay to account for their performing that complex and important work. The three-year contract also introduced a wage scale for PCAs, starting with a base rate of \$19.50 per hour and raising pay up to \$25 per hour by 2026 based on experience. Additionally, the contract included an increase in the number of paid holidays, compensation for professional development and training, and provisions that will enable PCAs to establish retirement counts.

Olmstead Voices: Robert

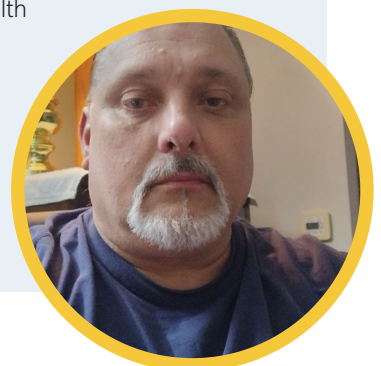
Program: MFP Demonstration; MFP-CL Waiver

Robert was accepted into the Moving Forward Plan - Community Living (MFP-CL) waiver operated by MassAbility on January 26, 2023. In May 2023, while continuing to reside in a nursing facility, he also enrolled in the Money Follows the Person Demonstration (MFP Demo) program, becoming a dual participant in both programs. Through the assistance of his MFP Demo transitional assistant worker, Robert completed multiple housing applications,

Eventually, his name was selected for an apartment in his preferred location. However, he was denied the subsidized apartment due to a prior eviction. Upon further investigation by Robert’s MFP-CL waiver case manager and his MFP Demo transitional assistant worker, they discovered that he owed several thousand dollars in arrears. This debt posed a significant barrier to securing housing and would remain an obstacle until it was resolved.

The setback left Robert feeling hopeless. Having lived in a nursing facility since October 2021 and faced with housing challenges, his future seemed uncertain. However, with continued support from the MFP Demo and MFP-CL waiver programs, Robert’s circumstances improved dramatically. After nearly two years of waiting and uncertainty, he successfully moved into an apartment on July 31, 2023.

Robert is deeply grateful for these two programs that helped him transition to independent living. He has formed friendships with several neighbors and is thriving in his new community. As he embraces this new chapter, he is focused on improving his physical and mental health while enjoying the stability and independence he has longed for.



WORKFORCE DEVELOPMENT AND SUPPORT FOR COMMUNITY-BASED PROVIDERS

The significant gains, enhancements, and expansions in community-based services will continue to be possible only with equivalent focus on adequate levels of the clinical and other workers providing those services. The healthcare workforce has faced recent challenges, including worker shortages, burnout, job satisfaction concerns, and aging of the workforce along with those in need of services. The COVID-19 pandemic exacerbated these workforce challenges for HCBS providers while at the same time increasing demand to a healthcare workforce that already needed to be revitalized. EOHHS has prioritized workforce development initiatives and engaged partners in government and the community in creating solutions to grow the healthcare workforce while strengthening access to services and improving the quality of services. This includes:

- **HCBS and Human Services Innovation Grants**
\$46 million has been allocated to 84 home and community-service providers through early 2025 to support workforce recruitment, retention, training, technology, and internships. Performance reporting collected in mid-2024 is helping to identify effective strategies to grow and improve the healthcare workforce.
- **Public-Private Partnerships**
EOHHS is working with private partners to promote nurse licensure compacts, improve college-to-career pathways, expand scholarship opportunities, and increase placement options for nurses.
- **Behavioral Health-Focused Initiatives**
A \$75.8 million investment has been made to a Trust that will fund numerous initiatives to bolster the existing behavioral health workforce to address growing need for behavioral health services. The Trust will help fund scholarships for attaining behavioral health degrees and certifications, promote field placements for behavioral health clinicians and those aspiring to do such work, distribute incentives to providers to supervise new and aspiring behavioral health

workers, and provide fee waivers for licensure and certification of behavioral health positions, as well as the creation of a workforce development center and research lab. These initiatives seek to incentivize the growth of the behavioral health workforce while maintaining and enhancing the quality of behavioral health services.

- **Peer Specialist Credentialing and Coverage of Peer Specialist Services**

A peer specialist is a nonclinical health professional who helps people recover from mental health or substance use disorders by sharing their own experiences and providing support. Efforts are underway to establish a peer specialist credential recognized by commercial insurers in Massachusetts. This effort seeks to promote coverage of peer specialists by private and commercial insurance, while also establishing standards for quality in service provision. Through these efforts, commercial plans participating in the Massachusetts Health Connector are now covering peer specialists in the same manner as the MassHealth program, and efforts to achieve full commercial coverage in Massachusetts are on-going.



Promoting Community-Integrated Employment of People with Disabilities

The promotion of employment opportunities for individuals with disabilities continues to be a high priority for Massachusetts. Primary agencies overseeing integrated employment strategies are collaborating across state government to ensure seamless programming that maximizes the resources and strengths of each entity.

MassAbility's career services department has recently embarked on several initiatives, investments, and partnerships reflecting the value of competitive integrated employment. Coordinating with the EOLWD, under the Workforce Innovations Opportunity Act (WIOA), MassAbility expanded access to pre-employment transition services, allowing anyone under age 23 to receive advocacy, work-based learning, counseling on postsecondary options, and opportunities for work experience. Through this expansion, job placement teams are able to continue providing services to individuals post-hire until they are stable in their jobs.

MassAbility is engaging in several strong collaborations for cross-agency opportunities. These partnerships promote innovation and flexibility beyond the general vocational rehabilitation (VR) services. MassAbility is partnering with Holyoke Community College to provide a free, intensive cybersecurity training program for people with disabilities. The certification students earn through this program is nationally recognized and is a highly sought-after workplace credential that provides the needed leverage to enter this high-paying industry. Through a public/private partnership, this program recently expanded to Roxbury Community College. With the success of these programs, MassAbility continues to explore opportunities for further expansion.

In April 2024, the Healey-Driscoll administration introduced the "Employment Program for Young Adults with Disabilities," funded by EOLWD and managed by the Commonwealth Corporation. This program supports initiatives led by community-based organizations with proven expertise in preparing young adults with disabilities for employment, job placement, and post-placement support to ensure employment retention.

Olmstead Voices: Aidan

Program: MassAbility Vocational Rehabilitation

Not long ago, Aidan was working in a local supermarket, making pizza for minimum wage. It was not a job he believed held much promise for him. Then he started a free, intensive cybersecurity training program for people with disabilities offered by Holyoke Community College and MassAbility. Ten months later, he is now poised to begin a career as a cybersecurity analyst.

"I liked working at Big Y and I could pay my bills, but there was nothing I could really do with that," he said. "Now I'm looking at positions that have salaries and benefits. That's a big change for me. It's fantastic. This class has just opened so many doors. It's life-altering or at least has the potential to be."

He had an internship with NetWerks Strategic Services, an Agawam-based technology company, and he has interviewed for full-time benefitted positions at the Massachusetts Educational Collaborative and the

Department of Youth Services. Aidan qualified for the program through their involvement with MassAbility. He was recommended by his caseworker. Candidates were screened and then took an entrance exam to make sure they could handle the material and the workload.

"People with disabilities don't necessarily get the same opportunities as others," said Aidan. "There's a stigma to it, and MassAbility is out there trying to erase that and show that we have value. That's what I really appreciate about them. They don't care about our labels and what's happened in our past. They just want to get us into a position where we can be fully functioning members of society and feel more useful."



Additionally, in September 2024, the administration announced grant funding to expand job training programs for individuals experiencing homelessness. These programs aim to meet the skilled workforce needs of businesses in Massachusetts and assist individuals experiencing homelessness in transitioning out of shelters.

DDS is also committed to fully implementing the goals outlined in its Blueprint for Success 2.0, highlighted previously. This includes increasing the number of individuals successfully employed in community businesses while tracking other quality measures such as increases in hours worked or wages earned. DDS is also focused on expanding access to individual and group employment opportunities, particularly for those with higher support needs who may face additional barriers, as well as increasing the number of individuals transitioning from Community-Based Day Services (CBDS) to employment. Additionally, DDS is working to ensure more young adults move directly from school into competitive integrated employment. Lastly, through its Blueprint for Success 2.0, DDS seeks to broaden the range of opportunities, and the amount of time individuals spend meaningfully participating in valued roles within the community.



Investing in Accessible Transportation for Individuals with Disabilities

Massachusetts continues to invest in transportation initiatives that seek to make the state's public transportation system more accessible to persons with disabilities. New investments and innovations include the following:

Under MassDOT's 2025–2029 Capital Investment Plan, the Department of Transportation's Accessibility Improvement Program includes \$4 million to expand the Community Transit Grant Program for projects expanding mobility for older adults, people with disabilities, and low-income individuals.

Furthermore, MassDOT is improving transportation accessibility through a Mobility Management pilot program, which includes hiring a statewide mobility manager to coordinate services, provide direct assistance, and foster partnerships. The program draws on research from other states and has received federal funding to address issues like promoting existing funding that can provide through-the-door escorts. A peer network for transportation providers will facilitate best practice sharing, while a statewide council that includes representatives from MassAbility and EOEA will collaboratively address transportation challenges for people with disabilities.

MBTA ACCESSIBILITY IMPROVEMENTS AND INNOVATION

The MBTA is undergoing significant transformations across its network, with major changes underway for the Green Line, Silver Line, and Commuter Rail — modes that have long struggled with inaccessible stations. In a determined effort to enhance accessibility, the MBTA plans to address many of these issues within the next three years. One of the most ambitious projects involves designing the next generation of Green Line trolleys, which will enable level boarding across the entire line. This development promises to make the Green Line more accessible to all riders, particularly those with mobility challenges.

In addition to these upgrades, the MBTA is also planning to pilot accessible wayfinding technology. This initiative aims to simplify navigation within the system's more complex stations, making it easier for all passengers, especially those with disabilities, to travel confidently. These efforts reflect the MBTA's commitment to creating a more inclusive transit system, ensuring that all riders can access and navigate its services with greater ease and independence.

Conclusion

The Healey-Driscoll administration celebrates the significant progress that has been made in Massachusetts towards community integration of persons with disabilities over the past 25 years. The administration also acknowledges that there is still work to be done.

The administration remains steadfast in its commitment to the vision and principles of Olmstead. It recognizes that every person with a disability should have the right to live in the community with dignity, autonomy, and access to the services they need. This commitment includes not only maintaining the progress already made but also pushing forward with new initiatives, such as the Community Living Initiative, to ensure all individuals have the opportunity to choose community living over institutional care.

As our state moves forward, we must also take on new challenges while continuing to uphold core Olmstead principles. Now that Massachusetts is finally emerging from the COVID pandemic, we must turn to combat the epidemic of loneliness that is challenging so many in our state. For individuals with disabilities, one way to address this is by ensuring that our community living options do more than simply provide housing. These options should foster a sense of community, helping the individuals we serve build and strengthen their social bonds and natural supports, which are essential for maintaining independence.

Looking ahead, Massachusetts will continue to invest in programs that expand housing options, strengthen the workforce delivering home and community-based services, and ensure that individuals with complex needs can receive personalized, high-quality care in the community. The administration looks forward to engaging with advocates, families, and individuals with lived experience to ensure that the vision and principles of Olmstead remain central to its approach and that ongoing efforts are responsive to the evolving needs of the disability community.



COMMONWEALTH OF MASSACHUSETTS



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

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



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August 28, 2025

Table of Contents

Abbreviations in this Document.....	iii
Introduction	1
Topic 1: Education	7
Topic 2: Employment	29
Topic 3: Health & Health Care.....	59
Topic 4: Home & Community-Based Services (HCBS)	73
Topic 5: Housing	89
Topic 6: Positive Supports	105
Topic 7: The Prevention of Abuse and Neglect.....	127
Topic 8: Transportation	149

Abbreviations in this Document

AAC – augmentative and alternative communication

ABA – applied behavior analysis

ABI – acquired brain injury

ABLE – Achieving a Better Life Experience

AC – Alternative Care

ACAP – Adult Community Autism Program

ACL – Administration for Community Living

ACT – Assertive Community Treatment

ADA – Americans with Disabilities Act

ADHD – Attention Deficit & Hyperactivity Disorder

ADSIS – Alternative Delivery of Specialized Instructional Services

AHCCCS – Arizona Health Care Cost Containment System

AJC – American Job Center

ANCOR – American Network of Community Options & Resources

APSE – Association of People Supporting Employment

ARMHS – Adult Rehabilitative Mental Health Services

ARPA – American Rescue Plan Act

ASD – Autism Spectrum Disorder

ASL – American Sign Language

BI – brain injury

BIRF – Behavior Intervention Reporting Form

BPI – Building Partnerships Initiative

BRYT – Bridge for Resilient Youth in Transition

CAC – Community Alternative Care

CADI – Community Access for Disability Inclusion

CAHOOTS – Crisis Assistance Helping Out On The Streets)

CARE – Community Addiction Recovery Enterprise

CCBHC – Certified Community Behavioral Health Clinic

CCD – Consortium for Constituents with Disabilities

CE – Customized Employment

CFSS – Community First Services and Supports

CHW – community health worker

CIE – competitive, integrated employment

CMS – Centers for Medicare and Medicaid Services

COO – Chief Operating Officer

CRF – Children’s Residential Facility

CRP – community rehabilitation provider

CTE – career and technical education

CWIC – Community Work Incentives Coordinator

DART – Disability Abuse Response Team

DCT – Direct care and treatment

DD – Developmental Disability

DEED – Department of Employment and Economic Development	IDEA – Individuals with Disabilities Education Act
DHS – Department of Human Services	IEP – Individualized Education Program
DOC – Department of Corrections	IHE – inclusive higher education
DPS – Department of Public Safety	IMDs – Institutes for Mental Disease
DSP – direct support professional	IPS-SE – Individual Placement and Support – Supported Employment
DV/SA – domestic violence/sexual assault	IPS – Individual Placement and Support
DWEL-AZ – Data Warehouse Enterprise for Linkage - Arizona	IPTN – Inclusionary Practices Technical Assistance Network
EBP – evidence-based practice	IRTS – Intensive Residential Treatment Services
EOHLC – Executive Office of Housing and Livable Communities	ISC – intensive support coordination
EPSDT – Early and Periodic Screening, Diagnostic and Treatment	ISD – intermediate school district
EW – Elderly Waiver	LEA – local education agency
FACT – Forensic Assertive Community Treatment	LGBTQ+ – lesbian, gay, bisexual, transgender, queer/questioning, and other marginalized sexual/gender identities
FDP – Friendships and Dating Program	LIHTC – Low Income Housing Tax Credit
FEP – first episode psychosis	LRE – least restrictive environment
HC – home care	LSU – Louisiana State University
HCBS – Home & Community-Based Services	LTSS – long-term services and supports
HIB – Housing Innovation Bond	MCO – managed care organization
HMIS – Homeless Management Information System	MDE – Minnesota Department of Education
HSRI – Human Services Research Institute	MDH – Minnesota Department of Health
HSS – housing stabilization services	MDVA – Minnesota Department of Veterans Affairs
HTC – housing tax credits	METO – Minnesota Extended Treatment Options
I/DD – intellectual or developmental disability/disabilities	MHEC – Minnesota Inclusive Higher Education Consortium
IA – interdepartmental/interagency agreement	MHFA – Minnesota Housing Finance Agency
ICA – Institute for Community Alliances	

MN VRS – Minnesota Vocational Rehabilitation Services	OSEP – Office of Special Education Programs
MOU – memorandum of understanding	PBIS – Positive Behavioral Interventions and Supports
MRO – Medicaid Rehabilitation Option	PCA – personal care attendant
MSA – Minnesota Supplemental Aid	PCP – person-centered planning
MSOP – Minnesota Sex Offender Program	PE – progressive employment
MTSS – multi-tier system of supports	POM – personal outcome measure
NADSP – National Association of Direct Support Professionals	PORT – Point of Reentry and Transition
NADTC – National Aging and Disability Transportation Center	POST – Peace Officer Standards and Training
NAMI – National Alliance on Mental Illness	PRA – Project Rental Assistance
NASDSE – National Association of State Directors of Special Education	pre-ETS – pre-employment transition services
NCAPPS – National Center for Advancing Person-Centered Practices and Systems	PRTF – psychiatric residential treatment facility
NCI-AD – National Core Indicators® - Aging and Disabilities	PSH – permanent supportive housing
NCI-IDD – National Core Indicators® - Intellectual and Developmental Disabilities	PWD – person with a disability
NEON – National Expansion of Employment Opportunities	QAP – Qualified Allocation Plan
NGA – National Governors Association	QDE – qualified disability expense
NHeLP – National Health Law Program	RAP – Registered Apprenticeship Program
NRI – National Research Institute	RCS – Residential Crisis Stabilization
NTACT – National Technical Assistance Center on Transition	REALD – race, ethnicity, language, and disability
ODEP – Office of Disability Employment Programs	RFP – request for proposals
OIO – Olmstead Implementation Office	RI DDS – Rhode Island Division of Disability Services
OPWDD – Office for People with Developmental Disabilities	ROSC – Recovery Oriented System of Care
	SAMHSA – Substance Abuse and Mental Health Services Administration
	SDLMI – Self-Determined Learning Model of Instruction

SDOH – social determinant of health	TA – technical assistance
SEA – state education agency	TAC – Technical Assistance Collaborative, Inc.
SEED – Support Education to Elevate Diversity	TIC – trauma-informed care
SMART – specific, measurable, achievable, relevant, and time-bound	TPSID – transition program for students with intellectual disabilities
SME – subject matter experts	UDL – Universal Design for Learning
SMI – serious mental illness	VR-JIT – Virtual Reality Job Interview Training
SOS – Start on Success	VR – Vocational rehabilitation
SPP – State Performance Plan	WBL – work-based learning
SSDI – Social Security Disability Insurance	WDBs – Workforce Development Boards
SSI – Supplemental Security Income	WIN – Workforce Innovation Network
STAR – Support Team Assisted Response	WINTAC – Workforce Innovation Technical Assistance Center
STEM – science, technology, engineering, and mathematics	WIOA – Workforce Innovation and Opportunity Act
SUD – substance use disorder	WIPA – Work Incentives Planning and Assistance

Introduction

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

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

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

“...concrete and reliable commitments to expand integrated opportunities....and there must be funding to support the plan.”

The Minnesota Olmstead Plan

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

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

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

The Best & Promising Practices Report

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

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

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

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

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

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

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

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

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

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

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

Cross-Cutting Considerations

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

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

The Importance and Strengths of Data Sharing and Data Coordination

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

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

Conclusion

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

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

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Topic 1: Education

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Overview of Education & Olmstead Planning

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

Subtopics

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

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

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

Populations of Particular Concern for Education & *Olmstead*

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

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

Education & *Olmstead* in Minnesota

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

2023 school year figures:

- 325 public school districts
- 169 charter schools

[Minnesota Education Statistics Summary 2025-2026](#)

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

Effective Education-Related Policies, Programs, and Strategies

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

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

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

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

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

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

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

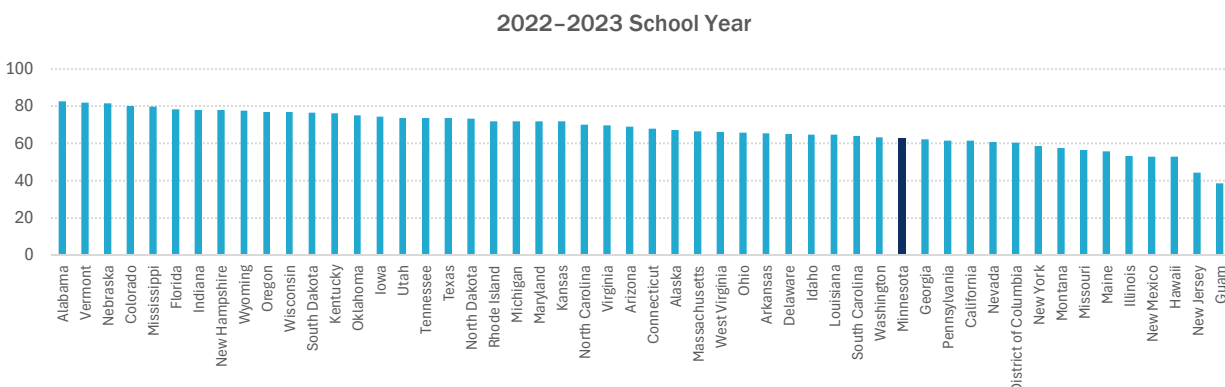
Table 1.1: Minnesota Students in Setting 1, 2019–2025

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

Source: [Data Profiles - Department of Education Open Data Platform](#)

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

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



Examples of Best Practices

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

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

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

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

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

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

Other promising strategies include:

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

¹ In this report’s descriptions of other states’ programs, “LRE 1, 2, & 3” are used. These are equivalent to “Settings 1, 2, & 3” in Minnesota.

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

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

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

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

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

Tennessee

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

New Jersey

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

Kentucky

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

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

Ohio

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

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

1C: Facilitating Transition to Adulthood

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

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

Supporting Employment and Work-Based Learning (WBL)

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

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

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

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

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

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

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

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

The Use of Technology to Enhance Independence

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

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

Example: JobPro Series (SimCoach Games)

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

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

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

Leveraging Pre-Employment Transition Services and Wraparound Models

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

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

Examples: Digitability, Start on Success, and RENEW

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

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

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

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

Supporting Pathways to Post-Secondary Education & Training

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

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

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

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

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

Examples: Landmark College; ACE-IT at VCU

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

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

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

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

Supporting Financial Independence and Self-Determination

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

Example: Self-Determined Learning Model of Instruction

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

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

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

Example: Better Money Habits

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

Opportunities

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

Implementation Considerations

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

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

Evaluating Impact and Investments

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

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

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

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

Cultural Responsiveness

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

Informed by Lived Experience

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

Challenges

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

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

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

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

Education: Works Cited & Additional Resources

Centers for Medicare and Medicaid Services (2014). [Medicaid payment for services provided without charge \(free care\)](#). *State Medicaid Director Letter #14-006*.

Kevin A. Gee. (2020) [Predictors of special education receipt among child welfare-involved youth](#). *Children and Youth Services Review*, Volume 114, 105018, ISSN 0190-7409.

Kim BE, Johnson J, Rhinehart L, Logan-Greene P, Lomeli J, Nurius PS. [The school-to-prison pipeline for probation youth with special education needs](#). *Am J Orthopsychiatry*. 2021;91(3):375-385. doi: 10.1037/ort0000538. PMID: 34138628; PMCID: PMC8432608.

Mazzotti, V. L., Rowe, D. A., Kwiatek, S., Voggt, A., Chang, W. H., Fowler, C. H., Poppen, M., Sinclair, J., & Test, D. W. (2021). [Secondary transition predictors of postschool success: An update to the research base](#). *Career Development and Transition for Exceptional Individuals*, 44(1), 47–64.

Minnesota Department of Education (2025). [Part B indicator guide: A resource for understanding the Minnesota Part B state performance plan indicators](#). Accessed August 12, 2025.

Minnesota Legislature, Office of the Revisor of Statutes (2017). [Minnesota Administrative Rules — 8710.5700 Teachers of special education: Learning disabilities](#).

National Center for Education Statistics (2024). [Students with disabilities](#). *Condition of Education*. U.S. Department of Education, Institute of Education Sciences.

National Conference of State Legislatures (2025, June 30). [Quality apprenticeship opportunities for individuals with disabilities](#).

Oh-Young C, Filler J. [A meta-analysis of the effects of placement on academic and social skill outcome measures of students with disabilities](#). *Research in Developmental Disabilities*, 47, 80–92.

Partners for Insightful Evaluation (2024). [Nebraska Olmstead Plan evaluation findings: Education summary report](#). Accessed August 12, 2025.

Salon, R. S., Boutot, N., Ozols, K., Keeton, B., & Steveley, J. (2019). [New approaches to customized employment: Enhancing cross-system partnerships](#). *Journal of Vocational Rehabilitation*, 50(3), 317–323.

Smith, M. J., Ginger, E. J., Wright, K., Wright, M. A., Taylor, J. L., Humm, L. B., Olsen, D. E., Bell, M. D., & Fleming, M. F. (2014). [Virtual reality job interview training in adults](#)

[with autism spectrum disorder](#). *Journal of Autism & Developmental Disorders*, 10, 2450–2463.

State of Vermont Agency of Education (n.d.). [Vermont multi-tiered system of supports framework and field guide](#). Accessed August 12, 2025.

Sung, C., Fisher, M. H., Okyere, C., Park, J., & Choi, H. (2023). [Employment outcomes and support needs of Michigan Project SEARCH graduates with intellectual and developmental disabilities: A mixed-method study](#). *Journal of Vocational Rehabilitation*, 59(3), 233-249.

U.S. Department of Education (2024). [IDEA Section 618 Data Products: Static Files | U.S. Department of Education](#)

U.S. Government Accountability Office (2018, September 6). [Students with disabilities: Additional information from education could help states provide pre-employment transition services](#). GAO-18-502.

White, H., LaFleur, J., Houle, K., Hyry-Dermith, P., & Blake, S. M. (2017). [Evaluation of a school-based transition program designed to facilitate school reentry following a mental health crisis or psychiatric hospitalization](#). *Psychology in the Schools*, 54(8), 868–882.

Topic 2: Employment

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

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

Overview of Employment & Olmstead Planning

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

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

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

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

Subtopics

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

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

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

Populations of Particular Concern for Employment & Olmstead

Minnesota has a robust and diverse network of home- and community-based service (HCBS) providers who deliver day and employment services for people with intellectual and developmental disabilities (I/DD). A partially overlapping network of community rehabilitation providers (CRPs) also provides employment services through contacts with Minnesota Vocational Rehabilitation (VR). Over the last decade, the state's Department of Human Services (DHS), Department of Employment and Economic Development (DEED), and Department of Education (MDE) have sought to improve collaboration and ensure that individuals who want to work have a pathway and support to do so.

Minnesota's E1MN partnership showcases the value of interagency collaboration, and has focused on advancing Employment First principles since the Olmstead Subcabinet adopted the state's Employment First policy statement in 2014. These agencies have made great strides to coordinate information and service delivery, particularly for transition-aged youth and some waiver populations. Transition-age youth and emerging adults require customized attention, and we note programs of interest for them below. School-to-work transition is discussed in [Topic 1: Education](#).

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

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

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

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

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

Employment & Olmstead in Minnesota

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

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

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

Effective Employment-Related Policies, Programs, and Strategies

2A: Individual Placement and Support

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

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

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

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

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

Strengths of IPS

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

Opportunities with IPS

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

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

Implementation Considerations for IPS

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

Evaluating the Efficacy of IPS

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

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

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

How IPS was informed by lived experience

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

Challenges in IPS

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

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

2B: Customized Employment

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

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

Strengths of Customized Employment

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

Implementation Considerations for Customized Employment

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

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

Opportunities with Customized Employment

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

Evaluating the Efficacy of Customized Employment

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

Employment Outcomes

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

Quality of Employment

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

Process Fidelity

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

Efficiency/Resource Utilization

- Time to job placement
- Cost per successful placement

Workforce Capacity

- Number of trained professionals

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

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

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

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

How Customized Employment was Informed by Lived Experience

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

Ways for Customized Employment to Collaborate across State Government

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

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

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

Challenges in Implementing Customized Employment

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

Cost and Funding Structures

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

Workforce Availability and Turnover

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

Providers Payment Rate

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

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

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

Waiting Lists and System Capacity

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

Systemic and Policy Barriers

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

Employer Engagement

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

2C: Progressive Employment

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

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

Strengths of Progressive Employment

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

Implementation of Progressive Employment

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

Evaluating the Efficacy of Progressive Employment

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

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

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

How Progressive Employment is informed by lived experience

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

Challenges in Implementing Progressive Employment

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

Example: Maine Department of Labor

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

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

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

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

Please see [Topic 6: Positive Supports](#) for additional information about ACT.

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

Strengths of Clinical Connections in ACT and FEP programs

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

Opportunities with ACT and FEP Programs

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

Implementation Considerations for ACT and FEP Programs

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

Evaluating the Efficacy of ACT and FEP Programs

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

Challenges of ACT and FEP Programs

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

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

2E: Benefits Counseling and Planning

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

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

Strengths of Benefits Counseling and Planning

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

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

Implementation of Benefits Counseling and Planning

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

Evaluating the Efficacy of Benefits Counseling and Planning

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

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

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

How Benefits Counseling and Planning is Informed by Lived Experience

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

Ways to Collaborate on Benefits Counseling and Planning

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

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

Challenges of Benefits Counseling and Planning

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

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

Example: Work Without Limits

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

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

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

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

Example: State-Driven ABLE Programs

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

Strengths of ABLE Accounts

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

Opportunities with ABLE Accounts

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

Implementation of ABLE Accounts

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

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

Evaluating the Efficacy or Impact of ABLE Accounts

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

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

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

How ABLE Accounts are Informed by Lived Experience

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

Challenges of ABLE Accounts

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

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

2G: Data Integration and Interagency and Interdepartmental Coordination

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

Strengths of Data Integration and Interagency and Interdepartmental Coordination

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

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

Opportunities with Data Integration and Interagency & Interdepartmental Coordination

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

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

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

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

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

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

Evaluating the Efficacy of Data Integration and Interagency & Interdepartmental Coordination

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

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

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

Challenges of Data Integration and Interagency & Interdepartmental Coordination

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

2H: Coordination with American Job Centers

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

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

Strengths of American Job Center Coordination

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

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

Opportunities from American Job Center Coordination

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

Implementation of Stronger Coordination with American Job Centers

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

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

Evaluating the Efficiency and Impact of Coordination with American Job Centers

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

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

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

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

How Coordination with American Job Centers was Informed by Lived Experience

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

Ways for American Job Centers to Collaborate across State Government

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

Challenges of Coordination with American Job Centers

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

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

2I: State Employment First Office

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

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

Strengths of an Employment First Office

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

Implementation of an Employment First Office

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

Evaluating the Efficacy of an Employment First Office

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

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

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

How an Employment First Office is Informed by Lived Experience

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

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

Ways for an Employment First Office to Collaborate across State Government

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

Challenges of an Employment First Office

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

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

Key Considerations Across Program Models and Strategies

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

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

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

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

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

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

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

Employment: Works Cited & Additional Resources

ABLE National Resource Center (n.d.). [ABLE account contribution limits \(2025\)](#). Accessed August 11, 2025.

Bond, G.R., Drake, R.E., & Becker, D.R. (2020). [An update on Individual Placement and Support](#). *World Psychiatry*, 19, 390–391.

Headrick, G., Ruth, A., White, S. A., Ellison, C., Seligman, H., Bleich, S. N., & Moran, A.J. (2022). [Integration and coordination across public benefit programs: Insights from state and local government leaders in the United States](#). *Preventive Medicine Reports*, 31:102077.

Inge, K. J. (2006). [Customized employment: A growing strategy for facilitating inclusive employment](#). *Journal of Vocational Rehabilitation*, 24(3), 191–193.

Kamau, E., & Timmons, J. (2018). [A roadmap to competitive integrated employment: Strategies for provider transformation](#). *Bringing Employment First to Scale*, 20. Institute for Community Inclusion, UMass Boston.

Mazzotti, V. L., Rowe, D. A., Kwiatek, S., Voggt, A., Chang, W. H., Fowler, C. H., Poppen, M., Sinclair, J., & Test, D. W. (2021). [Secondary transition predictors of postschool success: An update to the research base](#). *Career Development and Transition for Exceptional Individuals*, 44(1), 47–64.

McGrew, J. H., Bond, G. R., Dietzen, L., McKasson, M., & Miller, L. D. (1995). [A multisite study of client outcomes in Assertive Community Treatment](#). *Psychiatric Service*, 46(7), 696–701.

Minnesota Department of Employment & Economic Development (2025, March 27). [News and updates from VRS](#).

Roll, S., Ferris, D., Bufe, S., & Kondratjeva, O. (2024). Designing savings accounts to promote asset building for individuals with disabilities: Experimental evidence on ABLE accounts. *Journal of Disability Policy Studies*, 10442073241304109.

Rowe, D. A., Mazzotti, V. L., Fowler, C. H., Test, D. W., Mitchell, V. J., Clark, K. A., Holzberg, D., Owens, T. L., Rusher, D., Seaman-Tullis, R. L., Gushanas, C. M., Castle, H., Chang, W.-H., Voggt, A., Kwiatek, S., & Dean, C. (2021). [Updating the secondary transition research base: Evidence-and research-based practices in functional skills](#). *Career Development and Transition for Exceptional Individuals*, 44(1), 28–46.

Schall, C., Wehman, P., Avellone, L., & Taylor, J. P. (2020). [Competitive integrated employment for youth and adults with autism: Findings from a scoping review](#). *Child and Adolescent Psychiatric Clinics of North America*, 29(2), 373–397.

Serres, C. (2016, August 19). State scrambles to take action on low pay for disabled workers. *Minnesota Star Tribune*.

Weathers, R., Kelly, P., & Hemmeter, J. (2024). ABLE account use among Supplemental Security Income recipients. *Journal of Vocational Rehabilitation*, 60(1), 99–119.

Wehman, P., Schall, C., Avellone, L., Brooke, A. M., Brooke, V., McDonough, J., & Whittenburg, H. (2021). Achieving competitive integrated employment for individuals with intellectual and developmental disabilities. In L. M. Glidden, L. Abbeduto, L. L. McIntyre, & M. J. Tassé (Eds.), *APA Handbook of Intellectual and Developmental Disabilities, Volume 2: Clinical and Educational Implications: Prevention, Intervention, and Treatment*. American Psychological Association.

Winsor, J., Shepard, J., Zalewska, A., Domin, D., Migliore, A., Wedeking, R., White, A. & Butterworth, J. (2025). Summary of StateData: The national report on employment services and outcomes through 2022. *Data Note Plus*, 94. Boston, MA: University of Massachusetts Boston, Institute for Community Inclusion.

Workforce Innovation Technical Assistance Center (WINTAC). Resources (n.d.). Accessed August 11, 2025.

Topic 3: Health & Health Care

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

Overview of Health & Olmstead Planning

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

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

Populations of Particular Concern for Health & Olmstead

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

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

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

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

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

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

Health & *Olmstead* in Minnesota

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

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

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

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

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

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

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

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

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

1. **Ensure health care providers provide access to care.** States can enlarge the pool of accessible health care services by encouraging or requiring all health care providers to implement evidence-based practices (EBPs) for access to care for people with disabilities. EBPs generally fall into the following categories.
 - *Person-centered care* that aligns with the person's goals and actively involves the person in decision-making
 - *Physical accessibility* of buildings and medical equipment, including exam tables, dental chairs, weight scales, and radiology equipment, as well as sensory-friendly environments with adjustable lighting and reduced noise
 - *Effective communication* that accommodates differing needs, including using clear, plain language; providing information in accessible formats (e.g., large print, Braille, or auditory); and, where requested, including caregivers, sign language interpreters and other interpreters in office and telehealth appointments

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

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

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

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

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

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

- 3. Promote education for clinicians on caring for people with disabilities.** States can enlarge the pool of accessible health care services by promoting professional training to address the health care needs of people with disabilities.
 - States can encourage medical, nursing, and other health care professional schools to provide education and training to their students on caring for people with disabilities

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

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

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

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

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

Opportunities to Support Provision of High-Quality Health Care Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3B: Help People Access Needed Services through Targeted Assistance

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

1. **Provide navigation assistance.** States can support the use of auxiliary health workers to help people with disabilities navigate health and social services and engage in treatment. Navigation assistance can be particularly helpful during major life changes, such as onset of a disability, transition from childhood to adulthood, or discharge from a residential treatment facility. Employing auxiliary health workers is cost effective, helps mitigate workforce shortages, and can result in savings to the overall health and social services system. Extensive evidence shows that these workers help people achieve improved health outcomes, especially among members of underserved communities. (Kim, 2016; Scott, 2018, SAMHSA, 2017).
 - Community health workers (CHWs) are trusted members of the community who connect people to health and social services and help people manage their own health conditions. Medicaid programs in California, Kansas, Kentucky, Michigan, and Rhode Island cover CHWs providing navigation assistance services.
 - Peer specialists are people in recovery from mental illness and/or SUDs who support others to achieve long-term recovery. Medicaid programs in New Mexico and Virginia cover peer specialists providing navigation assistance services.
2. **Engaging people with serious behavioral health needs in integrated care before they are released from prisons and jails.** States can support programs to engage people with SMI, substance use disorders (SUDs), and I/DD in treatment before release. People are often held in county jails for short periods of time and are released back to the community with little support. After release from incarceration or detention, these individuals are at extremely high risk of destabilization and overdose. (Frank, 2014; Binswanger, 2007; Binswanger, 2013).

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

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

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

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

3. Implementing strategies to improve access to care for people with private insurance.

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

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

Strengths of Targeted Assistance

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

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

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

Opportunities to Provide Targeted Assistance

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

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

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

Implementation Considerations for Targeted Assistance

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

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

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

Evaluating the Efficacy of Targeted Assistance — Proposed Metrics

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

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

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

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

How the Need for Targeted Assistance was Informed by Lived Experience

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

Ways to Collaborate across State Government to Provide Targeted Assistance

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

Challenges to Providing Targeted Assistance

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

3C: Use Data to Inform Health Policy and Strategy

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

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

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

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

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

Strengths of Using Data to Inform Health Policy and Strategy

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

Implementation Considerations for Using Data to Inform Health Policy and Strategy

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

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

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

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

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

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

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

Challenges to Using Data to Inform Health Policy and Strategy

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

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

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

Health and Health Care: Works Cited & Additional Resources

Binswanger, I. A., Blatchford, P. J., Mueller, S. R., & Stern, M. F. (2013). [Mortality after prison release: Opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009](#). *Annals of Internal Medicine*, 159(9), 592–600.

- Bixby, L., Bevan, S., and Boen, C. (2022). [The links between disability, incarceration, and social exclusion](#). *Health Affairs*, 41(10), 1460–1469.
- Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). [Release from prison — a high risk of death for former inmates](#). *New England Journal of Medicine*, 356, 157–165.
- Breslin, E. & Lambertino, A. (2017). [A report to the Minnesota Department of Human Services \(DHS\). An account of health disparities in Minnesota's Medicaid population: Which populations within the Medicaid Program experience the greatest health disparities and poorest health outcomes?](#) Health Management Associates. Accessed August 15, 2025.
- Frank, J. W., Linder, J. A., Becker, W. C., Fiellin, D. A., & Wang, E. A. (2014). [Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: Results of a national survey](#). *Journal of General Internal Medicine*, 29(9), 1226–1233.
- Hopkin, G., Evans-Lacko, S., Forrester, A., Shaw, J., & Thornicroft, G. (2018). [Interventions at the transition from prison to the community for prisoners with mental illness: A systematic review](#). *Administration & Policy in Mental Health & Mental Health Services Research*, 45, 623–634.
- Kim, K., Choi, J. S., Choi, E., Nieman, C. L., Joo, J. H., Lin, F. R., Gitlin, L. N., & Han, H. R. (2016). [Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: A systematic review](#). *American Journal of Public Health*, 106(4), e3–e28.
- Landes, S. D. (2024). [Disability mortality disparity: Risk of mortality for disabled adults nearly twice that for nondisabled adults, 2008–19](#). *Health Affairs*, 43(8), 1128–1136.
- Scott, K., Beckham, S. W., Gross, M., Pariyo, G., Rao, K. D., Cometto, G., & Perry, H. B. (2018). [What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers](#). *Human Resources for Health*, 16, Article 39.
- Substance Abuse and Mental Health Services Administration (n.d.). [Peers supporting recovery from mental health conditions](#). Accessed August 15, 2025.
- Substance Abuse and Mental Health Services Administration (2019). [Principles of community-based behavioral health services for justice-involved individuals: A research-based guide](#). HHS Publication No. SMA19-5097. Substance Abuse and Mental Health Services Administration Office of Policy, Planning, and Innovation.

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

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

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

Overview of HCBS & Olmstead Planning

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

Subtopics

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

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

own behalf.” The 2024 [Small Community Conversations](#) confirmed that racism, poverty, language barriers and isolation are barriers to real change.

Populations of Particular Concern for HCBS & Olmstead

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

HCBS & Olmstead in Minnesota

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

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

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

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

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

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

Effective HCBS Policies, Programs, and Strategies

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

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

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

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

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

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

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

2. Embedding expectations in care planning documents

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

3. Moving beyond checklists in evaluating plans

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

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

All team meetings should only occur when the individual is present AND, if applicable, the family or guardian. The PCISP is driven by the individual and family. The outcomes, wants, and needs are centered on the individual's and/or family's vision for a good life. Their desires, cultural beliefs, and values are recognized, respected, embraced, and reflective in outcomes, formal services, and community activities. The PCISP demonstrates the individual's informed choice and allows for opportunities for learning.

Exemplary (3 Points)	Proficient (2 points)	Marginal (1 Point)	Unacceptable (0 Points)
My good life and/or vision of a preferred life specific to any life domain are reflective of the individual's input and/or interests. AND If applicable: PCISP identifies the wants and desires of the guardian. AND All outcomes, strategies, and/or action steps are linked to the individual's interests, good life and/or vision of a preferred life specific to the coordinating life domain. AND Team discussions on outcomes reflect input from the entire team, including the individual and family.	My good life and/or vision of a preferred life specific to any life domain are reflect of the individual's input and/or interests. AND If applicable: PCISP identifies the wants and desires of the guardian. AND All outcomes, strategies, and/or action steps are linked to the individual's interests, goodlife and/or vision of a preferred life specific to the coordinating life domain.	My goodlife and/or vision of a preferred life specific to any life domain are reflective of the individual's input and/or interests. AND/OR Individual's interests, desires, and wants are identified in the PCISP.	PCISP states that it is written without the individual present. AND/OR PCISP states that it is written without the guardian (if applicable) present. AND/OR Individual's interests, desires, and wants are not identified anywhere in the PCISP. AND/OR Individual and/or family vision for a good life is not identifies anywhere in the PCISP. AND/OR Individual and/or family's, if applicable, cultural beliefs and values are violated, discriminated against, disrespected or disregarded.

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

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

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

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

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

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

Strengths of an Integrated PCP Approach

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

Opportunities of an Integrated PCP Approach

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

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

Implementation Considerations with an Integrated PCP Approach

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

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

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

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

Evaluating Efficacy — Proposed Metrics for an Integrated PCP Approach

Data sources to monitor PCP and informed choice:

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

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

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

How an Integrated PCP Approach was Informed by Lived Experience

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

Ways to Collaborate across State Government on an Integrated PCP Approach

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

Challenges with an Integrated PCP Approach

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

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

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

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

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

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

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

Example: Perspectives Corporation, Rhode Island

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

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

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

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

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

Example: Regional Centers for Workforce Transformation, New York

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

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

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

- Worker credentialing to promote professionalism and engagement
 - Credentials are available through NADSP and the [SUNY/CUNY systems](#) and can be used for college credits and a degree
 - Linked to recognition, including new or expanded responsibilities and public celebrations
 - [An evaluation](#) found increased tenure among credentialled direct care workforce staff and reduced turnover compared to staff who were not credentialled
- Making a variety of investments and ongoing experimentation to see what works
- Centralizing the training and support infrastructure
- Communicating and collaborating to avoid duplication, such as multiple diversity, equity, and inclusion initiatives
- Encouraging providers to participate in the NCI State of the Workforce initiative, to track progress
- Using workgroups to guide initiatives that bring a variety of perspectives from self-advocates, families, DSPs, and underserved populations

Strengths of Supporting Workforce Development and Retention

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

Opportunities to Support Workforce Development and Retention

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

- People don’t get needed services in their communities
 - It is harder to have person-centered care, with informed choice
- Lack of continuity influences the quality of supports
 - Ongoing recruitment and loss of trained staff is costly for providers
 - Turnover undermines efforts to build connections and support a culturally responsive system

Implementation Considerations for Supporting Workforce Development and Retention

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

Potential next steps for DHS:

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

Potential next steps for the legislature:

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

Evaluating Efficacy in Supporting Workforce Development and Retention

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

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

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

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

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

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

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

Collaborating across State Government on Supporting Workforce Development and Retention

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

Challenges in Supporting Workforce Development and Retention

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

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

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

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

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

Minnesota Olmstead Implementation Office (2024). [Olmstead quality of life survey 2024 findings.](#) Accessed July 31, 2025.

Minnesota Olmstead Implementation Office (2025). [Synthesis of community input and recommended Olmstead planning focus areas.](#) Accessed July 31, 2025.

Minnesota Olmstead Implementation Office (2022). Olmstead Plan Survey Results, January 2022

Scales, K. (2021). [Transforming direct care jobs, reimagining long-term services and supports.](#) *Journal of the American Medical Directors Association*, 23(2), 207-213.

Wysocki, A., Murray, C., Kachalia, A., Carpenter, A., & Stepanczuk, C. (2024). [Trends in the use of and spending for Home and Community-Based Services as a share of total LTSS use and spending in Medicaid, 2019–2021.](#) Mathematica. Accessed July 31, 2025.

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

Topic 5: Housing

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

Overview of Housing & Olmstead Planning

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

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

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

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

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

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

Effective Policies, Programs, and Strategies Related to Housing

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

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

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

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

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

Opportunities to Strengthen Housing and Health Initiatives

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

5B. Interagency Data Matching and Data Integration

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

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

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

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

Example: Data Warehouse Enterprise for Linkage Arizona

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

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

Housing Data

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

Medicaid Data

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

Challenges in Interagency Data Matching and Data Integration

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

Opportunities for Interagency Data Matching and Data Integration

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

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

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

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

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

5C. Targeted Production and Referral to Housing

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

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

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

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

Challenges in Targeted Production and Referral to Housing

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

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

Targeted Referral

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

Opportunities for Targeted Production and Referral to Housing

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

Learning from Lived Experience

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

Leveraging Continuum of Care and Veterans System Data

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

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

Leveraging Department of Corrections Data

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

Additional Emerging Practices and Opportunities to Consider

State Bond Funds to Target Special Populations

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

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

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

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

5D. Group Home Alternatives

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

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

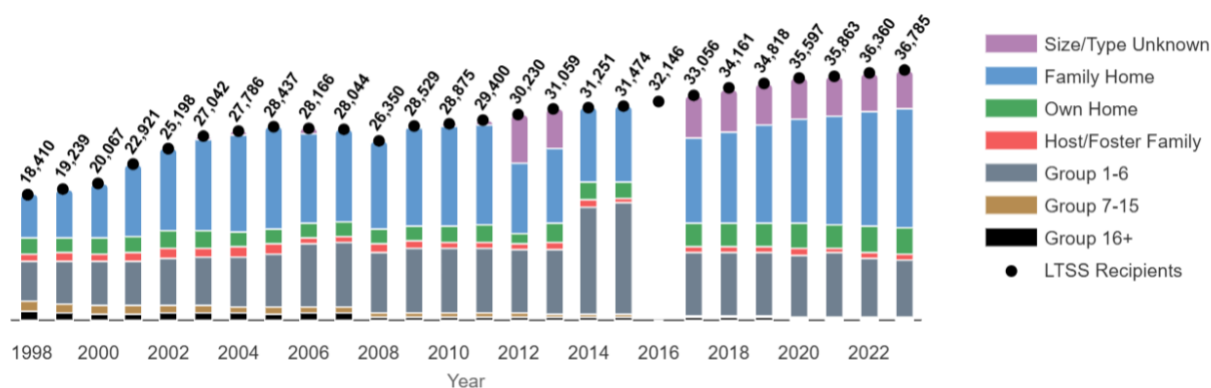
In addition to group home diversion or transition, shared living may be a housing choice for individuals leaving institutional settings such as nursing homes or Intermediate Care

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

Example: Shared Living in Vermont

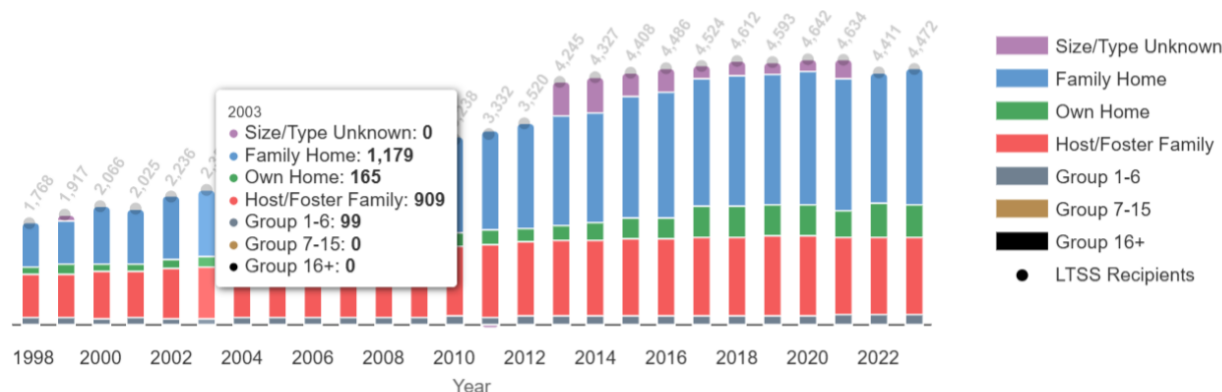
Vermont has invested heavily in the shared living model for decades. Ninety-two percent of individuals with I/DD who receive residential services live in homes, using a model that draws upon the transformative power of relationships. Individuals in shared living continue to receive supports, and shared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

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



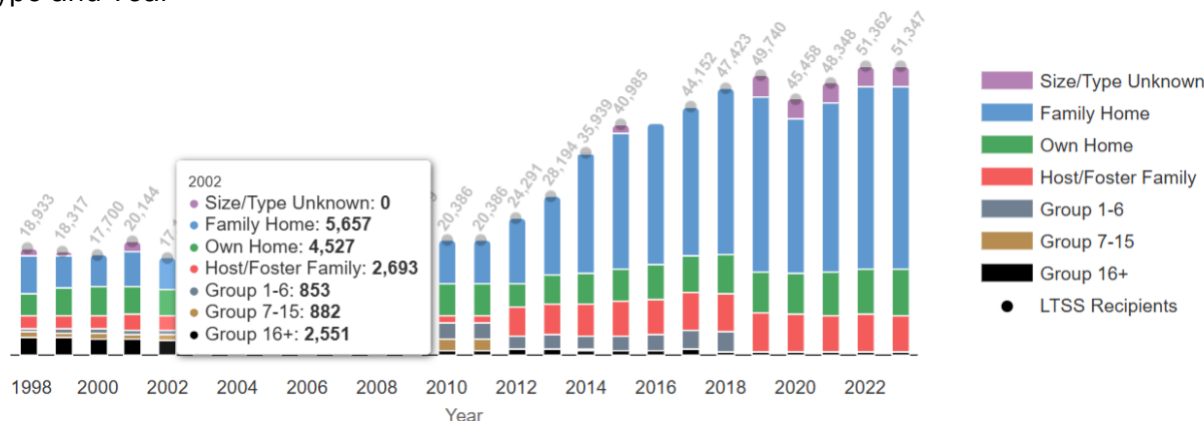
Source: [RISP State Profiles FY 2023 | Minnesota | State Profiles](#)

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



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

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



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

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

Crisis Respite Programs to Support Community Tenure in Group Home Alternatives

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

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

Example: Peer-Run Respite, New York

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

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

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

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

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

Challenges in Shared Living and Shared Housing Models

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

Opportunities for Shared Living and Shared Housing

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

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

Learning from Lived Experience in Shared Living and Shared Housing

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

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

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

Housing: Works Cited & Additional Resources

Atkeson, A., Levisohn, A., & Rosenthal, J. (2020). [Five states break down interagency silos to strengthen their health and housing initiatives](#). National Academy for State Health Policy.

Solari (n.d.). [The data warehouse enterprise for Linkage Arizona \(DWEL-AZ\)](#). Accessed August 12, 2025.

Arena, O., & Pettit, K. (2018). [Housing insights: Bringing open data to affordable housing decisionmakers](#). Civic Tech and Data Collaborative.

Sloane, L. (2024, January 10). [Priced Out: The affordable housing crisis for people with disabilities in 2024](#). Access: The TAC Blog.

National Low Income Housing Coalition (2023). [Gap report — Minnesota](#).

Human Services Research Institute (2020). [Minnesota Housing Finance Agency: Evaluation of permanent supportive housing — final report 2020](#).

Consortium for Constituents with Disabilities (n.d.). [CCD 2024 Housing Task Force annual report](#). Accessed August 12, 2025.

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Topic 6: Positive Supports

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

Overview of Positive Supports & Olmstead Planning

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

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

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

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

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

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

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

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

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

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

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

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

As characterized by the literature and key informants

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

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

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

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

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

Subtopics

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

Populations of Particular Concern for Positive Supports & Olmstead

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

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

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

Positive Supports & Olmstead in Minnesota

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

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

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

Strengths of Minnesota's adoption of positive supports include:

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

Barriers to these efforts include:

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

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

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

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

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

Effective Policies, Programs, and Strategies Related to Positive Supports

6A: Expanding Positive Supports to More People

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

Other strategies that may be helpful to consider are:

- Positive Behavioral Intervention and Support
- Recovery Oriented Model

- Trauma-Informed Care
- Harm Reduction

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

Positive Behavioral Intervention and Supports

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

PBIS has been shown to:

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

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

Recovery Oriented Systems of Care (ROSC)

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

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

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

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

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

Trauma Informed Care

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

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

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

6B: Coordinating Care

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

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

Integrated Care Coordination

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

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

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

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

Assertive Community Treatment (ACT)

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

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

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

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

Telehealth and Technology Supports

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

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

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

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

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

Diverting Institutional Placements

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

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

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

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

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

Transition Supports

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

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

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

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

Considerations

Strengths of Positive Supports

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

Opportunities for Positive Supports

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

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

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

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

Implementation for Positive Supports

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

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

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

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

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

Evaluating the Efficacy of Positive Supports

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

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

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

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

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

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

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

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

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

How Positive Supports were Informed by Lived Experience

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

Challenges of Positive Supports

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

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

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

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

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

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

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

Positive Supports: Works Cited & Additional Resources

Albertson, E. M., Chuang, E., O'Masta, B., Miake-Lye, I., Haley, L. A., & Pourat, N. (2022). Systematic review of care coordination interventions linking health and social services for high-utilizing patient populations. *Population Health Management*, 25(1), 73–85.

American Psychiatric Association (n.d.). What is telepsychiatry? Accessed July 31, 2025.

Association for Positive Behavior Support (n.d.). What is positive behavior support? Accessed July 14, 2025.

Austin, A., Herrick, H., Proescholdbell, S., & Simmons, J. (2016). Disability and exposure to high levels of adverse childhood experiences. *North Carolina Medical Journal*, 77(1), 30–36.

Autistic Self-Advocacy Network (2024, May 31). Beyond coercion and institutionalization: People with intellectual and developmental disabilities and the need for improved behavior support services.

Au-Yeung, C., & Bray, C. (2024). *Synthesis of Minnesota's behavioral health safety net system: An overview of the existing system and recommendations for the future*. Wilder Research.

Azeem, M., Aujla, A., Rammerth, M., Binsfield, G., & Jones, R. (2017). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing*, 30, 170–174.

Bloom, S., & Farragher, B. (2011). *Destroying sanctuary: The crisis in human service delivery systems*. Oxford University Press, Inc.

Bunger, A., & Beer, O. (2019). Recovery oriented systems of care (ROSC) in Ohio: Statewide assessment results (2018). Ohio Association of County Behavioral Health Authorities.

Byrne, G. (2018). Prevalence and psychological sequelae of sexual abuse among individuals with an intellectual disability. *Journal of Intellectual Disabilities*, 22(3), 294–310.

Center on Positive Behavioral Interventions and Supports (n.d.a). What is PBIS? Accessed July 31, 2025.

Center on Positive Behavioral Intervention and Supports (n.d.b). Why implement PBIS? Accessed July 31, 2025.

Chase, J., Bilinski, J., & Kanzaria, H. K. (2020). Caring for emergency department patients with complex medical, behavioral health, and social needs. *JAMA*, 324(24), 2550–2551.

Dillon, K., Gilbertson, L., Imbertson, K., Johnson, N., & Schauben, L. (2017). Minnesota veterans behavioral health needs assessment: Prepared for the Minnesota Department of Veterans Affairs. Wilder Research.

Dillon, K., Thomsen, D., Pham, J., & Serafin, M. (2019). Behavioral Health Home Services implementation evaluation report. Minnesota Department of Human Services.

Dinora, P., Bogenschutz, M., & Broda, M. (2020). Identifying predictors for enhanced outcomes for people with intellectual and developmental disabilities. *Intellectual and Developmental Disabilities*, 58(2), 139–157.

Direct Care and Treatment (2024). Direct Care and Treatment Agency Profile. St. Paul, MN: Minnesota Department of Human Services Direct Care and Treatment.

Stevens, K. (2025). 2025 Priority Admissions Review Panel report and recommendations to the Minnesota Legislature (PowerPoint slide deck). Minnesota Department of Human Services.

Dunlap, G., & Carr, E. G. (2007). Positive behavior support and developmental disabilities: A summary and analysis of research. In Odom, S. L., Horner, R. H., Snell, M. E., & Blacher, J. (Eds.), Handbook of Developmental Disabilities (pp. 469–482). The Guildford Press.

Fallot, R., & Harris, M. (2011). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol*. Community Connections. Accessed July 31, 2025.

Fisher, E., Hasselberg, M., Conwell, Y., Weiss, L., Padrón, N., Tiernan, E., Karuza, J., Donath, J., & Pagán, J. (2017). *Telementoring primary care clinicians to improve geriatric mental health care*. *Population Health Management*, 20(5), 342–347.

Gage, N., Grasley-Boy, N., Lombardo, M., & Anderson, L. (2020). *The effect of school-wide positive behavior interventions and supports on disciplinary exclusions: A conceptual replication*. *Behavioral Disorders*, 46(1), 42–53.

Georgia Department of Behavioral Health & Developmental Disabilities (n.d.). *Intensive support coordination*. Accessed July 31, 2025.

Hales, T., Green, S., Bissonette, S., Warden, A., Diebold, J., Koury, S., & Nochajski, T. (2019). *Trauma-informed care outcome study*. *Research on Social Work Practice*, 29(5), 529–539.

Handran, J. (2015). *Trauma-informed systems of care: The role of organizational culture in the development of burnout, secondary traumatic stress, and compassion satisfaction*. *Journal of Social Welfare and Human Rights*, 3(2), 1–22.

Health Resources & Services Administration, Office for the Advancement of Telehealth (n.d.). *What is telehealth?* Accessed July 31, 2025. Hughes, R., Robinson-Whelen, S., Raymaker, D., Lund, E., Oswald, M., Katz, M., Star, A., Ashkenazy, E., Powers, L. E., & Nicolaidis, C. (2019). *The relation of abuse to physical and psychological health in adults with developmental disabilities*. *Disability and Health Journal*, 12(2), 227–234.

Keesler, J. (2014). *A call for the integration of trauma-informed care among intellectual and developmental disability organizations*. *Journal of Policy and Practice in Intellectual Disabilities* 11(1), 34–42.

Merz, N., & Berg, J. (2024). *Acute Care Transitions Advisory Council report for the Minnesota Department of Human Services* (PowerPoint slide deck). Minnesota Department of Human Services. Accessed July 31, 2025.

Minnesota Department of Health (2024). *Study of telehealth expansion and payment parity: Final report to the Minnesota legislature 2024*. Accessed July 31, 2024.

Minnesota PBIS (n.d.). *Minnesota PBIS schools*. Accessed July 14, 2025.

Morin, D., Mélineau-Côté, J., Ouellette-Kuntz, H., Tassé, M. J., & Kerr, M. (2012). *A comparison of the prevalence of chronic disease among people with and without intellectual disability*. *American Journal on Intellectual and Developmental Disabilities*, 117(06), 455–463.

National Child Traumatic Stress Network (2015). The road to recovery: Supporting children with intellectual and developmental disabilities who have experienced trauma.

New Hampshire Institute on Disability (2024). Institute on Disability at University of New Hampshire - health professional training.

Ohio Department of Developmental Disabilities (n.d.). Technology first.

Ohio Department of Mental Health and Addiction Services (2025). <https://dodd.ohio.gov/about-us/mental-wellness/MIID-resourcesEligibility and Services>. Accessed August 20, 2025.

Poppes, P., van der Putten, A., & Vlaskamp, C. (2010). Frequency and severity of challenging behaviour in people with profound intellectual and multiple disabilities. *Research in Developmental Disabilities*, 31(6), 1269–1275.

Rich, E., Lipson, D., Libersky, J., & Parchman, M. (2012). Coordinating care for adults with complex care needs in the patient-centered medical home: Challenges and solutions. Agency for Healthcare Research and Quality. AHRQ Publication No. 12-0010. Accessed July 31, 2025.

Sailor, W., Dunlap, G., Sugai, G., & Horner, R. (2009). *Handbook of positive behavior support (Issues in clinical child psychology)*. Springer.

San Francisco General Hospital Foundation (2021, May 3). Social medicine team transforms care and culture in San Francisco.

Simacek, J., Dimian, A. F., & McComas, J. J. (2017). Communication intervention for young children with severe neurodevelopmental disabilities via telehealth. *Journal of Autism Development Disorders*, 47(3), 744–767.

Tanis, E. S., Wagner, J., Sedor, G., Pickard, K., & Tassé, M. J. (2023). Expanding the use of remote supports for people with intellectual and developmental disabilities: An interdisciplinary working group report. Communicore. Accessed July 31, 2025.

Tanis, S., & the American Network of Community Options & Resources (ANCOR) (2021). Advancing technology access for people with intellectual and developmental disabilities: Perspectives from intellectual and developmental disability service providers across the nation. ANCOR. Accessed July 31, 2025.

Tassé, M. J., Wagner, J. B., & Kim, M. (2020). Using technology and remote support services to promote independent living of adults with intellectual disability and related developmental disabilities. *Journal of Applied Research in Intellectual Disabilities*, 33(3), 640–647.

Tuzzio, L., Berry, A. L., Gleason, K., Barrow, J., Bayliss, E. A., Gray, M. F., Delate, T., Bermet, Z., Uratsu, C. S., Grant, R. W., & Ralston, J. D. (2021). Aligning care with the personal values of patients with complex care needs. *Health Services Research*, 56 (Supplement 1), 1037-1044.

U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. HHS Publication No. (SMA) 14-4884.

U.S. Department of Health & Human Services, Indian Health Service (n.d.). Indian Health Manual. Accessed July 31, 2025.

Vervoot-Schel, J., Mercera, G., Wissink, I., Mink, E., Van Der Helm, P., Lindauer, R., & Moonen, X. (2018). Adverse childhood experiences in children with intellectual disabilities: An exploratory case-file study in Dutch residential care. *International Journal of Environmental Research and Public Health*, 15(10).

Watanabe-Galloway, S., Haakenstad, E., Evans, J., & Liu, H. (2018). Barriers and best practices for using telehealth services in Nebraska. University of Michigan School of Public Health. Accessed July 31, 2025.

Wigham, S., Taylor, J., & Hatton, C. (2013). A prospective study of the relationship between adverse life events and trauma in adults with mild to moderate intellectual disabilities. *Journal of Intellectual Disability Research*, 58(12), 1131–1140.

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Topic 7: The Prevention of Abuse and Neglect

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

Overview of Abuse and Neglect Prevention & Olmstead Planning

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

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

Populations of Particular Concern for Abuse and Neglect Prevention & Olmstead

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

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

Abuse and Neglect Prevention & Olmstead in Minnesota

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

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

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

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

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

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

Opportunities of a Cross-Sector Alliance

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

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

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

Implementation Considerations for a Cross-Sector Alliance

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

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

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

Table 7.1. Proposed Actions of a Cross-Sector Council

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

Evaluating the Efficacy of a Cross-Sector Alliance

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

Table 7.2. Proposed Cross-Sector Council Metrics

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

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

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

How a Cross-Sector Alliance is Informed by Lived Experience

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

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

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

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

Challenges of a Cross-Sector Alliance

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

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

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

Strengths of a Multipronged & Collaborative Approach to Prevention and Investigation

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

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

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

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

Opportunities of a Multipronged & Collaborative Approach to Prevention and Investigation

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

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

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

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

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

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

Table 7.3. Proposed Criteria to Evaluate Abuse and Neglect Prevention

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

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

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

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

Table 7.5. Proposed Criteria to Evaluate Abuse and Neglect Redress

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

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

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

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

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

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

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

Challenges of a Multipronged & Collaborative Approach to Prevention and Investigation

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

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

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

Strengths of Trauma-Informed Care

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

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

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

Opportunities of Trauma-Informed Care

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

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

Implementation Considerations for Trauma-Informed Care

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

Prevention

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

Reporting and investigation

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

Redress

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

Evaluating the Efficacy of Trauma-Informed Care — Proposed Metrics

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

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

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

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

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

How Trauma-Informed Care was Informed by Lived Experience

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

Ways to Collaborate across State Government on Trauma-Informed Care

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

Challenges of Trauma-Informed Care

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

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

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

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

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

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

Opportunities of Specialized Approaches to DV/SA Prevention

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

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

Implementation Considerations for Specialized Approaches to DV/SA Prevention

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

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

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

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

FDP

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

DART

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

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

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

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

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

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

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

Challenges of Specialized Approaches to DV/SA Prevention

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

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

7E: Reduce Abuse through Crisis Response Reform

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

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

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

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

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

Strengths of Crisis Response Reform

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

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

Opportunities of Crisis Response Reform

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

Implementation Considerations for Crisis Response Reform

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

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

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

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

Evaluating the Efficacy of Crisis Response Reform

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

Metrics for law-enforcement-led crisis teams:

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

Metrics for civilian-led crisis teams:

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

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

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

How Crisis Response Reform was Informed by Lived Experience

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

Ways to collaborate across State Government on Crisis Response Reform

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

Challenges of Crisis Response Reform

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

Conclusion

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

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

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

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

Prevention of Abuse and Neglect: Works Cited & Additional Resources

Dunklin, R., Foley, R. J., Martin, J., McDermott, J., Mohr, H., & Seewer, J. (2024, March 28). [Why did more than 1,000 people die after police subdued them with force that isn't meant to kill?](#) *AP News*.

Fitzsimons, N., & Minnesota Olmstead Implementation Office (2018). [Comprehensive plan for prevention of abuse and neglect of people with disabilities: Report](#). Minnesota Olmstead Implementation Office. Accessed July 31, 2025.

Flynn, E., & Arstein-Kerslake, A. (2017). [State intervention in the lives of people with disabilities: The case for a disability-neutral framework](#). *International Journal of Law in Context*, 13(1), 39–57.

Gerety, R. M. (2020). [An alternative to police that police can get behind](#). *The Atlantic*, December 28, 2020.

Lazar, K., Swartz, M., & Moore, M. (2024). [Changing the route: Seeking compassionate alternatives to police transport in involuntary civil commitment](#). Wilson Center for Science & Justice at Duke Law.

Minnesota Olmstead Implementation Office (2022a). [Putting the promise of Olmstead into practice: Minnesota's Olmstead plan](#).

Minnesota Olmstead Implementation Office (2022b). [Olmstead Plan survey results](#). Minnesota Management & Budget.

Minnesota Olmstead Implementation Office (2022c). *Community Feedback on Olmstead Plan*.

National Center on Elder Abuse (n.d.). [Abuse of adults with a disability](#). Accessed July 31, 2025.

Institute for Community Inclusion (2023). Feature issue on sexual and gender identity for people with intellectual, developmental, and other disabilities. *Impact*, 36(2). University of Minnesota Institute of Community Integration. Accessed August 2025.

The Arc (2021). [Criminal justice system](#) (position statement). Accessed July 31, 2025.

The Arc (2018, January 22). [The Arc responds to new report exposing abuse and neglect of individuals with disabilities in group homes](#) (press release).

Trauma Policy (n.d.). [Trauma-informed care](#).

Ukeru Systems (n.d.). [About Perspectives Corporation](#) (Case Study). Accessed July 15, 2025.

Topic 8: Transportation

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

Overview of Transportation & Olmstead Planning

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

Subtopics

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

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

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

Populations of Particular Concern for Transportation & Olmstead

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

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

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

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

Transportation & *Olmstead* in Minnesota

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

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

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

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

Effective Transportation-Related Policies, Programs, and Strategies

8A: Coordination/collaboration across entities responsible for transportation

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

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

Promising Practices in Coordination/Collaboration

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

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

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

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

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

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

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

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

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

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

The project has identified these cross-cutting implementation concerns:

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

Promising Practices in Data Sharing

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

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

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

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

8B: Inclusive Planning

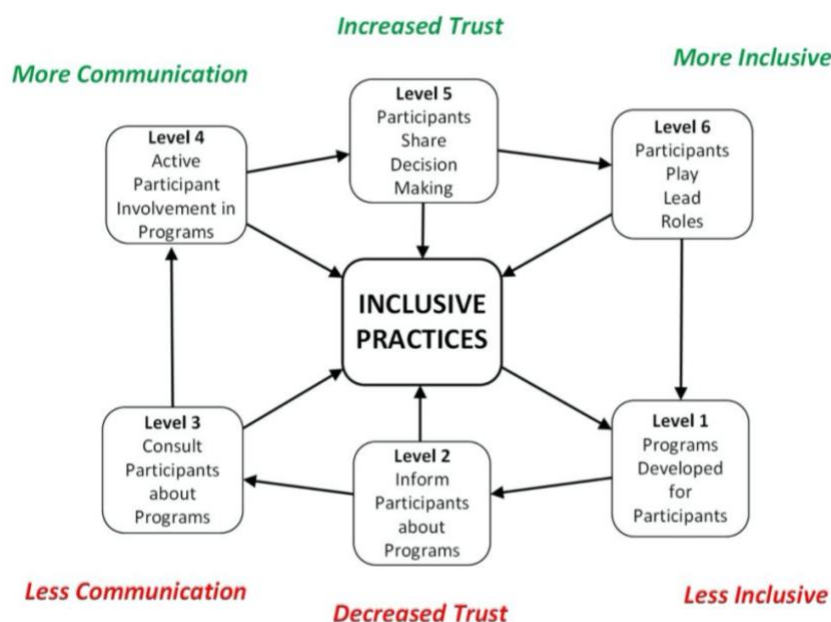
Inclusive planning is widely recognized as both a regulatory requirement and a best practice for achieving better transportation outcomes. Involving people with disabilities in transportation planning — through surveys, focus groups, equipment testing, and advisory committees — has been shown to improve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

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

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

TP4A's framework is illustrated in its “Pathways to Inclusion” model in [Figure 8.1](#) below.

Figure 8.1. Inclusive Transportation Practices



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

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

8C: Rural Transportation Challenges

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

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

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

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

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

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

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

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

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

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

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

8D: Emerging transportation topics

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

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

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

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

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

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

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

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

Transportation: Works Cited & Additional Resources

Bardaka, E., & Monast, K. (2023). [Public Microtransit pilots in the State of North Carolina: Operational characteristics, costs, and lessons learned](#). North Carolina State University Institute for Transportation Research & Education. Accessed July 31, 2025.

Bezyak, J., Kaya, C., Hsu, S., Iwanaga, K., Wu, J-R., Lee, B., Kundu, M., Chan, F., & Tansey, T. (2022). [Characteristics of individuals with disabilities receiving transportation services in vocational rehabilitation](#). *Journal of Vocational Rehabilitation*, 58(1), 79–88.

Bezyak, J. L., Sabella, S. A., & Gattis, R. H. (2017). [Public transportation: An investigation of barriers for people with disabilities](#). *Journal of Disability Policy Studies*, 28(1), 52-60.

Coordinating Council on Access and Mobility (2025, June 23). [What is CCAM-TAC and how can it impact your program and transportation in your community?](#) (webinar). Coordinating Council on Access and Mobility – Technical Assistance Center.

Dyles, C., & Sarles, R. (2023). [Mobility Ohio](#) (slide deck). Mobility Ohio.

Federal Transit Administration (2025). [FY21 innovative coordinated access & mobility project selections](#).

Gururaja, P., & Faust, R. (2019). [Objective-driven data sharing for transit agencies in mobility partnerships](#). Shared Use Mobility Center. Accessed July 31, 2025.

Herinckx, H., Kerlinger, A., & Cellarius, K. (2021). Statewide implementation of high-fidelity recovery-oriented ACT: A case study. *Implementation Research & Practice*, 2.

Jansuwan, S., Christensen, K.M., Chen, A. (2013) Assessing the transportation needs of low-mobility individuals: Case study of a small urban community in Utah, *Journal of Urban Planning and Development* 139(2), 104–114.

Lynott, J., Zmud, J., Stoeltje, G., Hansen, T., Geiselbrecht, T., Simek, C., Ettelman, B., & Fox-Grage, W. (2020). [Volunteer driver insurance in the age of ridehailing](#). AARP. Miah, M. M., Naz, F., Hyun, K., Mattingly, S., Cronley, C., & Fields, N. (2020). [Barriers and opportunities for paratransit users to adopt on-demand micro transit](#). *Research in Transportation Economics*, 84 (December 2020, 101001)

Minnesota Department of Employment & Economic Development (2025, March 27). [News and updates from VRS](#).

National Aging & Disability Transportation Center (n.d.). [Best practices: Volunteer transportation](#). Accessed July 31, 2025.

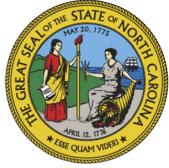
National Academies of Sciences, Engineering, and Medicine (2025). [Microtransit solutions in rural communities: On-demand alternatives to dial-a-ride services and unproductive coverage routes](#). National Academies Press.

National Center for Mobility Management (2023). [Effective coordination strategies: Mobility Ohio](#).

Ohio Department of Disabilities (n.d.). [Mobility Ohio](#). Accessed August 22, 2025.

Purdue University, Duerstock IAS Lab (n.d.). [EASI RIDER project](#). Accessed July 31, 2025.

Rural Health Information Hub (n.d.). [Volunteer models for rural transportation](#). Accessed July 31, 2025.



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

North Carolina

Olmstead Plan Implementation

Summary Report
from July 1 through September 30, 2025

December 1, 2025

Table of Contents

Background and Introduction.....	1
Status of Strategies	2
Engaging People with Disabilities and their Families as Partners.....	10
Next Steps in Olmstead Plan Implementation.....	14
Appendix A: Progress in Additional Priority Areas	15
Appendix B: Glossary of Key Terms	23

Background and Introduction

In the third quarter of 2025 (July 1 to September 30), the North Carolina Department of Health and Human Services (NCDHHS) worked with other state agencies and community partners to carry out the 2024–2025 Olmstead Plan. At the end of the quarter, each agency shared updates on what they did in the Plan’s six main areas. These updates help measure how much progress is being made.

This report focuses on two important areas:

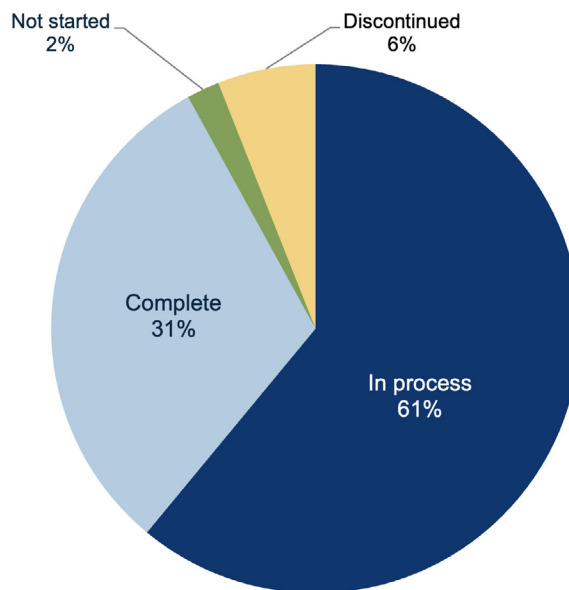
- **Priority Area 3:** Addressing gaps in community-based services
- **Focus Area:** Engaging people with disabilities and their families as partners

Progress on other parts of the Plan is listed in [Appendix A](#).

Status of Strategies

[Figure 1](#) shows how North Carolina is doing on the Olmstead Plan. It shows that the state has completed some parts of the Plan, and is working on others. Only a few parts have not been started yet or discontinued.

Figure 1: Progress on NC Olmstead Plan Strategies



Complete: The strategy and all its action steps were finished either before or during 2025 Quarter 3.

In Process: Staff were working on the strategy during Quarter 3; at least one action step had been taken.

Discontinued: Work related to the strategy or action steps was discontinued as of the end of the reporting period

Not Started: Work related to the strategy or action steps was not started by the end of Quarter 3.

Progress Highlights in Priority Area 3:

Address gaps in community-based services

Sometimes people can't get the help they need because the service either doesn't exist, or isn't available to everyone. When there aren't enough services in the community, people with disabilities may have to live in places that aren't very inclusive, like institutions. North Carolina is working to fix this. The Olmstead plan is a guide that helps the state find better ways to support people with disabilities in the community. Through the North Carolina

Olmstead Plan, the state has made a commitment to use proven ideas and practices for all groups of people with disabilities.

Children and Families

Evidence suggests that the most positive outcomes for children and their families occur when the child can keep living in their community. Additional services and supports for children in their homes can prevent institutionalization that separates families. North Carolina is making progress in this area, but communities still need more capacity to provide these services.

Access to Care

Only four of North Carolina's counties have enough people who provide mental health care. Often, primary care doctors are the only ones who can help children with mental health problems, but many doctors don't feel that they have enough training to provide this help. For this reason, the state started the NC Psychiatry Access Line (NC-PAL). This is a phone service that lets doctors talk to trained child psychiatrists for advice. ***More than a million kids have gotten help through NC-PAL.*** Beyond the telephone consultation, NC-PAL is a partnership between the North Carolina Department of Health and Human Services (NCDHHS) and the Duke University and UNC Chapel Hill Schools of Medicine — programs that offer help and training to many North Carolina providers, building their mental health knowledge and capacity. The NC-PAL website hosts a [youth mental health care dashboard](#), which shows the need and resources across the state.

Helping Families Take Breaks

It can be hard to take care of children with intellectual and developmental disabilities (I/DD), autism, traumatic brain injury (TBI), and mental health and substance use concerns. Respite programs give foster, kinship, adoptive, and birth families temporary breaks from their parenting responsibilities. Families need programs that they can rely on to offer safe spaces where their children can stay while they rest. NCDHHS provided ***\$3 million*** to start new programs, partnering with Trillium Health Resources. These two new "Henry's House" programs, which are provided through Victory Junction and Easterseals PORT Health, will offer short stays for children with disabilities. These programs are a place where children with disabilities can have fun and make new friends, while families rest and recharge.

Helping Kids in Crisis

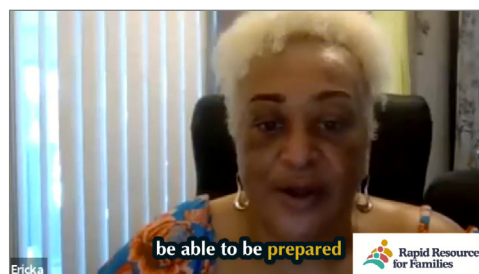
When children with disabilities are in crisis, the people who respond should understand their needs. This is why NCDHHS is expanding its Mobile Outreach Response Engagement and Stabilization program (MORES). MORES sends trained teams into the community to help children ages 3 to 21 with emotional or behavioral problems. Giving this help to children and support to their families can keep them out of hospitals and group homes. MORES now works in 20 counties, and the program has secured funding for another year.

If children in crisis need to leave home for safety, they should have a calm place to go. Emergency rooms can be scary and noisy, and may lead to hospital admissions. This quarter, Trillium Health Resources announced \$3.8M in funding to open a new center in Greenville that will give both children and adults a safe place for mental health care, open 24/7. This Behavioral Health Urgent Care center, which is run by Integrated Family Services, will be open to people from all parts of the state with any diagnosis, including mental illness, I/DD, substance use disorder, or TBI.

Below are more evidence-based programs that help children and their families:

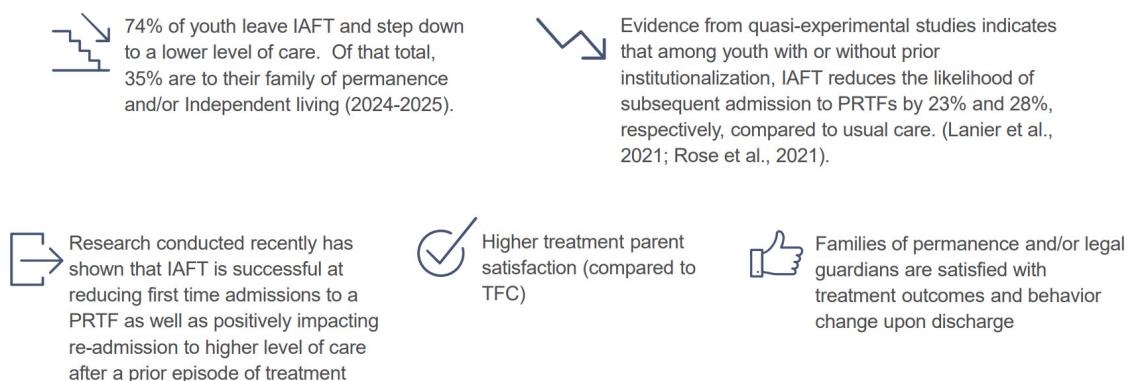
Intensive Alternative Family Treatment (IAFT) Program

NCDHHS has a contract with Rapid Resources for Families (RRF) to expand access to IAFT — which is a program for children with needs that make it hard to find a safe, supportive place for them to stay. IAFT helps to prevent these children from having to stay in institutions. IAFT offers family-based services in a therapeutic foster home with counseling and other mental health supports to keep children healthy and well. In its first year, RRF created **27** Treatment Parent Specialist homes, which was more than RRF's original goal of 25.¹ In a national presentation on the model in September 2025, the state shared several positive outcomes, shown in [Figure 2](#).



*Appreciation for IAFT's In-Depth Training:
[Being Prepared to Deal with Trauma in Children](#)*

Figure 2: Positive Outcomes of the Intensive Alternative Family Treatment Program²



1. Bell, S. (2025, September 7). Intensive Alternative Family Treatment (IATF) [PowerPoint slide deck]. Presented to the National Academy for State Health Policy Children's Behavioral Health Policy Academy.
2. Bell, S. (2025, September 7). Intensive Alternative Family Treatment (IATF) [PowerPoint slide deck]. Presented to the National Academy for State Health Policy Children's Behavioral Health Policy Academy.

High-Fidelity Wraparound

This service provides a team that works with families to help children with mental health challenges stay at home. The High-Fidelity Wraparound team supports the family and child to help them reach their goals. This program has helped to keep many children out of residential care, emergency rooms, foster care, and detention centers. For each child this program serves, the state saves \$33,000.

The Somethings App

To make more mental health supports available for teens, the Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) invested in a free app called “Somethings” that connects teens to peer mentors and mental health providers. As of May 2025, **369 teenagers in 54 counties** were using the Somethings app, and many said it helped them feel better. NCDHHS and its partners, Somethings and Alliance Health, have seen an increase in the number of people using the app, the number who report that they like it, and the number who say it helped them reduce crises. One 15-year-old Somethings user says “I feel more calm and confident because of my mentor.” An 18-year-old user says “I don’t know where I’d be without this app.”³



START Program

Parents’ use of alcohol and other drugs is the number one reason children are placed in foster care in North Carolina. Sobriety Treatment and Recovery Teams (START) help keep kids safe at home while their parents get treatment for their substance use. In Q3, two more counties began this program, for a total of six counties that use START. Funding for this program has been approved as part of the Title IV-E prevention services program.

In 2017, North Carolina’s Buncombe County became the second community in the nation to complete the START certification process. Since then, its START program has handled 198 cases, with 165 of them now closed.

The 165 closed cases in the Buncombe County START program served 252 children.

- **179** of those 252 children (**71%**) were either not removed from their parents’ care or were reunited with their parents.
- In **108** of the closed cases (**65%**), at least one of the child’s caregivers reached their recovery goals.

3. North Carolina Department of Health & Human Services (2025, July 8). [Free teen mentoring app grows in engagement and satisfaction](#). *Hot Topics*, July 8, 2025.

The two stories below show how the Buncombe County START program has helped parents with SUDs enter recovery, while making it possible for them to keep custody of their children.

START Success Story: Coming Together to Help a Family

They say “it takes a village” to raise kids. But what happens if you don’t have that “village” to help you? That was the case for one of the START families. Due to a mother’s substance use, her child was placed in a temporary placement days after being born, and remained there for four months. During this time, the mother did not make progress toward recovery, and her child was at risk of being placed fully into the custody of the Buncombe County Department of Human Services. But the START Team continued to show up, knock on the door, and support this mom, who eventually came back to the table, ready for change. Together with community partners at the Behavioral Health Urgent Care at the Neil Dobbins Center, Transformation Village, and the Women’s Recovery Center (WRC), the START program rallied together to be this parent’s village and get her the support she deserved. Everyone coming together provided the stability that was needed to reunite her with her daughter, preventing the need for an out-of-home placement. The ongoing support from Transformation Village and WRC contributed to a successful graduation from the START program. Building on this success, she motioned a case back into court regarding her older daughter, demonstrating her progress and regaining custody of her older daughter as well.

START Success Story: Regaining Hope

Fighting at the 11th hour — that is what one mom did to regain custody of her son. The Buncombe County Department of Human Services had custody of her child, but had not yet identified a safe home for him. The mother was doing the bare minimum to address the court’s substance use concerns. During supervised weekly visits, a social worker and a family mentor worked hard to convince this parent that hope was not lost, and that things could be turned around. As time went on, however, that hope started to fizzle, and the social worker on the case planned to recommend that the court choose a different long-term plan for the child instead of reunification. But this mom’s light was not put out yet. With the help of community partners at Project CARA, the Julian F. Keith Alcohol and Drug Abuse Treatment Center, and Mary Benson House, she was able to do a complete 180 and demonstrate to the Department that reunification with her son was still the best plan. Weeks passed, and while the seasons changed, she stayed consistent — all the way up to that long-awaited court hearing where the judge awarded custody of the child back to his mother.

Adults

To help people with disabilities live in the community instead of group homes or other institutions, NCDDHS must make resources available to people in the community who are in crisis. Without the right kind of support, people in crisis end up in hospital emergency rooms or even jail. In the Olmstead Plan, DMH/DD/SUS describes the steps it is taking to make things better for adults in crisis.

988 Suicide and Crisis Lifeline

One big step was improving the **988 Suicide and Crisis Lifeline**. This is a free phone number that people can call or text if they need help. When a person calls 988, trained helpers listen and give support. They can also send help if needed. To teach more people about 988, NCDHHS has been giving out free materials to schools and communities.

Recent surveys of people who use 988 show that most calls are about family, other relationships, or personal problems, and that teens 13–17 call the most.⁴ Before contacting 988, users were feeling stressed, worried, and afraid. After contacting 988, people reported feeling hopeful, energized, and thankful, with fewer bad emotions. Other notable findings:

- About **11,500** people use 988 every month.
- **1 in 3** users of 988 who responded to a recent survey said that 988 saved their life or the life of someone they love.
- Over **50%** learn ways to calm down and cope.
- Almost **90%** say 988 is important for their community.
- Over **80%** would tell others to use 988.



When a phone call isn't enough, mobile crisis teams can come to help in person. These teams include mental health experts and peer supporters. They help calm people and connect them to services.

4. North Carolina Department of Health & Human Services (n.d.). [Celebrating three years of the 988 Suicide & Crisis Lifeline](#). *Hot Topics special edition*.

One user named Faith says “I texted 988 because sometimes speaking gets hard for me, and they just helped me calm down, and then I was able to find a friend. It’s free, and you can get in touch with people who are trained to help through all sorts of crises.”

In places where there are not enough services, police were often the ones to respond to people in crisis. Mobile crisis and co-responder models provide another option. In this quarter, new co-responder programs started in Orange County and RHA Health Services through Vaya Health, and can now send trained helpers with or instead of police.



Watch [Faith's 988 story on YouTube](#).

Behavioral Health Urgent Care (BHUC)

Another option for people who need help is a new BHUC center that is opening in Greenville. This program will be available to all adults no matter where they live or what kind of insurance they have.

In Q3, it was announced that another new center in Concord will help adults with drug or alcohol problems and mental health needs. Pyramid Healthcare will offer proven treatments, including medicine for opioid addiction at Pyramid’s new detox and residential programs.

To make sure people with disabilities get care that fits their needs, NCDHHS started a Person-Centered Practice Learning Collaborative. In September, the Collaborative held its first training session, which was attended by more than 100 providers. This program helps service providers learn from national experts and from each other so they can improve care. The Learning Collaborative will run through 2026.

NCDHHS is also working to make sure that people with serious mental illness can get quality care. The Department launched and expanded a program to give extra help to Assertive Community Treatment (ACT) and Community Support Teams that support people with serious mental illness.

Older Adults

In North Carolina, **97%** of adults aged 65 and older live in the community. Of these households, **86%** own a computer and **78%** have internet. Many of these older adults need help learning how to use technology safely. Through the Social Bridging NC program, the Division of Aging offers resources that teach older adults about online safety, like avoiding scams and fake emails.

Social Bridging NC also helps older adults stay connected and fight loneliness. The state has completed its action steps identified in the Olmstead Plan to make sure older adults, including those with disabilities, can use technology for social connection and virtual social activities.

Engaging People with Disabilities and their Families as Partners

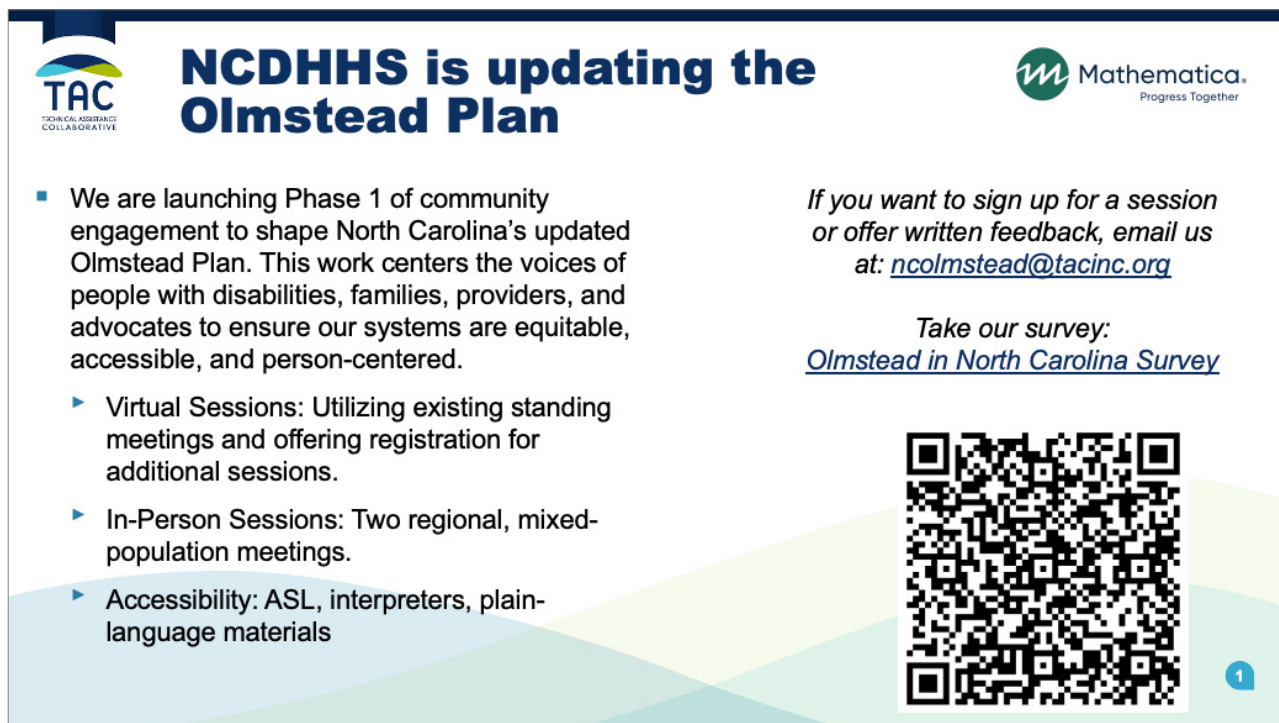
NCDHHS has many ways for people to participate in shaping services for people with disabilities. Some of these activities are specific to the Olmstead Plan, while others are advisory groups on services for particular groups of people. All of them can help change and improve the Plan.

Olmstead Plan Engagement

North Carolina will release its next Olmstead Plan update in July 2026. This update will show what has been done over the past two years. This new update will outline a five-year vision for improving services, getting rid of barriers, and making the system work better for people with disabilities.

To make sure the plan reflects what the community cares about, the Olmstead Director and Associate Director, supported by TAC, have begun a major effort to hear from the public (see overview in [Figure 3](#)). The goal of this effort is to:

- Listen to many voices and points of view, including people with disabilities, families and caregivers, providers, advocates, and community partners.
- Learn what people want and need most from the service system.
- Identify the biggest barriers that make it hard for people to succeed in the community they want to live in.
- Discover what is working well now.
- Make the plan relevant to real-world needs.
- Begin building shared understanding.

Figure 3: Community Engagement Plans for the 2026 Olmstead Plan Update


TAC
TECHNICAL ASSISTANCE
COLLABORATIVE

NCDHHS is updating the Olmstead Plan

Mathematica
Progress Together

- We are launching Phase 1 of community engagement to shape North Carolina's updated Olmstead Plan. This work centers the voices of people with disabilities, families, providers, and advocates to ensure our systems are equitable, accessible, and person-centered.
 - ▶ Virtual Sessions: Utilizing existing standing meetings and offering registration for additional sessions.
 - ▶ In-Person Sessions: Two regional, mixed-population meetings.
 - ▶ Accessibility: ASL, interpreters, plain-language materials

If you want to sign up for a session or offer written feedback, email us at: ncolmstead@tacinc.org

Take our survey: [Olmstead in North Carolina Survey](#)



Quarter 3 Engagement Activities

In Q3, the Olmstead office and TAC gave people many ways to share their ideas. They made sure the options worked for different communication needs and comfort levels.

Engagement activities included:

- Four online listening sessions, open to anyone who wanted to join.
- A community inbox, which got several emails with ideas, concerns, and questions.
- An English-language survey, which received 55 responses.

The goal of these activities was to hear from as many people as possible, learn about different experiences, and get honest feedback.

Planned Activities for Quarter 4

Community engagement will keep going in Quarter 4 of 2025 to include more people and make sure more voices are heard. Upcoming efforts include:

- Two in-person listening sessions
 - ◆ Greensboro – December 3
 - ◆ Asheville – December 4
- Launch of a Spanish-language survey
- One or two additional online sessions for people who didn't get a chance to join earlier

Engagement with State Divisions

Each division in the North Carolina state government that provides services for people with disabilities gives progress reports every three months. These reports are where most of the information comes from for these quarterly summary reports. The divisions will also play an important role in creating a new Olmstead Plan. The feedback from the community engagements will be shared with the divisions. Each division will:

- Look at its strategic plans and current work.
- Decide how to fix gaps and remove barriers.
- Make the things that are working well even better and more available.

This information will be written into the new plan as goals, strategies, and action steps for the divisions to work on over the next five years. Some strategies and actions may change during that time as divisions learn more about what people need; if there are changes in funding; or from other factors.

Engagement for the Draft Plan

Once the divisions complete their assessment and come up with goals, strategies, and action steps, a draft plan will be released in Quarter 2 of 2026. People with disabilities, families and caregivers, providers, and advocates will have the opportunity to offer feedback on the draft. NCDHHS will announce when the draft is available and how feedback can be given.

Olmstead Plan Stakeholder Advisory Committee

NCDHHS brings together the Olmstead Plan Stakeholder Advisory (OPSA) committee. This group includes state divisions, people with lived experience, professional organizations, and some members of the General Assembly. These meetings are open to the public. OPSA meets four times per year and shares updates about what the divisions are doing. At each meeting, OPSA helps guide the work of the Olmstead Plan by providing different points of view and expertise. In each meeting there is a time for the public to share comments.

State Consumer and Family Advisory Committee (SCFAC)

As it says on the [State Consumer and Family Advisory Committee's web page](#), "SCFAC serves as the representative voice of consumers and families with mental health, substance use, intellectual/developmental disabilities, and traumatic brain injury. It advises the Division of Mental Health, Developmental Disabilities and Substance Use Services, other NCDHHS agencies, and the General Assembly. SCFAC gives consumers a way to have input on the planning and management of the public system." These meetings are held monthly. SCFAC is not focused only on Olmstead, but the group talks about topics that are important to people with disabilities. There are also local CFACs.

Brain Injury Advisory Council

The Brain Injury Advisory Council (BIAC) looks at the causes and effects of brain injuries and gives advice to the divisions, the General Assembly, and the Governor on how to plan, fund, and provide services to people with brain injuries. The BIAC meets every other month.

Other Councils and Committees Relevant to Services for People with Disabilities

DMH/DD/SUS hosts the CFAC and BIAC, as well as many other groups and committees. These groups help shape services for people with disabilities, and some of them focus on specific disabilities. Information about each group is available on the [DMH/DD/SUS website](#).

The Division of Child and Family Well-Being brought together a [Transformation Team](#) made up of many different groups, including people with lived experience, to advise on the action plan.

The [State Rehabilitation Council](#) works with the Division of Employment and Independence for People with Disabilities to give all North Carolinians a way to have input on the direction of vocational rehabilitation. The full council has public meetings every three months, and different committees meet monthly.

The Division of Aging (DA) has many community advisory councils and committees that hear from the community about what's important to older adults. Many of the topics discussed are connected to Olmstead. Information about each council or committee can be found on the [DA website](#).

The Division of Health Benefits (DHB), or NC Medicaid, also hosts several councils, committees, and workgroups. Several of these groups are relevant for people with disabilities, including Money Follows the Person and the Personal Care Services Committee. More information about these opportunities is on the [DHB Committees and Workgroups webpage](#).

Next Steps in Olmstead Plan Implementation

Quarterly reports will continue documenting progress on the six priority areas of the 2024–2025 Plan. TAC, NCDHHS, and Mathematica will make sure all action steps and measures are useful, and will update them when needed. Keeping these goals and steps aligned will help North Carolina track its progress toward building communities where everyone is included.

Appendix A: Progress in Additional Priority Areas

Priority Area 1: Increase opportunities for individuals and families to choose community inclusion through access to Medicaid waiver home and community-based services and supports

The Division of Health Benefits (DHB) continued to watch how the 1915(i) services are being used. The division did this by looking at “encounter data,” which means records of the services people actually received, and by holding monthly meetings with Tailored Plans to review how the services are working.

DHB is also working on updates to the Tailored Plan contracts to make services easier to get and more consistent across the state. DHB is working to fill the last 15% of the 350 waiver spots it gave to the Tailored Plans. Efforts continue to determine whether they qualify for the services/meet the rules to receive the help.

Earlier this year, DHB increased access to home and community-based services (HCBS) for children by adding 500 new spots to the CAP/C waiver. DHB also finished setting up a monitoring process to make sure children can use these spots. DHB continues to review all CAP/C referrals that involve behavioral health or cognitive challenges. Decisions about whether children can enroll are based on clinical information and what staff learn during in-person assessments.

Priority Area 2: Strengthen opportunities to divert and transition individuals from unnecessary institutionalization and settings that separate them from the community

In Q3, DHB’s Money Follows the Person (MFP) program taught 381 staff members in nursing homes about the program through its Community Inclusion Consultants. MFP and the Long-Term Services and Supports (LTSS) program also met every week with the North Carolina Linking Individuals and Families to Long-term Services and Supports (NCLIFTSS)

vendor to help increase referrals. The program recently celebrated Vaya's successful completion of its first year helping older adults and people with physical disabilities move back into the community. Work is still getting started with the [Long-Term Care Ombudsmen](#), a group of state officials who help residents in long-term care facilities understand their rights. The MFP Project Director began a pilot program to help fix problems that make it hard for people who are Medicaid eligible because they are in an institution to transition out of long-term care facilities.

The Division of Child and Family Well-Being (DCFV) continued using the Child Behavioral Health Dashboard in Q3, a tool that shows how often children and youth enter psychiatric residential treatment facilities (PRTFs). This information helps the state decide when and where extra support is needed to reduce unnecessary placements.

DCFV is also working on expanding High Fidelity Wraparound (HFW), an intensive, team-based service that helps children with serious emotional or behavioral needs and their families. HFW brings together the child, family, school, and service providers to make one clear plan that supports the child at home, in school, and in the community.

This quarter, DCFV worked with child behavioral health staff to plan how to use funding from the Governor's Task Force to expand HFW to more counties throughout 2025. In July additional capacity building funds were provided to the Tailored Plans to expand to the remaining counties. The state is also planning a new Clinical Policy, expected in 2026, which will help make the program sustainable in all 100 counties.

In Quarter 3, the Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) continued its work to help youth stay in their communities and avoid unnecessary time in psychiatric facilities. DMH/DD/SUS is studying how residential treatment works across the state so they can find out what makes it hard for youth to get support before and after treatment. This division is also working on new types of specialty residential programs for youth with complex needs, such as aggressive behaviors, sexual behavior concerns, or co-occurring conditions (like behavioral health needs plus substance use, developmental disabilities, or justice involvement). DMH/DD/SUS is also planning a quality assurance system to make sure all PRTFs provide safe and effective care.

In Q3, DMH/DD/SUS reported that 70% of the money meant to improve facilities has already been used. The division also launched "Ukeru," a program that helps treatment facilities reduce the use of physical restraints and other restrictive interventions.

DMH/DD/SUS made progress on expanding peer-operated respite services. Peer-operated respite is a voluntary, short-term place where people experiencing a mental health crisis can get support from trained peers — people with lived experience — rather than going to the hospital. The Division is using the Mental Health Block Grant (MHBG) to fund more programs where peers help people with recovery, housing, and employment. It is also

developing new Requests for Proposals (RFPs) so that every region in the state will have at least one peer-run respite by 2027. The Peer Support Line is expanding to include chat and text options.

At the same time, DMH/DD/SUS noted that funding for peer-run living rooms and recovery centers is still at risk, and the division may need additional support to continue these programs.

In Quarter 3, the Division of State Operated Healthcare Facilities (DSOHF) made good progress helping people with disabilities learn more about community living options and supporting smoother transitions out of State Developmental Centers (SDCs).

First, DSOHF partnered with the University of North Carolina at Chapel Hill's Carolina Institute for Developmental Disabilities (CIDD) to build new, accessible surveys. These surveys will help people with disabilities — and those legally responsible for them — share how interested they are in community-based services instead of staying in institutions. CIDD also began recruiting interviewers, and SDCs started identifying people who can act as “proxies” to help residents share their choices if needed.

DSOHF also worked with MFP and University of North Carolina Centers for Aging Research and Educational Services (UNC CARES) to provide staff trainings on guardianship and supported decision-making. Supported decision-making is a way for people with disabilities to make their own choices with help from trusted supporters instead of having someone else make decisions for them. This quarter, staff attended two trainings focused on understanding community resources that can help people transition out of SDCs.

DSOHF also made progress on its “escalation process” for people facing major barriers to transitioning to the community. They worked more closely with the PRTFs to understand their discharge systems, and they continued meeting with Local Management Entity/Managed Care Organizations (LME/MCOs) — the groups that manage mental health and intellectual/developmental disability (I/DD) care — to plan next steps for people who have been in an SDC for nine months or longer.

Finally, DSOHF helped launch new opportunities for community providers. The division started an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) provider collaborative, which brought together about 15 providers to work on improving services. DSOHF also invited community members to join the upcoming I/DD Clinical Collaborative, which will begin in November.

In Quarter 3, the Division of Social Services (DSS) made progress in helping more children stay with family instead of going into group homes or institutions. DSS continued its Unlicensed Kinship Care program, which started in 2023. Kinship care means children in foster care live with relatives or close family friends they already know. This helps children

stay connected to their families and communities. As of August 2025, **1,907** children were living with kinship caregivers who received financial support through this program.

DSS is also working on new kinship licensing standards, which will make it easier for relatives to become licensed foster parents. Licensed kinship parents receive more support and training. DSS continues its work on the state laws, rules, and policies needed to fully support these new kinship licensing standards.

Since January 2025, counties have been able to use a training program called the National Training and Development Curriculum (NTDC). Foster parents usually need 30 hours of training, but kinship families who are related to the child only need 15 hours, which makes the process faster and easier. As of 7/7/25, more than 156 staff across the state have completed NTDC “train-the-trainer” courses, so they can now teach kinship families.

DSS also continues tracking progress toward its long-term goals for kinship care. Recent data collected shows:

- **31.26%** of children in foster care are placed with kin
- **37.83%** of children are first placed with kin when they enter foster care
- **2.76%** of children are placed with *licensed* kin
- **5.59%** of children are living in group homes that are not treatment-focused

One earlier goal — tracking the percentage of kinship placements that are licensed — was removed because the current data system cannot track it accurately.

Priority Area 3: Address gaps in community-based services

This Priority Area is featured under “[Status of Strategies](#)” in the main body of this report.

Priority Area 4:

Increase opportunities for pre-employment transition services for youth with disabilities, and competitive integrated employment for adults with disabilities

The Division of Aging (DA) continues work towards its goal to increase the number of people in the Senior Community Service Employment Program, including people with disabilities and those without disabilities. As of Quarter 3, there were **12** participants with disabilities and **215** total participants in the program. This is a small drop from last quarter.

DA did not identify any clear reasons for the decrease. One possible issue is that some people may not have shared that they had a disability when they first signed up.

The Division of Employment and Independence (EIPD) continued making progress on its goals in Priority Area 4 this quarter. One of EIPD's goals is to build a strong and stable workforce through simpler hiring processes. To help with this goal, the division hired and trained a new assistant director. This person regularly meets with the Human Resources (HR) team to keep track of hiring and onboarding (the process of helping new staff learn about their jobs and workplaces). The assistant director and the HR team also look for ways to accelerate hiring, so that open jobs can be filled faster.

Additionally, EIPD made progress on its goal of increasing pre-employment transition services (pre-ETS), which help students with disabilities learn job skills before they leave school. To grow this program, EIPD has created a clear, consistent process for new providers who want to apply to offer these services. EIPD is especially working on contracting with new providers from communities that have not had enough pre-ETS in the past.

EIPD continued working with Work Together NC and the Post-Secondary Education Alliance this quarter. The Intellectual/Developmental Disabilities (I/DD) Program Specialist joined monthly meetings to get feedback about services and to learn about new resources, including college programs for people with I/DD.

EIPD also continued partnering with Work Together NC on a project to make it easier for people with I/DD to get competitive, integrated employment (CIE). **Competitive, integrated employment** means people with disabilities work in regular jobs in the community and earn the same pay as others doing similar work. As part of this project, people receive job assessments and supports. If someone says they are interested in working, they are connected with a CIE Liaison from EIPD or their Tailored Plan. A CIE Liaison helps answer questions, solve challenges, and make sure the person is smoothly connected ("warm handoff") to the local EIPD office when they are ready to start services.

EIPD strengthened its partnership with the NC Community College System. They are working together to place case managers in six community colleges. These case managers help students with I/DD get vocational rehabilitation (VR) services, which support them in preparing for and keeping a job. Three colleges already have a Bridge to Success case manager: Alamance Community College, College of the Albemarle, and Wilkes Community College. Enrollment in the program has grown from **57** students last quarter to **80** students in Q3.

Lastly, EIPD made progress on the SWTCIE/SPARK grant, which gives wraparound supports — like coaching, job help, and problem-solving — to help people get and keep competitive jobs. Project SPARK increased enrollment at its pilot sites (Chatham Trades, Tri County Industries, and Wake Enterprises) from **85** people in Quarter 2 to **113** people in Quarter 3. At the time of this report, 18 SPARK participants now have competitive jobs, which is a **28%** increase from last quarter. Success stories continue to be shared on Project SPARK's [Facebook](#) and [LinkedIn](#) pages, social media, in newsletters, and during meetings.

Priority Area 5:

Strengthen opportunities to divert and transition individuals from the criminal justice system that promote tenure in and successful reentry to inclusive communities

The Division of Employment and Independence (EIPD) provides pre-employment transition services (pre-ETS) to youth in Youth Detention Centers. In Quarter 3, EIPD continued working to build stronger connections with juvenile justice programs so they can offer these services in more locations.

In Q3, EIPD held two additional professional development sessions — one in Greensboro and one in Greenville — building on a session held in Morganton the previous quarter. Twenty-six staff members attended the Greensboro training, and 19 attended the Greenville session.

EIPD noted two main challenges this quarter:

- Ongoing staff turnover among the EIPD team members who deliver the pre-ETS curriculum.
- Difficulty connecting with enough juvenile justice facilities that have the staffing and supervision needed to host these services.

In Quarter 3, DMH/DD/SUS also worked on plans to better support youth and adults involved in the criminal justice system, but progress varied across different strategies. For Strategy 5-2, the state is working on ways to bring proven mental health and substance use services into Youth Detention Centers. This includes plans to place community-rooted leaders — people who have real-life experience with the justice system — inside youth facilities to support young people. DMH/DD/SUS also plans to pilot a new adolescent substance use treatment program offering therapy in the community, inside detention centers, and after a youth is released. While no progress was made this quarter, the plans remain in place.

DMH/DD/SUS also provided an update on a program it had previously funded through the Alliance of Disability Advocates North Carolina (ADANC) to help people with intellectual and developmental disabilities (I/DD) and traumatic brain injury (TBI) safely return to the community after incarceration. This program helped people find housing, support, and necessary items when leaving prison or jail. However, the program was discontinued in Q3 due to the loss of Governor’s Task Force (GTF) funding.

Lastly, the state is working on a plan to expand access to medication for opioid use disorder (MOUD) in jails and prisons. MOUD includes medications like buprenorphine or methadone, which help people manage opioid dependence safely. The goal is to ensure people can continue their medication while incarcerated or start treatment (induction) if needed. The Division of Mental Health, Developmental Disabilities, and Substance Use Services is collaborating with the Department of Adult Corrections and county sheriffs, while specific action steps are being developed.

Priority Area 6: Promote workforce development, recruitment, and retention

The Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) is working on several projects to improve training and support for direct service professionals (DSPs) and certified peer support specialists. In North Carolina, DSPs help people with disabilities or behavioral health needs to live safely in their homes and communities. For example, a DSP might help someone learn daily living skills, like cooking or getting ready for the day, or taking someone into the community to go to work or appointments. Certified peer support specialists are people who use their own experience of mental illness or substance use disorder recovery to help others. In Quarter 3, DMH/DD/SUS launched a new advanced DSP training program with community colleges. This program will be available in the fall of 2025. All locations already have waitlists, even though the financial rewards for joining the program have not started yet. The money for these rewards has been approved, which is a good sign.

Additionally, two new peer courses are now available: Foundations of Peer Support Part I and Part II. This goal is now fully completed. DMH/DD/SUS wants to keep these trainings low-cost or free so more people can participate. The division also launched the Peer Workforce Center, which helps peers with making a résumé, finding jobs, and getting training that fits the needs of specific groups they may work with. One challenge in Q3 is that DMH/DD/SUS had to put its plan for a directory of all DSPs on hold because there was not enough funding.

The Division of Health Benefits continued working on improving pay and support for the community-based direct care workforce and family caregivers, but they did not report any progress in Q3.

Appendix B: Glossary of Key Terms

1915(i) State Plan Option – Allows the state to provide certain HCBS services to a target population that does not have to meet institutional level of care. In North Carolina, these services target children and adults with mental health conditions, substance use disorders, traumatic brain injuries, or intellectual/developmental disabilities.

Community Alternatives Program for Children (CAP/C) Waiver – A 1915(c) Home and Community-Based Services waiver that provides Medicaid services for medically fragile children under 21 who are at risk of institutional care. CAP/C can help these children stay at home with their families by providing in-home nursing care, case management, and other supports.

Community Alternatives Program for Disabled Adults (CAP/DA) Waiver – A 1915(c) Home and Community-Based Services waiver that provides an alternative to institutionalization for a Medicaid beneficiary who is medically fragile and at risk for institutionalization. The services allow the beneficiary to remain in a home- and community-based setting, to or return to the community from an institutional stay.

Assistive Technology – An item or piece of equipment that helps a person with a disability to increase, maintain, or improve their ability to function. Assistive technology can range from “low-tech” devices, such as a cane or wheelchair, to “higher-tech” devices, such as a software program on a computer, or screen readers.

Behavioral Health I/DD Tailored Plans – An integrated health plan for individuals with significant behavioral health needs and intellectual and other developmental disabilities (I/DDs). The Behavioral Health I/DD Tailored Plan also serves people who are enrolled in the Innovations and Traumatic Brain Injury (TBI) waivers or are on the waitlist. The Tailored Plan is responsible for managing the state’s non-Medicaid behavioral health, developmental disabilities, and TBI services for people in North Carolina who don’t have enough health insurance to cover the services.

Competitive Integrated Employment – A full or part-time job for a person with a disability that is paid at least minimum wage. This can include self-employment. The person should be paid the same as nondisabled coworkers doing a similar job, and they should get the same level of benefits. The job should be at a location where the employee interacts with other individuals without disabilities, and they should have opportunities for advancement similar to other employees without disabilities in similar positions.

Direct Support Professional – Staff who work one-on-one with individuals with disabilities and help them become integrated into the community or the least restrictive environment. North Carolina’s Rule 10A NCAC 27G.0104, Staff Definitions, includes this definition: “Direct

Support Professional’ means an individual who has a GED or high school diploma hired to provide intellectual disability, developmental disability, or traumatic brain injury services.”

Healthy Opportunities – A North Carolina Department of Health and Human Services initiative that tests and evaluates programs related to housing, food, transportation, and interpersonal safety for high-needs Medicaid enrollees. This initiative is no longer funded.

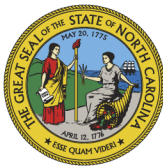
High Fidelity Wraparound – Care coordination for children and youth (3-20 years old) with serious emotional disturbance, including those with a co-occurring substance use disorder or intellectual and other developmental disability. “In Lieu Of” service definitions have been developed to promote the use of High Fidelity Wraparound services across the state. “In Lieu Of” services are alternative mental health, substance use disorder, or intellectual and other developmental disability services that are not included in the state Medicaid plan or managed care contract. “In Lieu Of” services are not required. Local Management Entities / Managed Care Organizations choose which ones they may want to provide.

Home and Community-Based Services – Health and human services that address the needs of people with disabilities who need help with everyday activities, like getting dressed or bathing. Home and community-based services (HCBS) are often designed to let people to stay in their homes, rather than moving to a facility for care. Medicaid funds HCBS through its waivers as well as through the 1915(i) State Plan amendment.

Innovations Waiver – A 1915(c) waiver that helps children and adults with intellectual and developmental disabilities who meet the level of care provided by Intermediate Care Facilities for individuals with Intellectual and Development Disabilities (ICF-IDDs) to live in the community.

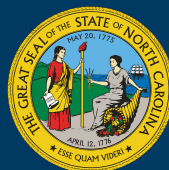
Money Follows the Person (MFP) – A program that helps Medicaid-eligible people who live in institutional facilities to move into their own homes and communities with the support they need. North Carolina was awarded its initial MFP grant from the Centers for Medicare and Medicaid Services in 2007 and began supporting individuals to transition to community living in 2009.

Transitions to Community Living (TCL) – An Olmstead-based court agreement to make sure that eligible adults with serious mental illness can live in their communities in the least restrictive settings of their choice. The North Carolina Department of Health and Human Services has in-reach, transition, diversion, and community-based services to help people remain in the community or transition from facilities to the community.



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North Carolina

Olmstead Plan Implementation

Summary Report
from October 1 through December 31, 2025

May 1, 2026

Table of Contents

Background and Introduction..... 1

Progress Highlights 2

Next Steps in Olmstead Plan Implementation 7

Appendix A: Progress in Additional Priority Areas 8

Appendix B: Glossary of Key Terms 15

Background and Introduction

In the fourth quarter of 2025 (October 1 to December 31), the North Carolina Department of Health and Human Services (NCDHHS) worked with other state agencies and community partners to carry out the 2024–2025 Olmstead Plan. At the end of the quarter, each agency shared updates on what they did in the Plan's six main areas. These updates help measure how much progress is being made.

This report focuses on two of these areas:

- **Priority Area 1:** Increase opportunities for individuals and families to choose community inclusion through access to Medicaid waiver home and community-based services and supports.
- **Priority Area 5:** Strengthen opportunities to divert and transition individuals from the criminal justice system that promote tenure in and successful reentry to inclusive communities.

In [Appendix A](#) you can read about progress on other parts of the Plan.

Progress Highlights

Progress Highlights in Priority Area 1:

Increase opportunities for individuals and families to choose community inclusion through access to Medicaid waiver home and community-based services and supports

Home and Community-Based Services (HCBS) help people with disabilities get support in their homes and communities rather than in institutions. North Carolina offers four Medicaid waivers that fund HCBS: (1) the Innovations waiver for people with intellectual and other developmental disabilities (I/DD); (2) the Traumatic Brain Injury (TBI) waiver; (3) the Community Alternatives Program for Children (CAP/C) waiver for children who are medically fragile or medically complex; and (4) the Community Alternatives Program for Disabled Adults (CAP/DA) waiver for adults 18 and older who are medically fragile and at risk of being placed in institutions.

In July of 2023, NCDHHS started new Medicaid 1915(i) State Plan services such as community living and supports, respite, and supported employment for people with I/DD and serious and persistent mental illness (SPMI). Now, access to these services no longer requires an Innovations “slot,” allowing people to get support while they are on the Innovations waitlist.

Access to Waiver Slots

The Olmstead Plan goal of increasing the number of Innovation and CAP/C waiver slots was met early in the Plan’s implementation.

- The Division of Health Benefits (DHB) added **500** additional CAP/C waiver slots to the waiver in March 2024.
- DHB received approval for an additional **350** Innovation Waiver slots. These slots were distributed to the Tailored Plans to assign to people on the waiting list.

NCDHHS posted an Innovations Waiver waitlist [dashboard](#). Along with the number of people on the waitlist, the dashboard includes other information such as demographics (age, race, and gender), time on the waitlist, average wait time by county, and whether people are receiving any services while they wait. This information is the first step in better understanding the needs of people on the waitlist.

The Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) made a concerted effort to inform people with I/DD, their families, and caregivers about access to services through the 1915(i) program. As a result, **2,000** more people with I/DD began receiving 1915(i) services in calendar year 2025. There are now **12,000** people receiving these services in the state. This total was determined by actual billing information, not just authorizations.

Progress Highlights in Priority Area 5:

Strengthen Opportunities to Divert and Transition Individuals from the Criminal Justice System that Promote Tenure in and Successful Reentry to Inclusive Communities

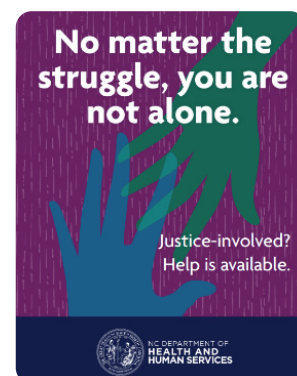
There are many points in the justice system where there are opportunities to help people with mental health disorders, substance use disorders (SUDs), I/DD, or TBI. North Carolina has made progress in developing and implementing interventions across these different points for youth and adults. In February 2025, DMH/DD/SUS announced its **\$11 million** investment to strengthen treatment, recovery, and reintegration pathways for justice-involved individuals who need support with mental health, substance use, I/DD, and TBI.

Deflection and Diversion Programs

Progress in the area of preventing people from going to jail or prison includes the launching of four new Law Enforcement-Assisted Diversion (LEAD) programs, which allow police and sheriffs to help people connect to mental health, medical, and social services instead of being arrested. A 2022 study by Duke University showed that North Carolinians who were engaged in LEAD programs had fewer citations and arrests and were more likely to receive treatment. As one LEAD participant noted:

“It was odd having an officer actually be like, ‘Hey, this could benefit you and we don’t want you to be arrested, we want to help you, get you some help.’ And that was just very weird. I was like, ‘What?’ That blew my mind...”¹

DMH/DD/SUS has extended its partnership with law enforcement



Justice reentry and recovery pocket guide.

1. Gilbert, A. R., Siegel, R., Easter, M. M., Caves Sivaraman, J., Hofer, M., Ariturk, D., Swartz, M. S., & Swanson, J. W. (2023). [Law Enforcement Assisted Diversion \(LEAD\): A multi-site evaluation of North Carolina LEAD programs](#). Duke University School of Medicine.

and others in criminal justice by offering training throughout the justice system to promote trauma-informed, recovery-oriented practices when engaging with people with mental health and SUD needs. NCDHHS is offering free justice reentry and recovery pocket guides to help law enforcement, courts, probation officers, LEAD teams, Community Intervention Teams, and providers connect people to care when they are leaving the justice system. Each guide includes quick links to mental health, substance use, I/DD, TBI, housing, and reentry supports.

Success Story: Supporting Community Reengagement



First Lady Stein and Director Crosbie join Jubilee Home for a ribbon cutting on a new home for women re-entering their communities.

A lot of progress has been made to support people leaving jails and prisons. Funding was provided to Hope Mission, Jubilee Home, Vaya Health, Alamance Academy, and Hope Restorations, Inc. to ensure that people involved in the justice system, including those re-entering their communities, have access to housing and supported employment services that meet their needs. One resident credits Jubilee Home with giving him a “crash course of life skills,” helping him to secure his own apartment and a job and to maintain a strong relationship with his therapist. In November 2025, Jubilee Home opened a new home where women leaving jail or prison can heal and find stability in a safe, supportive place. Women living in the home will receive employment services and wraparound peer support from individuals with lived experience of incarceration.

NCDHHS has expanded the NC Formerly Incarcerated Transition (NC FIT) program to four new counties to connect people with mental health and SUD services, including support from a community health worker, as they leave prison. NC FIT connects people who were in prison and have a chronic disease, mental illness, and/or SUD with essential health services and other resources. These efforts are led by community health workers who have firsthand experience of being in prison or jail.

UNC has established the first residency program for its high-impact FIT Wellness clinics. NC FIT Wellness provides psychiatric and physical health care services along with connections to community supports such as housing, transportation, and other resources for people released from the state prison system and jails who have serious mental health needs. Now, medical residents are being trained in this whole-person approach, which builds capacity for more psychiatrists to offer such services in the future.

Success Story: Creating a “Safe Space” After Incarceration Through NC FIT Wellness

NC FIT Wellness has shown tremendous success and promise for expansion. In particular, the community health worker model has been effective in engaging people who historically have not used health care services and have high mistrust of institutions like hospitals. Some patients have shared that they view the clinic as a safe space to visit, even if they don't have a scheduled appointment.



*An NC FIT Wellness patient
at the clinic*

NCDHHS has launched new Forensic Assertive Community Treatment (FACT) teams covering 12 counties (Mecklenburg, Buncombe, Wake, Durham, New Hanover, Pender, Brunswick, Pitt, Martin, Tyrell, Washington, and Beaufort) to provide intensive, community-based support for individuals with serious mental illness (SMI) who have been incarcerated. These teams include licensed professionals, a psychiatrist or nurse practitioner, a registered nurse, and a peer support specialist. Teams also include people who can help with SUD recovery, school/work needs, and housing. FACT teams can engage faith leaders, probation and parole staff, family members, and service providers to help clients as needed. All funded FACT teams are fully operational and have received referrals.

Supporting Justice-Involved Youth Through Evidence-Based Programs

Both the Division of Employment and Independence for People with Disabilities (EIPD) and DMH/DD/SUS have been coordinating with the NC Division of Juvenile Justice and Delinquency Prevention (DJJDP) to support youth involved in the juvenile justice system by introducing and strengthening evidence-based programs.

EIPD is collaborating with DJJDP to offer Pre-Employment Transition Services (Pre-ETS) to youth in Youth Development Centers (YDCs), educating YDC staff and other juvenile justice programs about the Pre-ETS services available to the youth in their care. EIPD published training materials from some of these sessions to promote program continuity and ongoing relationships between EIPD and juvenile justice staff.

Through a partnership with DJJDP and UNC Greensboro, DMH/DD/SUS has provided training in trauma-informed and evidence-based practices to over **40** juvenile justice clinicians. In addition, DMH/DD/SUS is working to link DJJDP with Ukeru resources for facilities. Ukeru is a simple and effective approach to managing aggressive behavior that offers alternatives to coercive interventions such as seclusion and restraint.

DMH/DD/SUS offers free mental health and well-being support through the [Talkspace](#) online therapy platform for youth ages 13–17 who are involved in the criminal justice system. Recent data from North Carolina shows that **100%** of young people in YDCs had at least one mental health diagnosis, with more than half also having an SUD diagnosis.² When youth download the app or go to the website, they're connected with a trained clinician who can be matched by age, culture, gender, or other categories. The platform offers 24/7 text, audio, and video access, as well as self-guided activities. Talkspace offers “asynchronous” therapy, allowing therapists and clients to communicate in various formats without scheduled appointments. Clients engage in therapy whenever and wherever is most convenient.

Expanding Access to Capacity Restoration Programs

North Carolina expanded access to programs for people with mental illness who have been determined “Incapable to Proceed (ITP)” to trial. People in this category require services to restore their ability to understand and continue trial proceedings. Previously, only state hospitals could provide these services, which resulted in these hospitals being overwhelmed with increased demand. In April 2025, DMH/DD/SUS started these capacity restoration services in Wake County, building upon the success of programs in Mecklenburg and Pitt counties. Now, people have quicker access to services and are restored to capacity sooner through detention or community-based capacity restoration programs. From 2023 to 2025, there has been a **135%** increase in people who receive this service in detention or community-based settings.

2. North Carolina Department of Public Safety (n.d.). [Did you know?](#) Accessed April 14, 2026.

Next Steps in Olmstead Plan Implementation

Quarterly reports will continue documenting progress on the six priority areas of the 2024–2025 Plan. TAC, NCDHHS, and Mathematica will make sure all action steps and measures are useful and will update them when needed. Keeping these goals and steps aligned will help North Carolina track its progress toward building communities where everyone is included.

Appendix A: Progress in Additional Priority Areas

Priority Area 1: Increase opportunities for individuals and families to choose community inclusion through access to Medicaid waiver home and community-based services and supports

This Priority Area is featured under “[Status of Strategies](#)” in the main body of this report.

Priority Area 2: Strengthen opportunities to divert and transition individuals from unnecessary institutionalization and settings that separate them from the community

The Division of Child and Family Well-Being (DCFV) finished its goal of expanding High Fidelity Wraparound, an intensive, team-based service. High Fidelity Wraparound helps children with serious emotional or behavior needs and their families. During this quarter, DCFV worked with the Division of Health Benefits (DHB), which provided capacity-building funds to the Tailored Plans for expansion to 12 counties in the state that do not yet have this service.

In Quarter 4, the Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS), kept working to improve oversight and quality in psychiatric residential treatment facilities (PRTFs). Progress included ongoing Environment of Care site visits. Most of these visits were either in progress or finished. DMH/DD/SUS provided technical assistance to PRTFs on important state and federal rules about compliance, incident reporting, and yearly attestation.

DMH/DD/SUS began early work to use Ukeru, a trauma-informed behavior management approach that reduces the use of restraint and seclusion. The division certified **26** new trainers, ordered equipment, scheduled trainings, and conducted cultural assessments for trauma-informed care. The division helped participating providers to organize baseline data such as rates of restrictive interventions and behavior incidents.

DMH/DD/SUS also worked on larger system improvements during Quarter 4. This included reviewing rules about restrictive interventions and making recommendations for changes. DMH/DD/SUS chose providers for specialty care pilot programs, explored a pilot program for people with complex trauma, and identified ways to strengthen trauma-informed care across all PRTFs.

DMH/DD/SUS focused on better discharge planning for youth with long stays. The division brought together a cross-divisional workgroup that meets every two weeks to focus on more appropriate PRTF use, shorter stays, stronger discharge planning, and better connection to community-based services.

One challenge identified by DMH/DD/SUS in Quarter 4 was that some incidents may not have been reported when they should have been. The definition of this kind of “incident” is “an adverse event that is not consistent with the routine operation of a facility or service or the routine care of a consumer).”³ The division expects that reporting will increase as it strengthens monitoring and reviews provider patterns.

In Quarter 4, the Division of State Operated Healthcare Facilities (DSOHF) made progress helping people with disabilities learn about community living choices and supporting smoother transitions out of State Developmental Centers (SDCs). This work uses a survey developed through a contract with the University of North Carolina at Chapel Hill Institute for Developmental Disabilities. The survey is meant to gather information about how people see community-based services and whether they are interested in them. During this quarter, interviewers were trained and went on tours of the SDCs so they could better understand those settings. Survey materials and education materials were finalized. The survey is expected to begin in February or March 2026 and continue through the rest of the contract period, which is about a year and a half.

DSOHF also continued working with the Money Follows the Person (MFP) program and the University of North Carolina Centers for Aging Research and Educational Services (UNC CARES) program. This work included training staff on guardianship and supported decision-making. Supported decision-making is a way for people with disabilities to make their own choices with help from trusted supporters, instead of having someone else make choices for them.

3. North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (2011). [*Incident response and reporting manual*](#).

In Quarter 4, training was completed to support understanding of the SDC memorandum of agreement (MOA) process. An MOA is a written agreement about how work will be done. UNC CARES also began making a video to help residents, families, and other stakeholders understand the MOA. The video will explain expectations for time-limited SDC stays and for transition planning.

DSOHF made progress on its escalation process for people who face major barriers to leaving SDCs. An escalation process is a step-by-step way to raise difficult cases for more help and review. DSOHF issued revised guidance to SDC Olmstead Specialists about how to prioritize people on the Community Transition List. The Olmstead Specialists are expected to start using the guidance in January 2026. DSOHF also set up a plan for escalation meetings to address barriers to transition. These meetings are expected to begin in February 2026.

DSOHF worked toward its goal of training community providers so they can better support people with developmental disabilities in the community. It continued the monthly meetings of the Intermediate Care Facility Provider Collaborative. It also organized and planned the Intellectual and Developmental Disabilities Clinical Collaborative, which is expected to begin in February 2026.

In Quarter 4, the Division of Social Services (DSS) made progress on kinship care by continuing unlicensed kinship care payments, expanding kinship training, and moving forward with early parts of a kinship-specific licensing approach. Kinship care means children are cared for by relatives or other close family connections. Unlicensed kinship care payments are payments to kinship homes that are not yet licensed as foster homes. As of November 2025, **1,855** children resided in kinship homes that received these payments.

DSS also continued rolling out a national training development curriculum for kinship families. This included offering a shorter 15-hour pre-service training option for relatives related by blood, marriage, or adoption. From June through November 2025, **317** staff from county child welfare agencies and private child-placing agencies completed train-the-trainer instruction. This increased the state's ability to deliver kinship-specific training.

As of November 2025, **31.07%** of children in foster care were placed with kin. Two point seven four percent were placed with licensed kin. Another **5.86%** were placed in non-treatment group settings. In State Fiscal Year 24-25, **37.83%** of children in foster care were initially placed with kin.

During Quarter 4, DSS built more of the structure needed to support kinship licensing. Since January 2025, the state has approved five training modifications and nine waivers related to kinship licensure. It also developed a kinship-specific licensing form. DSS continues to face challenges because the current state law and rules do not allow a separate kinship licensing track. This means kinship foster homes still have to meet the same stan-

dards as other foster homes. DSS is still working through the policy, legal, and operational changes needed.

Priority Area 3: Address gaps in community-based services

DHB has a large role in making sure community-based services are available. DHB oversees the work of the Tailored Plans to make sure enough providers and services are available for people who need care (“network adequacy”). In Quarter 4, DHB reported more collaboration and problem-solving between DHB and Tailored Plan staff on these issues. This included a shared understanding of how to submit required reports.

DCFW focused on filling gaps in community-based care for children, youth, and families by expanding intensive alternative family treatment (IAFT) and therapeutic foster care (TFC). As of Quarter 4, DCFW reported that it completed its goal of contracting with Rapid Resources for Families for expansions of IAFT, and that implementation was underway.

DCFW also reported progress on expanding respite services. Respite services give caregivers a short break by providing temporary support for the person they care for. DCFW reported that funding was given to three of the four Tailored Plans, and those Tailored Plans are working to build more respite capacity.

In Quarter 4, DMH/DD/SUS continued several efforts to strengthen community-based supports for people with I/DD and traumatic brain injury (TBI). This work focused on improving workforce capacity, expanding crisis access, and supporting transitions from institutions through the Transitions to Community Living program.

DMH/DD/SUS continued implementing Inclusion Connects and Inclusion Works. These efforts connect people with I/DD and their caregivers to services and supports, including employment opportunities. DMH/DD/SUS used several outreach efforts to increase awareness and participation, including: a Medicaid Deep Dive; a Housing Summit presentation; activities for National Disability Employment Awareness Month; an “Empower to Work” lunch and learn session; and Advisory Committee meetings. Through the Inclusion Connects Advisory Committee, DMH/DD/SUS also created a working subcommittee focused on the issue of intimate partner violence.

To help people understand which services are available to them and how to access them, DMH/DD/SUS developed an I/DD Services Navigator program. The division also created postcards with information about supports and services for people on the Innovations waitlist.

DMH/DD/SUS worked with DHB to change how often reports are made for metrics that show unmet service needs among people getting 1915(i) services.

In relation to TBI side, DMH/DD/SUS worked to expand the TBI waiver by educating stakeholders for advocacy with the General Assembly, gathering feedback from Tailored Plans on waitlist/registry of interest procedures, and presenting approved waitlist reports to the State Budget Office, the Expansion and Reinvestment Committee, and DHB Plan Administration. The division also worked to improve access to high-quality TBI services by reviewing current service use, updating available service options, and assessing procedures for collecting data, including data related to screening and prevalence.

DMH/DD/SUS supported the Brain Injury Advisory Council (BIAC) to meet more frequently, and to gather in person more often. DMH/DD/SUS established regular report-out sessions with the BIAC to request its feedback and input on program implementation. The division started developing a TBI State Action Plan by creating a stakeholder survey and finishing the first stakeholder feedback session. The TBI State Action Plan will be posted for public comment from 3/27/26 to 4/27/26, and will be implemented beginning on 7/1/26. Through the TCL program, a total of **129** people with serious and persistent mental illness (SPMI) or serious mental illness (SMI) and co-occurring I/DD moved from institutional settings in Fiscal Year 2025.

The Division of Social Services funds and carries out Sobriety, Treatment, and Recovery Teams (START) pilot program, which helps parents with SUD to access treatment and keep their families together. START is being expanded, along with training, to more counties in North Carolina. The six counties now in this pilot program are hiring staff and are getting close to being able to serve families. The Craven County pilot site is fully staffed and has accepted its first START client. DSS will host its first START Summit with service providers in August 2026.

Priority Area 4:

Increase opportunities for pre-employment transition services for youth with disabilities, and competitive integrated employment for adults with disabilities

The Division of Employment and Independence for People with Disabilities (EIPD) took several steps toward its goals in this priority area during Quarter 4. In November, EIPD helped coordinate a statewide career fair and provided funding for people who had to travel long distances to attend. EIPD had a booth at the fair along with other state agencies and universities. More than **1,700** people registered for the event; others also attended without registering.

To attract enough workers in to deliver services, EIPD funded paid internships for college students as a recruitment strategy. It adopted a temporary-to-permanent employment process to make hiring easier. It also adopted Workday, a new human resources platform, to speed up job posting, hiring, and onboarding.

EIPD reported challenges that kept them from making more progress in Quarter 4. A hiring blitz in an earlier quarter filled a number of vacant positions, but EIPD reported that the lack of a state or federal budget for salary raises has led some staff to leave. EIPD reported that staff turnover rates stayed steady in Quarter 4.

EIPD also reported progress on increasing Pre-Employment Transition Services (Pre-ETS) by approving new vendors to work in areas that were underserved. Pre-ETS are services that help youth with disabilities get ready for work.

EIPD continued working with Work Together North Carolina and the Post-Secondary Education Alliance during this quarter. EIPD staff joined ongoing monthly advisory and leadership committee meetings to receive feedback about services and to learn about resources for people with I/DD, including college and other post-secondary education opportunities.

EIPD continued another partnership with Work Together North Carolina to improve and simplify services that help people with I/DD get competitive integrated employment (CIE). CIE means a job in the community where a person with a disability works alongside nondisabled workers and earns the same pay as others doing similar work. The joint effort between EIPD and Work Together provides employment assessments and supports for workers with disabilities. People who say they are interested in CIE are connected with a CIE Liaison from EIPD or their Tailored Plan to get help with referral and application.

EIPD also continued its partnership with the North Carolina community college system to place case managers from the Bridge to Success program in six community colleges. A fourth college now has case managers in place. The four colleges are Alamance Community College, Asheville-Buncombe Technical Community College, College of the Albemarle, and Wilkes Community College. Eighty-eight students are now served through Bridge to Success. The case managers provide and coordinate vocational rehabilitation services for students with I/DD. Outreach and expansion in Quarter 4 were limited by staff turnover and vacancies.

EIPD also made progress on the Project Spark grant. This grant provides wraparound supports to help participants get and keep competitive employment. Project Spark increased enrollment to **128** people receiving services through three pilot sites: Chatham Trades, Tri-County Industries, and Wake Enterprises. Project Spark currently has **135** people receiving services through these same three pilot sites. To date, **26** Project Spark participants are now competitively employed. Four of these individuals moved from subminimum wage work to CIE. The other **22** were considering subminimum wage work but were redirected to CIE.

These numbers are higher than in earlier quarters. Success stories continue to be shared through social media, newsletters, and internal and external meetings.

Priority Area 5:

Strengthen opportunities to divert and transition individuals from the criminal justice system that promote tenure in and successful reentry to inclusive communities

This Priority Area is featured under “[Status of Strategies](#)” in the main body of this report.

Priority Area 6: Promote workforce development, recruitment, and retention

In Quarter 4, DMH/DD/SUS continued its work with the community college system to build a high-quality curriculum for direct service professionals (DSPs). DSPs are workers who help people with disabilities with daily support and services. DMH/DD/SUS launched its Advanced DSP curriculum with early adopter groups at Stanley Community College, Asheville-Buncombe Technical Community College, and Forsyth Technical Community College. Each course was filled to capacity and had a waitlist. DMH/DD/SUS expects the first group of DSPs to be fully certified by spring 2026.

In Quarter 4, DHB continued its work to support higher wages for the community-based direct care workforce.

DHB took part in a direct technical assistance program led by Tennessee’s Medicaid program through the Quality Improvement in Long-Term Services and Supports (QuILTSS) initiative. Through QuILTSS, part of the Medicaid program’s payment to nursing facilities is tied to performance and quality measures.

DHB reported that competing budget priorities and other barriers have slowed their progress in securing adequate wages and supports for family caregivers.

Appendix B: Glossary of Key Terms

1915(i) State Plan Option – Allows the state to provide certain Home and Community-Based Services to a target population that does not have to meet institutional level of care. In North Carolina, these services target children and adults with mental health conditions, substance use disorders, traumatic brain injuries, and intellectual/developmental disabilities.

Community Alternatives Program for Children (CAP/C) Waiver – A 1915(c) Home and Community-Based Services waiver that provides Medicaid services for medically fragile children under 21 who are at risk of institutional care. CAP/C can help these children stay at home with their families by providing in-home nursing care, case management, and other supports.

Community Alternatives Program for Disabled Adults (CAP/DA) Waiver – A 1915(c) Home and Community-Based Services waiver that provides an alternative to institutionalization for a Medicaid beneficiary who is medically fragile and at risk for institutionalization. The services allow the beneficiary to remain in a home- and community-based setting, to or return to the community from an institutional stay.

Assistive Technology – An item or piece of equipment that helps a person with a disability to increase, maintain, or improve their ability to function. Assistive technology can range from “low-tech” devices, such as a cane or wheelchair, to “higher tech” devices, such as a software program on a computer, or screen readers.

Behavioral Health I/DD Tailored Plans – An integrated health plan for individuals with significant behavioral health needs and intellectual and other developmental disabilities (I/DDs). The Behavioral Health I/DD Tailored Plan also serves people who are enrolled in the Innovations and Traumatic Brain Injury (TBI) waivers or are on the waitlist. The Tailored Plan is responsible for managing the state’s non-Medicaid behavioral health, developmental disabilities, and TBI services for people in North Carolina who don’t have enough health insurance to cover the services.

Competitive Integrated Employment (CIE) – A full or part-time job for a person with a disability who is paid at least minimum wage. This can include self-employment. The person should be paid the same as nondisabled coworkers doing a similar job, and they should get the same level of benefits. The job should be at a location where the employee interacts with other individuals without disabilities, and the disabled employee should have opportunities for advancement similar to nondisabled employees in similar positions.

Direct Support Professional (DSP) – A staff member who works one-on-one with individuals with disabilities and helps them become integrated into the community or the least restrictive environment. North Carolina’s Rule 10A NCAC 27G.0104, Staff Definitions, includes this definition: “‘Direct Support Professional’ means an individual who has a GED or high school diploma hired to provide intellectual disability, developmental disability, or traumatic brain injury services.”

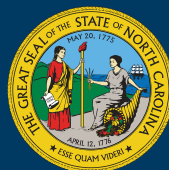
High Fidelity Wraparound – Care coordination for children and youth (3-20 years old) with serious emotional disturbance, including those with a co-occurring substance use disorder or intellectual and other developmental disability. “In Lieu Of” service definitions have been developed to promote the use of High-Fidelity Wraparound services across the state. “In Lieu Of” services are services that a managed care plan can offer in place of a state plan service. The individual has to choose this service over the state plan service. “In Lieu Of” services are not required. Managed care organizations choose which ones they may want to provide. These services must be cost-effective and approved by the State.

Innovations Waiver – A 1915(c) waiver that helps children and adults with intellectual and developmental disabilities who meet the level of care provided by Intermediate Care Facilities for individuals with Intellectual and Development Disabilities (ICF-IDDs) to live in the community

Money Follows the Person (MFP) – A program that helps Medicaid-eligible people who live in institutional facilities to move into their own homes and communities with the support they need. North Carolina was awarded its initial MFP grant from the Centers for Medicare and Medicaid Services in 2007 and began supporting individuals to transition to community living in 2009.

Transitions to Community Living (TCL) – An *Olmstead* settlement agreement between NCDHHS and the United States Department of Justice to make sure that eligible adults with serious mental illness living in, or at risk of being admitted to, an adult care home (ACH) can instead live in their communities in the least restrictive settings of their choice. This program has in-reach, transition, diversion, housing and community-based services to help people remain in the community or transition from facilities to the community.

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NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

Services for People with Disabilities in North Carolina Survey

(<https://docs.google.com/forms/d/e/1FAIpQLSdKrEyQIE4oe8UHNvEgAWrvOI9MYU6e2WQi6LHmOdwj64bO6w/viewform>)

Introduction:

This survey asks what you think about two things:

- How services for people with disabilities are working in North Carolina right now.
- Some new ideas we want to use to guide these services.

These ideas will help make sure services help people with disabilities to live in their communities. Your answers will help North Carolina improve services now and in the future.

The Technical Assistance Collaborative (TAC) is helping North Carolina with this work. The survey is anonymous. You don't have to give your name, and your answers will be grouped with others.

When we say "services for people with disabilities," we mean many kinds of help. You don't need to know about all of them to take the survey. Some examples are:

- Help at home or in the community (like CAP/C, CAP/DA or Innovations)
- Services for people with traumatic brain injuries (TBI)
- Mental health care
- Group homes or nursing homes
- Job help or training
- Help with living on your own
- Technology that helps with daily life
- Money help
- Transportation
- Services for older adults
- Childcare for kids with disabilities
- Home health care or personal care

If you have a disability, care for someone with a disability, or work in services for people with disabilities, you can take this survey.

Please choose the answer that best describes you.

- I am a person with disabilities and use services for people with disabilities.
- I am a person with disabilities and trying to access disability services for myself.
- I help a family member with a disability.
- I work with people with disabilities
- Other:

Section 1: How services are working now

These questions are about your experience with the disability services as they are today.

Q1. Services for people with disabilities help me, my family, or the people I serve.

1 = Strongly Disagree – 5 =Strongly Agree

Q2. NC is trying to fix problems in services for people with disabilities.

1 = Strongly Disagree – 5 =Strongly Agree

Q3. What are the biggest problems with getting or giving good services?

Please rate each one: Not a problem Somewhat a problem Big problem

- Not enough money
- Not enough support from leaders
- Not enough training
- Not enough workers/issues with workers
- Stigma (being judged unfairly)
- Cultural barriers
- Hard to get services
- Hard to find or understand help
- Not enough money
- Not enough support from leaders
- Not enough training
- Not enough workers/issues with workers
- Stigma (being judged unfairly)
- Cultural barriers
- Hard to get services
- Hard to find or understand help

Q4. I feel included and supported when decisions are made about services.

1 = Strongly Disagree – 5 = Strongly Agree

Q5. What one change that would make services better for you or others?

Section 2: New Ideas (Principles) to Guide Services

This section asks about the new ideas we want to use to guide services. They are:

People with disabilities:

- *Can make their own choices and get support that respects them.*
- *Are part of the community—living, working, and doing things they enjoy.*
- *Get the right help at the right time, without being treated unfairly.*
- *Live in places that are easy to get around, affordable, and welcoming.*

Systems that help people with disabilities:

- Work together and are easy to use at all stages of life.
- Are fair, responsible, and support families and caregivers.

Q6. I understand these ideas.

1 = Strongly Disagree – 5 = Strongly Agree

Q7. These ideas matter to me, my family, or the people I help.

1 = Strongly Disagree – 5 = Strongly Agree

Q8. Please rank these ideas from most to least important (1-6).

- Making your own choices and being respected.
- Being part of the community.
- Getting help quickly and fairly.
- Accessible, affordable, and inclusive communities
- Living in places that are easy to use and affordable.
- Systems that work well and are easy to use.

- Systems that are fair and help families and caregivers.
 - Making your own choices and being respected.
 - Being part of the community.
 - Getting help quickly and fairly.
 - Accessible, affordable, and inclusive communities
 - Living in places that are easy to use and affordable.
 - Systems that work well and are easy to use.
- Systems that are fair and help families and caregivers.

Q9. Do you have ideas to make these principles easier to understand or more helpful to your life?

Q10. If NC could change one thing tomorrow to follow these ideas better, what should it be?

Q11. Do you have anything else to share about how to improve services for people with disabilities in NC?

Cost sheet
RFP 125999 O3
Nebraska Olmstead Plan Evaluation

Bidder Name: **Technical Assistance Collaborative, Inc.**

Important Instructions: Bidders are to complete all fields highlighted in yellow.

Do not alter existing format or content within the Cost Sheet. However, if Bidder identifies that other items are essential in **Part I** to create full functionality, and meet the requirements as outlined in the RFP document and any related attachments, then additional lines may be inserted as needed. **Important:** In case of a mathematical error in extension of price, unit price shall govern.

All prices, costs, and terms and conditions submitted in the solicitation response shall remain fixed and valid commencing on the opening date of the solicitation until the contract terminates or expires.

Basis for award of points is the "Total Project Cost" for the Nebraska Olmstead Plan Evaluation **\$382,900**

This amount shall equal the sum of Deliverables 1-5 for **Part I**.

Part I: Project section requirements as outlined in Section (V) of the Request for Proposal (RFP) document and Attachment A – Technical Requirements. Bidder to provide pricing for each of the project deliverable categories listed as fixed price per deliverable.

Description	Cost per completed deliverable
Deliverable 1: Data Collection and Evaluation Plan	\$145,820
Deliverable 2: Olmstead Plan Evaluation Report	\$95,320
Deliverable 3: Communications Plan and Supporting Materials	\$68,130
Deliverable 4: Olmstead Plan revision recommendation draft language	\$33,735
Deliverable 5: Summary of Technical Assistance and Final Recommendations for Plan Revisions	\$39,895
TOTAL PROJECT COST:	\$382,900