Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40

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Table of Contents

Contents

Table of Contents ii
Introduction from the Department of Human Services 1
Rule 40 Advisory Committee Recommendations 3
History 3
Rule 40 3
Ombudsman's Office Investigation 3
Jensen Settlement Agreement 3
Summary 6
Values and Mission of the Advisory Committee 7
Rule 40 Advisory Committee 8
Groups Represented 8
Committee Assembled 8
Rule 40 Advisory Committee Members 8
Rule Advisory Committee Meetings 9
The Committee Process 10
Resources Utilized 11
Overview of Advisory Committee Recommendations 13
General Recommendations 14
Positive Support Strategies 15
Person-Centered Planning 17
Permitted Techniques 18
Prohibited Techniques 19
Emergency Use of Manual Restraint 20
Temporary Use of Mechanical Restraint for Self-Injurious Behavior 20
Staff Training 21
Reporting and Notifications 25
Emergency Use of Manual Restraints 26
Other Events 27
Monitoring 27

Goals and Values 27
Restraint Monitoring 27
Internal Review 28
External Review 28
Oversight 28
Licensing 29
Data 29
Committees and Teams 29
Implementation 30
Initial Implementation 30
Sustaining the Changes 33
Advisory Committee Recommendation Concerns 35
Closing Words from the Department 36
Next Steps for the Department 37
Appendix A – Glossary of Technical Terms 38
Appendix B – Jensen Settlement Agreement 43
Appendix C – CMS Waiver Instructions 44
Appendix D – Positive Support Strategies Summary (REVISED 8.6.12) 45
Appendix E – Person-centered Planning Summary (REVISED 8.6.12) 50
Appendix F – Emergency Use of Manual Restraint Summary (REVISED 9.7.12) 54
Appendix G – Training Notes and Additional Recommendations (Added 9.7.12) 60
Appendix H – Monitoring, Reporting and Oversight Summary (REVISED 10.22.12) 77
Appendix I – Implementation Summary (REVISED 9.7.12) 86
Appendix J – Rule 40 Advisory Committee Meeting Summary 6.20.13 90

Introduction from the Department of Human Services

Ensuring that the Minnesotans who receive services are treated with respect and dignity is a key element of the mission of the Department of Human Services (the Department or DHS). As an agency with responsibilities for the administration and oversight of services, as well as a provider of services, we are committed to fulfilling our mission consistent with the current best practices and principles that support inclusive community living and quality of life.

To that end, DHS will prohibit procedures that cause pain, whether physical, emotional or psychological, and establish a plan to prohibit use of seclusion and restraints for programs and services licensed or certified by the department. It is our expectation that service providers, including state operated services, will seek out and implement therapeutic interventions and positive approaches that reflect best practices.

Each person comes to the system with unique needs, and may have co-occurring conditions that draw on multiple services. Best practice standards have changed and will continue to evolve. Punishment is not only non-therapeutic but the consequences of punishment are counter to therapeutic intervention and are unacceptable. Consistent use of best practices will lead to enhanced effectiveness in services and better outcomes for people. Current best practices include, but are not limited to, the use of positive and social behavioral supports, prohibitions on use of restraints and seclusion, trauma informed care, and the development of community support plans that are consistent with the principles of the "most integrated setting" and "person centered planning," consistent with the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).

To achieve these changes across our service system, we will create a culture that honors the trust placed in us both as a provider and as a department responsible for the administration and oversight of many of the services that support citizens. Such a culture will help the agency and providers regulated by the agency adapt to best practices that continue to evolve over time.

In December 2011, the Jensen Settlement Agreement[1] (the Settlement Agreement) set a new course toward best practices in how people with disabilities are treated. The Jensen Agreement resulted from unhealthy conditions in the Minnesota Extended Treatment Options (METO) program. One key provision of the Jensen Agreement was a requirement that the Department of Human Services empower a committee to examine the issues of seclusion and restraint as they pertain to persons with developmental disabilities. In particular, the Agreement called for a review, and update, of a DHS administrative rule commonly known as Rule 40. However, while abiding by the Jensen's Agreement directive on Rule 40, it is DHS's belief that there is a great opportunity to create broader policies on positive supports, prohibited practices, training, monitoring and reporting across the programs we regulate. Therefore, with recognition that there are some providers and advocacy groups whose opinions differ, DHS, along with a growing number of our clients, advocates, and providers, support a change in Department policy to prohibit procedures that cause pain, whether

[1] *The true measure of a civilized and democratic society is the way each of us treats those individuals most in need and the most vulnerable amongst us. That, of course, means that all people are entitled to be treated with patience, dignity, and respect, and to be extended kindness, whoever they may be, regardless of their social standing in the community and especially if they have special needs. Order approving Jensen Settlement Agreement December 5, 2011*

physical, emotional or psychological and prohibit programmatic use of seclusion and restraints for programs and services licensed or certified by the Department.

It is the intent of the Department of Human Services to adopt the following principles for programs and services licensed or certified by the Department:

- Prohibit techniques that include any programmatic use of restraint, punishment, chemical restraint, seclusion, time out, deprivation practices or other techniques that induce physical, emotional pain or discomfort.
- Emergency use of manual restraint may only occur if a person's *"conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. Client refusal to receive/participate in treatment shall not constitute an emergency."*[2] All use of emergency restraint will require monitoring and oversight by the appropriate regulatory authority, advocacy and expert clinical resources and will be tracked and analyzed.
- The rights of all individuals will be protected in accordance with applicable Bills of Rights.
- Standards for services transcend diagnostic labels, although must remain sensitive to the unique needs of each person and their presenting conditions.
- DHS, with consumer and stakeholder input, will create a common set of standards of positive supports and practices across all providers which include:
    - Trauma informed care practices
    - Person centered thinking/planning, and
    - Analysis and review of all use of emergency restraints or emergency seclusion.
- The commissioner may allow use of emergency seclusion in limited programs, such as the Minnesota Security Hospital, during a transition period.

In order to implement these principles, the Department will:

- examine the feasibility and rule making authority to adopt best practices in person-centered planning and positive supports;
- consult with advocates, providers, case managers, persons receiving services and their families and consultants who have demonstrated success and expertise on best practices;
- adopt and promote the use of positive practices, social supports and the development of plans consistent with the most integrated setting and person centered planning;
- implement strategies to achieve the agreed-upon practices in the most expeditious and effective manner;
- include consumers and stakeholders in the phased development of the statute, rule, bulletins, waiver plans/amendments and any policy or practices manual that addresses these standards; and,
- complete these objectives by December 31, 2014.

The Department will evaluate service regulations for other services for which it has program and policy responsibility against the principles outlined in this document and the recommendations from the Advisory Committee for the modernization of Rule 40. This evaluation will include services managed through the Children's Mental Health Division, Adult Mental Health Division, Alcohol and Drug Abuse Division and Nursing Facility Rates and Policy Division. Each division will determine what changes are necessary in programs and policies they administer to assure consistency with the principles adopted by

[2] Jensen Settlement Agreement - Attachment A.

the Department.

Rule 40 Advisory Committee Recommendations

The Rule 40 Advisory Committee provides their recommendations to the Minnesota Department of Human Services to modernize Minnesota Rules 9525.2700 to 9525.2810, commonly referred to as "Rule 40," to reflect current best practices when providing services to individuals with disabilities. Current best practices include, but are not limited to, the use of positive and social behavioral supports, prohibitions on use of restraints and seclusion, trauma informed care, and the development of community support plans that are consistent with the principles of the "most integrated setting" and "person centered planning," consistent with the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999). The outcome of these practices is to increase quality of life, and appropriately respond to the behavior of the person. The advice and recommendations of the advisory committee is the product of many hours of meetings, contemplation, research and discussions.

History

Rule 40

"Rule 40," *Use of Aversive and Deprivation Procedures in Licensed Facilities Serving Persons with Developmental Disabilities,* implements Minnesota Statute Section 245.825 by setting standards that govern the use of aversive and deprivation procedures with persons who have a developmental disability and who are served by a license holder licensed by the commissioner of the Department of Human Services under Minnesota Statutes Chapter 245A and Section 252.28, subdivision 2.

Rule 40 was promulgated in 1987 and was intended to represent best practices at the time. However, it does not represent current best practices, including those supported by the Association of Positive Behavior Supports.

Ombudsman's Office Investigation

On September 18, 2008, the Minnesota Ombudsman for Mental Health and Developmental Disabilities issued an extensive report entitled "Just Plain Wrong" following an in-depth investigation of the Minnesota Extended Treatment Options program ("METO"). METO is a facility operated by the Minnesota Department of Human Services' State Operated Services Division. METO was a facility statutorily charged under Minnesota Statutes Section 252.025, subd. 7 to serve "Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety." The Ombudsman found that METO was engaged in the systematic use of restraints and seclusion on individuals with developmental disabilities in contravention of best practices. Current best practice standards focus on positive behavioral supports.

Jensen Settlement Agreement

In July 2009, three former residents of the METO program, and their parents, brought a class action lawsuit against the State of Minnesota and the Minnesota Department of Human Services in the United States District Court, District of Minnesota, on behalf of residents of METO who were subjected to the use of restraints and seclusion in alleged violation of the United States Constitution and other federal and state laws. In June 2011, the Plaintiffs, on behalf of the class, and the State reached a comprehensive class action Settlement Agreement, which was approved by court on December 5, 2011. See Appendix B for a link to a copy of the Jensen Settlement Agreement.

Among other important provisions, the Jensen Settlement Agreement includes a provision on prohibited techniques, and provides in relevant part:

V. PROHIBITED TECHNIQUES

> A. Except as provided in subpart V. B., below, the State and DHS shall immediately and permanently discontinue the use of mechanical restraint (including metal law enforcement-type handcuffs and leg hobbles, cable tie cuffs, PlastiCuffs, FlexiCuffs, soft cuffs, posey cuffs, and any other mechanical means to restrain), manual restraint, prone restraint, chemical restraint, seclusion, and the use of painful techniques to induce changes in behavior through punishment of residents with developmental disabilities. Medical restraint, and psychotropic and/or neuroleptic medications shall not be administered to residents for punishment, in lieu of adequate and appropriate habilitation, skills training and behavior supports plans, for the convenience of staff and/or as a form of behavior modification.
>
> B. **Policy.** Notwithstanding subpart V. A. above, the Facility's policy, "Therapeutic Interventions and Emergency Use of Personal Safety Techniques," Attachment A to this Agreement, defines manual restraint, mechanical restraint, and emergency, and provides that certain specified manual and mechanical restraints shall only be used in the event of an emergency. This policy also prohibits the use of prone restraint, chemical restraint, seclusion and time out. Attachment A is incorporated into this Agreement by reference.

Since the adoption of the Settlement Agreement by the Court, the parties have sought an amendment to paragraph B, above, which will prohibit the use of mechanical restraints even in an emergency.

In addition, the Jensen Settlement Agreement required the State to close METO by June 30, 2011, and mandated that any successor program comply with the U.S. Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999) and utilize person centered planning principles and positive behavioral supports. The Settlement Agreement also mandated that as part of system wide improvements, DHS establish a "Rule 40 Advisory Committee" ("Advisory Committee") "to study, review and advise the Department on how to modernize Rule 40 to reflect current best practices. Specifically, the Settlement Agreement provides:

X. SYSTEM WIDE IMPROVEMENTS

> **C. Rule 40.**
>
> 1. Within sixty (60) days from the date of the Order approving this Agreement, the Department shall organize and convene a Rule 40 (Minn. R. 9525.2700-.2810) Advisory Committee ("Committee") comprised of stakeholders, including parents, independent experts, DHS representatives, the Ombudsman for Mental Health and Developmental Disabilities, the Minnesota Governor's Council on Developmental Disabilities, Minnesota Disability Law Center, Plaintiffs' counsel and others as agreed upon by the parties, to study, review and advise the Department on how to modernize Rule 40 to reflect current best practices, including, but not limited to the use of positive and social behavioral supports, and the development of placement plans consistent with the principle of the "most integrated setting" and "person centered planning, and development of an 'Olmstead Plan'" consistent with the U.S. Supreme Court's decision

in Olmstead v. L.C., 527 U.S. 582 (1999). The Committee's review of best practices shall include the Arizona Department of Economic Security, Division of Developmental Disabilities, Policy and Procedures Manual, Policy 1600 Managing Inappropriate Behaviors.

2. Within sixty (60) days from the date of the Court's approval of this Agreement, a public notice of intent to undertake administrative rule making will be issued.

3. DHS will not seek a waiver of Rule 40 for the Facility.

Summary

The Minnesota Department of Human Services ("the Department" or "DHS") convened the Rule 40 Advisory Committee ("advisory committee") pursuant to the Jensen Settlement Agreement, which was approved on December 5, 2011. Rule 40 refers to Minnesota Rules 9525.2700 to 9525.2810. The advisory committee was charged to study, review and advise the Department on how to modernize Rule 40 to reflect current best practices. The advisory committee met for day-long meetings eleven times from January 2012 to February 2013. The last formal meeting was held on June 20, 2013[3].

Advisory committee members studied and reviewed hundreds of pages of materials and heard a wide variety of presentations on best practices, including a presentation by Derrick Dufresne and Michael Mayer, two national leaders in helping states implement shifts to best practices.

The research into best practices was a foundation for the committee to reach agreements on a set of recommendations to support best practices and positive approaches. Subgroups delved into specific areas and brought their recommendations to the full advisory committee for discussion, revision and final agreements. Language and terminology that would capture the intended message required careful consideration. On some of the more difficult issues, committee members generally agreed on a recommendation under most circumstances but there often was a real-life example that would prompt a discussion about how this would work on a practical basis. These examples lead to questions and discussion about the strategies, including a reasonable transition plan that could support providers in their successful implementation of the committee's recommendations.

The original scope of the advisory committee as described in the State Register notice seeking membership was limited to licensed services for people with developmental disabilities. However, because of the quality initiatives[4] the Department had underway to enhance home and community-based services, the Department asked the committee members to consider recommendations based on best practices that could be applied more broadly to other services.

On a similar note, the original charge to the committee was to modernize Rule 40. As the process continued, there was consensus to provide recommendations in a format that could be used by the Department to amend statute, revise a rule, amend waiver plans, create a manual or to establish an implementation plan. This narrative document represents the advisory committee's official set of recommendations with the expectation that statute, rule and a positive practices manual will follow as the recommendations are operationalized.

The Rule 40 Advisory Committee provided the following advice and recommendations to the Department to reflect current best practices when providing services to individuals with disabilities to increase quality of life and decrease interfering behaviors. Key elements of the advisory committee recommendations are: elimination of programmatic use of all restraints and seclusion, use of positive support strategies and person-centered planning, an emphasis on training and competency of providers, new monitoring and data collection, continuous updating of standards to reflect the ever-improving best practices and standards for emergency use of manual restraint. Implementation of these recommendations will require a culture change with necessary support to embed positive practices throughout the standards and service delivery system.

[3] Please see Appendices D through J at the end of this document.

[4] Other quality initiatives include Waiver Provider Standards, State Quality Council, rate setting, case management reform, Reform 2020, MnCHOICES and waiver application renewals and updates.

Values and Mission of the Advisory Committee

The purpose for the changes recommended in this document and the replacement of Minnesota Rules 9525.2700 to 9525.2810 is to modernize Minnesota's standards with current national best practices for equipping people with disabilities to fully succeed in lives of their choosing. Best practices are ever-changing as leaders in the health, mental health, and disability fields develop and refine innovative methods that respect the humanity of persons receiving services while helping them to build effective performance repertoires, reduce symptoms and eliminate behavior inconsistent with their desired life.

At the first rule advisory committee meeting, the group began with an exercise to express and clarify the values that undergird the mission of modernizing Rule 40.

The top six values were:

1. Person-centered practices
2. Oversight and metrics related to use of Rule 40 procedures
3. Respect of persons
4. Positive behavior and social supports
5. Human rights of persons
6. Choice of persons

The challenges to meeting or achieving best practices as noted by committee members include the need for training and retraining all levels of personnel on a statewide, system-wide basis; the development and implementation of metrics for monitoring; and the shift from control over people to a system of supporting individuals to make their own choices.

Over the course of seventeen months of meetings, particular values were emphasized more than others. The advisory committee's additional values are:

1. Best practices
2. Person-first language
3. Quality of life
4. Competency of staff and not just credentials

The Rule 40 Advisory Committee's mission is to improve the lives of individuals with disabilities receiving services by recommending policies and best practices to DHS that will create safe, integrated settings and practices for persons receiving services by initiating a culture shift from the use of aversive and deprivation techniques to the use of positive approaches in the most integrated setting. These changes could save Minnesota money and support a person in the most integrated setting. Minnesota can once again be a national leader for persons with developmental and other disabilities.

With those values and mission in mind, the Rule 40 Advisory Committee recommends the following policies and best practices.

Rule 40 Advisory Committee

Groups Represented

Pursuant to the Jensen Settlement Agreement, the rule advisory committee must be "comprised of stakeholders, including parents, independent experts, DHS representatives, the Ombudsman for Mental Health and Developmental Disabilities, the Minnesota Governor's Council on Developmental Disabilities, Minnesota Disability Law Center, settlement class counsel and others as agreed upon by the parties." The parties agreed that counties, a variety of size and types of providers, families and self-advocates should be represented on the committee. The Department relinquished its committee position so that an additional provider representative could be added to the committee while maintaining a reasonable committee size.

Committee Assembled

The Department, with agreement from settlement class counsel, created and utilized a "statement of interest" process in which individuals and entities could express interest in serving on the advisory committee. A request for statements of interest was published in the State Register for three consecutive weeks in December 2011 and January 2012.The Department selected advisory committee candidates based on each candidate's qualifications and sought to establish an advisory committee that represented many interests. DHS presented the list to settlement class counsel, along with all submitted statements of interest. Settlement class counsel added one more committee member to the department's list. The selected candidates were invited to join the committee, and they all accepted. Their names and organizational affiliations or stakeholder role are listed below.

Rule 40 Advisory Committee Members

- Steve Anderson – Provider; Mount Olivet Rolling Acres
- Kay Hendrikson – Office of Ombudsman for Mental Health and Developmental Disabilities
- Anne Henry – Minnesota Disability Law Center
- Barbara Kleist – Parents and Family Members, Advocate; Arc Greater Twin Cities (joined July 2012)
- Patricia Kuehn – Minnesota Association of County Social Service Administrators (MACSSA), Ramsey County
- Traci Lisowski – Provider; Home & Community Options, Inc.
- Tim Moore – Independent Expert; University of Minnesota, Institute for Community Integration
- Leanne Negley – Provider; Rural Living Environments
- Shamus O'Meara and M. Annie Santos – Settlement Class Counsel
- Dan Reed – Provider; Partnership Resources
- Kelly Ruiz - Minnesota Association of County Social Service Administrators (MACSSA), Dakota County
- Bonnie Jean Smith – Parent and Family Member
- Gloria Steinbring – Self-Advocate
- Colleen Wieck – Minnesota Governor's Council on Developmental Disabilities

- Andrew Pietsch – Provider; Lifeworks (resigned November 2012)
- Rebecca Walsh – Parent and Family Member (resigned June 2012)
- Sheryl Grassie – Parent and Family Member (resigned May 2012

Rule Advisory Committee Meetings

The advisory committee first met on January 30, 2012, consistent with Settlement Agreement terms requiring the advisory committee to convene within sixty days from the date of the order approving the Settlement Agreement. The Department followed Minnesota's open meeting law[5] found in Minnesota Statutes chapter 13D.

The advisory committee continued to meet on a monthly basis. The Department provided educational materials to committee members on a variety of relevant topics requested by committee members and department subject matter experts. The department brought in subject matter experts from within the department, other state agencies, external experts and used the expertise of committee members to provide both oral presentations and written handouts.

From January through May, committee time and efforts were focused on studying and reviewing a plethora of resources and materials. One premise established at the first advisory committee meeting in January was that the committee could benefit from studying and reviewing other systems and standards. With that in mind, the Department arranged for presenters and materials on topics and areas such as:

1. Personal story of Gloria Steinbring, committee member and self-advocate
2. Person-centered planning and positive practices with presentations by Tim Moore, University of Minnesota, Institute of Community Integration and Richard Amado, Department of Human Services.
3. Adult Mental Health Division and Children's Mental Health Division statutes and standards regarding restraint and seclusion
4. Alcohol and Drug Abuse Division standards regarding restraint and seclusion
5. Minnesota Department of Education's current standards regarding restraint and seclusion
6. Minnesota Department of Health current statutes and standards regarding protection of rights of individuals and restraint and seclusion
7. Measures and data about current restraint use:
    a. At the individual level, to measure positive practices attempted, outcomes observed, and evaluations of effectiveness
    b. At the provider level to measure use of restraints for review and continuous improvement
    c. At the statewide level, to measure trends that may highlight the need for training, other interventions to improve services and prevention of restraint use.
8. Assessment processes necessary to understand interfering behavior
9. Centers for Medicare &Medicaid Services (CMS) waiver requirements

[5] The underlining indicates this is a link to a Web site page.

10. Crisis services for children and adults with disabilities, including a presentation by Lorraine Pierce on Adult Mental Health Mobile Crisis Services and by Barb Roberts of Community Support Services on its training services, clinical support and technical assistance to help persons remain in their communities.
11. Other states' approaches, including a presentation by external experts Mike Mayer and Derrick Dufresne. Their report, titled "Considerations for Committee work Regarding Minnesota Rules 9525.2700-9525.2810 (Known as Rule 40): A Review of the States and related Resources" was prepared at the request of the Governor's Council on Developmental Disabilities and was shared with the committee. The report reviewed and analyzed practices in many states and made recommendations on revamping Minnesota's Rule 40.

For additional information on each topic, please see the meeting notes on the Rule 40 website.[6]

The Committee Process

The Department provided staffing to the advisory committee so that the meetings would be as productive as possible. Department staff provided guidance, resources, expertise and helped to set direction to keep moving toward a set of recommendations that could result in legislative changes, rule revision, waiver plan changes and a best practices manual. At the May 2012 advisory committee meeting, settlement class counsel and the Department presented to the committee the elements in the Jensen Settlement Agreement as a review of best practices agreed upon by the parties to the Settlement Agreement. The advisory committee adopted a framework based on the Settlement Agreement. Overarching framework elements were positive support strategies, prohibited techniques and restraint reporting and monitoring. The framework was the basis for its discussions and recommendations. The recommendations could be expressed in different formats including narrative, statute language, rule language, waiver plans or amendments or manual. Committee members decided to express their recommendations in a narrative format.

Considering time constraints and challenges of large group discussions, the advisory committee established work groups. Some committee members opposed forming work groups because the expertise in each work group meeting would not be afforded to the entire committee for discussion. Not all committee members were able to attend some of the work group meetings that they would have liked to attend. Despite these challenges, work groups were formed.

The work group sessions were voluntary and open to anyone interested in attending and participating. Each work group session considered policies, processes and standards for each topic as well as related subjects. Six work groups were formed to reflect the framework's points. The work groups were:

1. Person-centered planning – discussion included what is important in person-centered planning and evaluation of a person-centered plan
2. Positive support strategies – discussion included the components of positive support strategies and various triggers of different assessments and who can perform some of the roles

[6] The underlining indicates this is a link to a Web site page.

3. Emergency use of restraints – this work group expanded its discussion topic to include recommended prohibited techniques
4. Training – discussion included goals, recommended training topics for various roles involved in service delivery such as direct care staff, policy staff, case managers and others as well as methods of evaluating training delivered
5. Implementation of the new standards - discussion encompassed initial implementation of the standards broadly and how it will affect individuals as well as sustaining the changes
6. Monitoring, reporting, review and oversight of the use of restraints – discussions touched on the multiple aspects and levels of reporting and oversight and what roles need to perform what functions

Most work groups met twice for two-hour meetings. Each work group provided a verbal report of the work group's recommendation to the advisory committee. The advisory committee modified the work groups' recommendations and adopted a final set of recommendations[7] of its own to the department.

Resources Utilized

Pursuant to the Settlement Agreement, the advisory committee was provided and reviewed "the Arizona Department of Economic Security, Division of Developmental Disabilities, Policy and Procedures Manual, Policy 1600 Managing Inappropriate Behaviors" as part of its review of best practices. The corresponding Arizona Administrative Code section was also provided.

The Department provided additional resource materials both in original format and summary format for the advisory committee's use. The materials were provided in print at advisory committee meetings, via email to committee members and interested parties and on the department's public Rule 40 Advisory Committee website.[8] Resource materials included:

1. Professional and scholarly works regarding best practices (e.g., Association of Positive Behavior Supports, Substance Abuse and Mental Health Services Administration - SAMHSA)
2. All other states' rules, statutes and manuals (particularly Georgia, Nebraska, Arizona, Kansas, Michigan)
3. Subject matter expert presentations and selected resource materials
4. Presentations on other state agency and DHS divisions' statutes, standards and rules
5. CMS waiver application requirements

The Department established an internal work group to provide subject matter expertise to advisory committee members and during discussions. The purpose of this group was to gain insight on how the advisory committee discussions might impact other service areas and how their areas might serve as an example of how to implement positive practices. Members of this group attended the monthly Rule 40 Advisory Committee meetings as available. The internal work group met after each committee meeting to discuss any concerns about the committee's discussions and how it might impact or conflict with practices in their respective areas. Members also provided advice that might be helpful to advisory

[7] Please see Appendices D through J at the end of this document.
[8] The underlining indicates this is a link to a Web site page.

committee members and provided feedback on the committee meeting agendas. Many of the internal group members presented an informational presentation about their respective practice areas at a Rule 40 Advisory Committee meeting, as indicated by an asterisk (*)below.

The internal work group had representatives from:

1. Adult Mental Health Division*
2. Aging and Adult Services
3. Alcohol and Drug Addiction Division*
4. Children's Mental Health Division*
5. DHS Licensing Division*
6. Disability Services Division*
7. Federal Relations
8. Minnesota Department Health: Office of Health Facility Complaints*
9. Minnesota Department of Education*
10. Minnesota State Operated Community Services
11. Nursing Facility Rates and Policy
12. State Operated Services*

In keeping with the open meeting law, the committee meetings were regularly attended by representatives of other groups. These representatives were given an opportunity to participate in discussions. The groups include:

1. Advocating Change Together
2. Arc Greater Twin Cities
3. Barbara Schneider Foundation
4. National Alliance on Mental Illness (NAMI) Minnesota
5. Office of the Ombudsman for Long-Term Care
6. Office of the Ombudsman for Mental Health and Developmental Disabilities
7. Traumatic Brain Injury State Advisory Committee
8. University of Minnesota – Institute on Community Integration
9. Chrestomathy, Inc.

Overview of Advisory Committee Recommendations

The advisory committee discussed and through a consensus process adopted recommendations for the six work group topics listed above. The shift from a deficit model to a strengths model comes with many difficult challenges. Whenever possible, this document will describe the best practices followed by a brief description of why there was a lack of consensus when applicable.

The recommendations establish responsibilities for providers. That is, at the provider level, there must be policies, practices and plans in place. Providers must collect data and report incidents. The staff must review the data and make adjustments if there is no progress in plans or if there are two or more emergencies in six months, for example. Debriefing guidelines must be established and followed to reduce the number of future emergency uses of manual restraint.

The recommendations are provided here in a narrative format. For additional detail, please see the recommendation outlines[9] or meeting notes available on the Rule 40 website.[10]

At the June 20, 2013 meeting the Settlement Class counsel went on record regarding every recommendation. "Regarding the revised draft narrative document, the *Jensen* Settlement Class reiterates its previously stated position (*see, e.g.,* e-mail correspondence dated April 2, 17, May 4 and 6) that the Settlement Class does not support any provision of the Rule 40 Committee narrative that is inconsistent with, or in violation of, the Settlement Agreement. The revised draft narrative continues to include exceptions for the use of mechanical restraint with erroneous statements that the "advisory committee members recommend" the temporary use of mechanical restraints, that "the advisory committee acknowledges" situations allowing for temporary use of mechanical restraints, and that "the advisory committee recommends" that providers may continue temporarily using mechanical restraints. *See* Draft Narrative at pp. 20, 23. We have never agreed to such provisions. Rather, the parties to the *Jensen* Settlement Agreement, including the State of Minnesota and Department of Human Services, agreed to eliminate the use of mechanical restraint for the Facility as defined in the Settlement Agreement. As we have repeatedly conveyed, the definition of Prohibited Techniques in the Settlement Agreement was reached by consensus between the parties with active assistance from the consulting experts. The Prohibited Techniques section, like other sections of the Settlement Agreement, is best practices provisions that should be present throughout all State of Minnesota facilities.

The Settlement Class expressly preserves, and does not waive, all of its rights and positions."

Scope

The advisory committee recommends its recommendations be placed in Minnesota Statute chapter 245A so that it will have broad application to all DHS-licensed services and programs. These recommendations focus on positive support practices, person-centered planning and the most integrated setting and will apply to children and adults. The advisory committee recommends repeal of the current Rule 40 and that these recommendations manifest in rule, statute, and a positive support manual, and waiver plan amendments.

[9] Please see Appendices D-J at the end of this document.

[10] The underlining indicates this is a link to a Web site page.

General Recommendations

There are some recommendations that the advisory committee makes that applies generally and is not limited to just one work group topic.

1. The positive practices manual should provide examples to illustrate what the standards mean and intend. The examples should include application of the standards in mental health situations.
2. The Plan - Advisory committee members discussed and decided that instead of creating confusion over different plan names and what elements would go in which plans, they recommend one plan for each person affected by this policy. Throughout this document, you will see references to different plan sections, all of which may be part of the one plan for each person. All plans and sections would be developed using positive approaches and be person-centered. Within each plan, there will be different sections that address the individual needs and desires of the person for whom the plan is designed. Each plan will be comprised of, among other things, the following required components :
    a) Person's goals – lists the person's goals
    b) Positive strategies – describes what positive strategies will be used with the person, describes what is important to the person
    c) Person's needs – describes what is important for the person
    d) Intervention – describes what to do in a crisis short of emergency use of manual restraint
3. Committee members recommend the Department establish a small group of stakeholders to review the Georgia and Vermont positive support manuals and recommend adoption with modifications of other states' work.

Positive Support Strategies

The purpose of positive support strategies is to build repertoires of personal effectiveness for persons in licensed services. Skill building is a key purpose of services. On a pragmatic level, positive support strategies have been shown to be cost-effective.[11] All services and plans should be positive with a focus on quality of life improvement, including building skills they need to achieve their articulated desired life, self-management and self-efficacy, and not just alleviating target symptoms.

Advisory committee members created a framework of positive support strategies which informed their recommendations. Positive support strategies is the broader approach which encompasses person-centered planning, needs assessment, direct correspondence between the person's assessment and the person's positive supports, trauma-informed care, consultative and technical support for providers, and data, reporting and monitoring to ensure accountability.

Advisory committee members recommend:

1. Requiring providers to be trained, competent and use positive support strategies;
2. Proper screening tools or checklists be used to determine when functional assessment/functional behavioral assessments are necessary;
3. Using the existing mental health crisis services for children and adults and mobile crisis teams

Assessment. Based upon individual need there will be assessments in the areas of medical, habilitation/rehabilitation therapies, dental, mental health, or other necessary therapies. These assessments may be concurrent with a functional assessment/functional behavior assessment.

Advisory committee members recommend DHS develop criteria for providers to use to help the provider determine when a functional assessment/functional behavior assessment is necessary.

Specifically, the mental health assessment:

1. Should be completed by a mental health professional as defined in Minnesota Statutes section 245.462, subd. 18.
2. Mental health history and trauma history should be included.
3. Should assess for chronic stressors that do not rise to the level of trauma, such as economic stress and family dysfunction.
4. Should include a functional or diagnostic assessment.
5. Symptoms of mental illness should be treated with appropriate medications along with positive strategies. When working with people with mental illness, there is a role for a plan that builds skills and accounts for the role of environmental circumstances in symptom expression.
6. Should include the person's perspective and input.

[11] See "The Business Case for Preventing and Reducing Restraint and Seclusion Use" by the Substance Abuse and Mental Health Services Administration, Printed 2011. Advisory Committee members were provided an electronic copy. The underlining indicates this is a link to a Web site page.

The medical assessment:

1. Must assess for the presence of pain or discomfort.
2. Must assess whether the behavior relates to a physiological condition.
3. May include a dental exam.

Once the various assessments have concluded, the assessor with experience in multimodal assessment must integrate all findings. The assessor is to assume interfering behavior is intended to control the person's environment or to communicate something unless a mental health assessment finds the behavior is the result of symptoms of a mental illness. The providers should be cognizant of the possibility that dental pain is causing the interfering behavior. The assessor must hypothesize about what specifically is being controlled or communicated and then develop a plan to address that. The important point here is that providers must pay attention to the function of interfering behavior. Some committee members recommend the assessor be a positive behavior support expert.

Functional behavior assessments and functional assessments would occur whenever there is interfering behavior for which a positive strategies section is needed such as:

1. At the person's annual review or a MnCHOICES annual assessment;
2. If an emergency use of manual restraint is used;
3. If a person enters a new placement and has a history of having restraint used on them or interfering behaviors;
4. If a person is asked to leave their current setting due to interfering behaviors or if this is being considered;
5. If a decision has been made on a person's behalf that gets in the way of the person's ability to live their life (e.g., "you look too upset right now so I'm going to hold you back from work today.");
6. If a person engages in criminal conduct or conduct that could be criminal;
7. If a person is taking psychotropic medications AND
    a. Any change in DHS-licensed provider or
    b. The psychotropic medication is used to manage behavior or
    c. The provider needs to reassure that the person is still growing, improving, increasing and developing skills to improve richness and quality of life;
8. If a functional behavior assessment is done elsewhere such as at school or if the person is at risk of suspension from school; or
9. A person enters a DHS-licensed service with a dependency on a mechanical restraint.

Positive strategies section of a person's plan. The positive strategies section fills the role of an "intervention plan" that equips and prepares providers to positively and effectively help the person make progress in their personal repertoire towards the life they desire to live. The section must include:

1. Results of a functional behavior assessment done by a team or in consultation with a team of people that links to the positive strategies section;

2. The following five components:
    a. Contextual strategies
    b. Antecedent strategies
    c. Prompting and instructional strategies
    d. Reinforcement strategies
    e. Positive responses to problem behavior;
3. Desired outcomes that drive the positive strategies section including indicators that treatment has plateaued and when additional expertise on the treatment team is needed;
4. A clear and measurable description of the interfering behavior, including:
    a. description of events,
    b. times and situations that predict the occurrence and non-occurrence of the interfering behavior, and
    c. a description of consequences that maintain the interfering behavior;
5. A hypothesis based on data about why this behavior happens and what sustains it;
6. Identification and confirmation of the function of the interfering behavior (it is assumed the person uses the interfering behavior to control their world or to communicate something. The planner must get to specifics about what is being controlled and what is being communicated to determine the function of the interfering behavior.); and
7. Person-first language.

Committee members recommend a positive strategies section:

1. Accommodate the need for rapid and persistent changes;
2. Focus on quality of life improvement and not just whether target symptoms are alleviated;
3. Based upon best practices across disciplines; and
4. A screening tool or checklist for providers and counties to determine when there is a need for functional assessment /functional behavior assessment as considered in the positive strategies plan.

The advisory committee recommends a non-exhaustive list of permitted positive support strategy examples be provided in the forthcoming positive support manual.

Person-Centered Planning

Person-centered planning means a process for planning and supporting the person receiving services that builds upon the person's capacity to engage in activities that promote community life and that honors the person's preferences, choices, and abilities.[12] The person is always at the center of the process and their choices should be reflected in the selection of services and supports. Even in instances when a person is subject to legal restrictions, such as conservatorship, guardianship or commitment, the person should be given maximum authority possible within the legal restrictions. Person-centered

[12] Michigan Department of Community Health; Mental Health and Substance Abuse Administration; Person-Centered Planning Policy and Practice Guideline, 3/15/2011.

planning is not a one-time event. The case manager plays a critical role in a person accessing resources for person-centered planning.

Person-centered planning as a concept has been widely known for decades and utilized in Minnesota. The advisory committee wants to emphasize the centrality of person-centered planning for the future and recommend improved training and understanding of person-centered planning. The person is at the center of the planning process and the person identifies their circle of supportive individuals who should be included in the planning process with them. The advisory committee recommends that person-centered planning begin as early as possible.

The advisory committee recommends a separate person-centered section in each person's plan. The advisory committee further recommends that person-centered planning be done with a competent facilitator who has been trained in person-centered planning tools and be available to everyone who wants it.

The person decides what their goals are, what supports they want by whom, what services they would like; persons decide as much as possible for themselves. The person must be present for any planning done on their behalf.

1. The person can choose to do a person-centered planning section.
2. A person-centered plan section belongs to the person.
3. The person-centered plan section must:
    - Encompass and improve the person's quality of life, not just quality of care
    - Gather and consider the person's history from the person, the family or guardian and professionals
    - Be individualized based on the person's strengths, needs, culture and preferences.
    - Inform the provider of what actions to take with the person

Permitted Techniques

Permitted techniques are treatment methods that providers may use. Some techniques are obviously permitted, such as positive verbal feedback, while the permissibility of other techniques might be less clear, such as techniques that entail physical contact with the person.

Advisory committee members recommend that the following techniques, although they might entail some physical contact with the person, should be permitted. This is not an exhaustive list of permitted techniques.

1. Physical guidance such as hand-over-hand contact to facilitate a person's completion of a task or response that is directed at learning a skill when the person does not resist or the resistance is minimal as determined by the support team. The support team is the service planning team identified in Minnesota Statute section 256B.49, subdivision 15, or the interdisciplinary team identified in Minnesota Rules, part 9525.0004, subpart 14, whichever applies
2. Corrective verbal feedback
3. Physical contact, with no resistance from the person, to calm or comfort the person in distress

4. Minimal physical contact or physical prompt necessary to redirect a person's behavior when the behavior does not pose a serious threat to the person or others AND the behavior is effectively redirected with less than 60 seconds of physical contact by staff OR the physical contact is used to conduct a necessary medical examination or treatment by a licensed health professional
5. Response blocking
6. Mechanical devices for medical conditions
7. Temporary withholding or removal of objects being used as a weapon
8. Emergency use of manual restraint

The advisory committee recommends that use of permitted techniques be tied to notifications and reporting.

Some committee members raised concerns about guided escort and are unclear whether consensus was met. Some committee members recommend permitting brief, five-second or less holds. The concern is that if every single hold, even for a few seconds, is reported that the more concerning restraints will be lost in the sheer number of reports being made.

The committee members recommend the Commissioner develop a process for review of specific permitted techniques.

Prohibited Techniques

For further explanation of items listed below, please see the Glossary in Appendix A. Advisory committee members recommend the following techniques be prohibited:

1. Use of mechanical restraint
2. Prone restraint
3. Manual restraint except in the case of emergency
4. Seclusion
5. Time out and room time out
6. Chemical restraint
7. Use of painful techniques
8. Use of faradic shock
9. Deprivation or restriction of rights
10. Use of punishment of any kind
11. Any program that requires the person to earn normal goods and services or interferes with their fundamental rights.
12. All level programs that move a person down the hierarchy of levels or use a response cost procedure.
13. Speaking to a person in a manner that ridicules, demeans, threatens, or is abusive or other inappropriate vocalizations;
14. Requiring a person to assume and maintain a specified physical position or posture as an aversive procedure, for example, requiring a person to stand with the hands over the person's head for long periods of time or to remain in a fixed position;
15. Totally or partially restricting a person's senses, including a pillow or blanket over a face;

16. Presenting intense sounds, lights, or other sensory stimuli as an aversive stimulus;
17. Using a noxious smell, taste, substance, or spray, including water mist, as an aversive stimulus;
18. Forced exercise;
19. Using a person receiving services to discipline another person receiving services;
20. Any hyperextension or twisting of body parts;
21. Tripping or pushing;
22. Any exacerbation of any medical or physical issue;
23. Containment that is medically contraindicated; and
24. Containment without monitoring
25. Physical intimidation or show of force

The recommended prohibitions above represent the advisory committee's understanding of current best practices.

There is a lot of concern around the definition of "chemical restraint." Some committee members wish to clarify their intent that PRN use to treat a psychiatric symptom or disorder must:

- Be within the person's prescribed use of the medication;
- Be given to the person at the person's request;
- Be taken voluntarily; and
- "Standard treatment" may include PRN use of medication.

It must be noted that these standards allow for accommodations. For example, certain therapies (deep pressure interventions) for persons with disabilities may appear as manual restraint but are not.

Emergency Use of Manual Restraint

The Advisory Committee recommends that a provider may apply only manual restraint against a person in an emergency, which is defined as a situation, where the person's actions:

- pose imminent risk of physical harm to the person or others, and
- less restrictive strategies will not achieve safety.
- a person's refusal to receive or participate in treatment does not constitute an emergency.

Advisory committee members feel that the costs of restraint to the person are too high to include damage to property as the sole basis for restraint or refusal to participate in treatment or take medications. However, property destruction that poses an imminent risk of physical harm to the person or others when less restrictive strategies will not achieve safety meets the definition of an emergency that warrants emergency use of manual restraint.

The manual restraint techniques that will be permitted in an emergency cannot restrict the person's breathing, must not be medically contraindicated or apply pressure to the person's chest. Prone restraint is prohibited.

Temporary Use of Mechanical Restraint for Self-Injurious Behavior

Some committee members acknowledge that sometimes, albeit rarely, situations arise where temporary use of mechanical restraints for self-injurious behavior should be permitted. Some advisory

committee members recommend that a provider may temporarily continue the use of mechanical restraints when:

- The person exhibits serious self-injurious behavior;
- The person comes into a DHS regulated setting from a setting where mechanical restraints are permitted;
- Immediate removal of the mechanical restraints cannot be safely accomplished without significant risk to the person;
- Application of mechanical restraint has been initiated and was routinely used in other settings; and
- Positive behavioral support strategies have been tried.

Some committee members acknowledge that although the use of mechanical restraints needs to be eliminated, when an individual coming from other settings and has become dependent on the use of mechanical restraints, immediate cessation may present an unwarranted risk to the person.

Some committee members believe the use of any mechanical restraints does not represent best practices and should be prohibited.

Advisory committee members were not able to come to consensus on the use of mechanical restraints such as the use of seat belt restraints, guided escort, arm limiters, or other mechanical restraints intended to protect the individual from serious self-injurious behavior. Some committee members recommend seat belt restraints be permitted with a plan in place to move away from the dependency; they consider seat belt adapters to be different from mechanical restraints. Other committee members consider seat belt restraints like any other mechanical restraint that will be strictly prohibited with the exception of use during an implementation period.

Some committee members recommend specifically allowing the use of arm limiters when such use is under the care of a highly qualified mental health professional and used to prevent serious self-injurious behavior. The highly qualified mental health professional would develop and oversee the positive strategies used to wean the person's use of the arm limiters. The use of arm limiters would not be subject to an arbitrary time limit. Permitted use would be based on the person's progress. If progress plateaus, then additional mental health professionals should be consulted. The minimum professional level required to use arm limiters with a person would be a staff person subject to the third tier of the recommended staff training. The advisory committee recommends all of the same notifications, reporting requirements and monitoring as the Emergency Use of Manual Restraint section. Some committee members recommend that data be collected, analyzed and shared publicly while in compliance with HIPAA privacy.

Staff Training

Staff training is very important to the advisory committee. Training, and more importantly demonstrated competence, are keys to successful culture change. The overall goal of training is to produce highly competent staff who understand the new culture of how to work with persons with

disabilities. The advisory committee values making training affordable and accessible. This means providing interactive online curriculum when possible and appropriate. The committee recommends the effectiveness of training be measured through demonstrated competency of the skills in the setting in which services are provided.

The advisory committee established the following broad goals of training:

a. Improved quality of the service system
b. Improved culturally competent and responsiveness of the system
c. Increased recognition of the wide diversity of people protected by these standards
d. Increased and improved community capacity as described by John McKnight
e. Demonstration of competency by those receiving training
f. Provides a path to certification levels
g. Training methods incorporate the practices we are teaching (use PBS in training approach)

In addition to core training, the advisory committee recommends additional tiered training requirements for people based on the level of responsibility and qualifications. Core training is recommended for:

1. Direct care staff
2. Staff who implement positive support sections
3. Staff who create positive support sections
4. Staff who oversee positive support sections
5. Provider executives, manager and owners (non-clinical roles)

Training was discussed as an annual requirement and as orientation material. The advisory committee emphasized the importance of competency in the topics recommended without coming to consensus on a set hour requirement. Some advisory committee members recommend twenty hours of annual training. For comparative purposes, current training requirements in Minnesota Statutes Chapter 245B require 30 hours of orientation and annual training ranges from twelve to forty hours depending on how long the employee has worked in the field and if they work full- or part-time. Minnesota orientation training requirement is that within 60 days of hiring staff who provide direct services, the license holder must provide 30 hours of staff orientation. Minn. Stat. §245B.07, subd. 5.

Core training topics include, in non-priority order[13]:

1. De-escalation and crisis management[14]
2. Positive behavior supports
3. Review of prohibited techniques and why they are not effective or safe
4. Culture change

[13] The Advisory Committee did not set training topic priorities and recommends that additional work be done to establish priorities.
[14] The core elements of the Jensen Settlement Agreement were shared with the committee and adopted by it. The committee chose to use different topic headings. For example, the Settlement Agreement requires Therapeutic Interventions training while the committee's equivalent topic is de-escalation and crisis management.

5. Safety requirements
6. Person-specific knowledge and competence
7. Rights of the person
8. Basics of behavior change [and motivational interviewing]
9. Trauma-informed care
10. Vulnerable Adult Act and Maltreatment of Minors Act
11. Cultural competency
12. Person-centered planning
13. Staff roles
14. Reporting and documentation requirements
15. Human relations and respectful communications
16. Client-specific knowledge and competence
17. Personal accountability
18. Employee self-care and collegial care
19. Understanding diagnosis and medications
20. When to communicate with a person's family or guardian and when to call 911
21. Emergency use of manual restraint techniques and monitoring its use for signs of distress that require cessation.

The advisory committee recommends hands-on training including mentoring of staff. As noted above, the advisory committee values demonstration of competency and not just knowledge acquisition. Some committee members recommend that training on person-centered planning be provided on an as-needed basis or subject to competency testing in lieu of an annual training requirement.

The first tier of additional training is for behavior staff who implement positive support sections.

1. Additional de-escalation training
2. Additional positive support strategies training, subject to practical competency demonstration
3. Relationship between behavior and a person's environment
4. Staff self-care after emergencies
5. Supervisory skills, including collegial care and knowing how and when to communicate with the person's family, monitoring and training staff documentation and reporting
6. Diagnosis and medications
7. When to utilize crisis resources

The second tier of additional training is for behavior staff that develop positive support sections.

1. Additional theory training
2. Additional demonstrations of practical competency
3. Experience and demonstrated competence in developing actual behavior plans under supervision
4. Research and resources
5. Supervision, including how to train, coach and evaluate staff and communicate effectively

6. Continuing Education requirements relevant to their field

The third tier of additional training is for behavior staff who oversee positive support sections. The recommended training topics are:

1. Functional behavior assessment/functional assessment
2. How to apply person-centered planning
3. Recognizing the relationship of behavior and biology
4. How to integrate disciplines to develop plans
5. How to design and use data systems to measure effectiveness of care
6. Understanding resources of the human services system, its procedures and people in the local system

The fourth tier of additional training is for provider executives, managers and owners (non-clinical roles). The recommended training topics are:

1. Outcomes they and their staff are responsible to achieve
2. Clarity in role of clinical staff and non-clinical staff
3. How to include staff in organizational decisions
4. Where providers can access additional resources
5. Management of the organization based upon person-centered thinking and practices
6. Continuing education
7. Person-centered thinking at the organizational level and how to address it in their organization

Some committee members recommend combining the training in tiers two through four for Designated Coordinators and Qualified Developmental Disability Professionals into an interactive online curriculum.

The advisory committee further recommends the following training topics for case managers.

1. Continuing Education Units to keep current on innovations and evolving knowledge
2. Available resources
3. Case management monitoring and oversight roles and responsibilities
4. The monitoring and oversight roles and responsibilities of providers, licensing and others
5. In-depth person-centered planning and how to talk teams through it
6. The different approaches of person-centered planning (e.g., Planning Alternatives for Tomorrow with Hope (PATH), McGill Action Planning System (MAPS), Essential Lifestyle Planning (ELP), Personal Futures Planning (PFP), Person Centered Thinking (PCT))
7. Different components of the individual plan

The advisory committee recommends the following training topics be available to family members, legal guardians and conservators:

1. Resources about the system
2. Voluntary informed consent and the difference between substitute decision making versus making a decision in a person's best interest

3. Positive support strategies
4. Person-centered planning
5. De-escalation strategies

The advisory committee did not address the issue of resources needed to provide training for family members or what priority system could be put in place. Some committee members also recommend increasing compensation to providers to cover the extensive training recommended for staff.

For persons receiving services, the advisory committee recommends the following training be made available to them:

1. What their rights are in accordance to the applicable bill of rights
2. Person-centered planning
3. Access to training offered under core training topics

The advisory committee recommends the following training for DHS policy staff:

1. Core training topics
2. Same training recommended for case managers
3. In-depth training on person-centered planning for individuals and organizations and annual training in innovations and best practices in their field (e.g., aging, mental health, developmental disabilities)
4. Experiential learning through field trips and field work
5. Performance management: Evaluating program success and effectiveness

The advisory committee recommends evaluation of training. Committee members discussed and recommended using the Donald Kirkpatrick five levels of evaluation.[15] The five levels are:

1. Participant's satisfaction with the training
2. Competency demonstration by trainee, whether a test or skills demonstration
3. Measurement of behavior change as a result of training
4. Measurement of improved outcomes for persons as a result of training
5. Measurement of return on investment for training: Do outcomes make training sustainable?

In order to support a system of positive strategies, there must be sufficient formal and experiential training for case managers and providers. It is important that the training result in new observed and adequately demonstrated competencies, not simply knowledge or awareness-level learning.

Reporting and Notifications

Advisory committee members strongly value the role of reporting and oversight. The purpose of reporting and notifications is to reduce and eliminate the use of restraints. The advisory committee recommends a format for reporting that can be submitted electronically or by mail. The committee further recommends that the electronic form includes the ability to request additional help and requires

[15] See Appendix G.

the reporting of all permitted and unpermitted use of restraints. A person's voluntary use of restraints must also be reported.

The value of reporting can be expanded to include multiple purposes including trend analysis, incident analysis and moving the entire system away from past practices toward positive approaches.

The reporting and notification recommendation is in addition to and separate from other reporting requirements such as the Vulnerable Adult Act or Maltreatment of Minors Act.

Emergency Use of Manual Restraints

The advisory committee makes a detailed recommendation about what should be reported to the Department's licensing division and to whom additional notification of the emergency use of manual restraint should be submitted.

First, the advisory committee recommends that reporting should either work in conjunction with an existing process or be modeled after an existing incident reporting process. The initial report on the emergency use of restraint should be preserved as an original document and additions can be made as a follow up to the original report.

Process. The advisory committee recommends that reports be filed online and be computer-based. The advisory committee also recognizes the role of oral reports, written reports, aggregate reports, reviews and debriefing.

Notifications. The advisory committee recommends notifications go to:

1. Administration of the organization (owner, manager, etc.)
2. Designated internal reviewer within the organization
3. Person's family or guardian
4. Person's case manger
5. External reviewer
6. DHS – licensing and policy areas

What is reported. The advisory committee recommends the following information be reported to members on the notification list above:

1. All the people involved in the emergency use of restraint (e.g., staff, person, other clients, etc.)
2. Types of restraint used
3. Start and end time of restraint, including back-to-back uses of one or more restraints and when release attempts were made
4. What de-escalation measures were taken to avoid the restraint
    a. What techniques tried
    b. When were they tried
    c. How long were they tried
5. What was learned
6. Outcome of the restraint including:
    a. Any injury to staff or person and if so, provide a description

b. Whether any medical diagnostic or treatment occurred
c. How the persons involved were reintroduced into their environment

Other Events

Advisory committee members recommend reporting requirements for other events when used in response to mood and behavior in addition to emergency use of manual restraint. These other events are:

1. The person's hospitalization
2. Emergency responder/law enforcement/911 calls regarding a person
3. Any violations of the new standards such as use of a prohibited procedure with a person
4. PRN use of medications

The purpose of reporting and tracking hospital usage and calls to law enforcement or 911 is to be able to detect excessive use of such services. Excessive use of hospitals or 911 calls might indicate a provider's inability to properly serve the person or persons.

Although committee members acknowledge that some PRN use of medications is appropriate, some committee members recommend reporting all PRN use. There is general consensus that a person's hospitalization should be reported but inquiry was made about whether all hospitalization should be reported or just unplanned hospitalization.

Monitoring

Goals and Values

The advisory committee states that the goals of successful monitoring, reporting and oversight are:

1. Improved skills and growth of articulated desired life aspects of the persons by providing resources and non-punitive support to providers
2. Improved quality of life by improving quality of a person's care and support
3. Improved safety of persons and others
4. Reduced emergency use of manual restraint

The overall system goals are in keeping with how all persons should be treated with dignity and respect. This includes using positive supports rather than punishment to improve a person's care. This means improvement of service delivery, standards, resources and incentivizing desired outcomes. The committee hopes that these values and goals will result in the growth of provider competency and improve a person's skills and satisfaction.

Restraint Monitoring

Advisory committee members recommend monitoring persons during the emergency use of manual restraint to ensure the restraint is done in the safest way possible and to reduce risk of injury. When possible, a staff member who is not implementing the restraint should monitor the person. Advisory committee members recognize that some providers might not have sufficient staff on duty to monitor the use of individual restraint incidents in some instances.

There is another level of restraint monitoring in which the techniques the provider uses will be monitored to ensure appropriate techniques are used. Providers would report the emergency use of manual restraint techniques to the Department and other designated entities.

Internal Review

Some advisory committee members recommend an internal review process following every emergency use of manual restraint and other reportable events, to determine what happened and what can be learned from the situation. The internal review would focus on the emergency use of manual restraint context and antecedent circumstances.

The internal review should be led by a named individual who has been trained to conduct an internal review. Other staff involved in the restraint should participate. The internal review should include a debriefing of all staff involved, and include the person restrained when possible, to address any trauma, feelings or immediate emotional needs of the staff and person involved. The internal review should begin as soon after the emergency use of manual restraint as possible but no more than 24 hours after the restraint. Some committee members recommend allowing five days to complete the internal review.

The internal review should generate data that would be reported to the license holder.

This internal review is modeled after the internal reviewer role mandated in the Jensen Settlement Agreement for the MSHS-Cambridge facility.

External Review

Some advisory committee members recommend an external review process following every emergency use of manual restraint and other reportable events. The external review would focus on the broader context of the provider organization and its system to look for patterns, trends and ascertain a provider's overall capacity to serve the person. The external review is intended to determine whether the provider and the person are an appropriate fit. In addition, to the external review should help the provider improve and is non-punitive and could offer technical assistance. It would be the external reviewer's discretion to determine the level of necessary intervention.

The external reviewer entity would consist of a panel of people with a clinical focus and expertise. For example, members of the external reviewer entity should have both formal education and demonstrated competency and experience working with people with disabilities. The advisory committee recommends the external reviewer be resourced effectively.

Oversight

The purpose of oversight is to ensure the protection of persons' rights and safety. To that purpose, the advisory committee recommends that the following outcomes and indicators be measured and reported:

1. The use of emergency use of manual restraint
2. The use of positive support strategies
3. Trend analysis to determine where changes are necessary

4. Indications that persons' recovery, growth, or skill development is progressing and
5. Indications the new standards are accomplishing what they were intended to accomplish

Licensing

DHS Licensing is responsible to monitor and enforce licensing requirements for programs and services licensed to provide home and community based services according to Minnesota Statutes, chapters 245A and 245D. Monitoring is achieved through licensing reviews and investigations of licensing violation allegations. These functions include, in part, onsite visits and reviews of service recipient and personnel records, program policies and procedures, and program practices. Enforcement is limited to determining compliance with program planning and service delivery requirements; not making clinical judgments about treatment or service decisions.

Data

Advisory committee members recommend the oversight entity gather and maintain data sufficient to conduct trend analysis on a system-wide level and to detect potential problems at the provider level. The data should include all the restraint data above as well as data about training related to emergency use of restraints, monitoring, reporting, reviews and who has been trained and on what topics they have been trained.

Committees and Teams

Advisory committee members discussed piecemeal various forms and duties of different committees, teams and panels. For example, during implementation discussions, some committee members suggested an interdisciplinary team / steering committee to guide implementation of the changes. There would also be two separate teams handling the internal reviews and the external reviews. The external reviewer would consist of a panel including clinical experts. Interdisciplinary teams were again raised during the monitoring discussions. The composition and role of the interdisciplinary teams in the monitoring context was different from in the implementation context and would possibly be internal to the provider and required during an internal review. Department oversight functions would include regional committees/interdisciplinary teams and a statewide review board.

The advisory committee recommends a state level committee could serve in one or multiple capacities such as:

1. Performance reporting system and checking on the reliability, validity, and timeliness of data including emergency use of restraint, injuries, deaths, and not to prevent restraint, injuries and deaths
2. Review and advise on biennial review of positive practices manual
3. Make recommendations regarding resources

The advisory committee recommends formation of regional committees comprised of members from multiple disciplines and clinical expertise to participate in oversight, implementation and evaluation of practices.

Implementation

The advisory committee recognized that implementation will occur over a period of time and interpreted it to mean two stages. The initial stage includes passage of statutes, promulgation of rules, development of waiver plans and amendments as well as creation of a positive supports manual and gradually enforcing the new standards. Training must be implemented statewide and system-wide. The second stage is sustaining the changes.

Initial implementation recognizes the need to educate providers, family members, guardians, persons, advocates and other interested parties of the new standards and initiate the culture change toward positive supports. Providers will need time to come into compliance with the new standards before they are enforced. The department will need time to design and implement processes to effectively enforce the new standards. The implementation process will include an established date at which all prohibitions are in place and enforced.

Sustaining the changes recognizes the importance of maintaining the new standards to prevent regression to old practices and continue the momentum forward.

Initial Implementation

The advisory committee recommendation addresses the following key processes and elements, which are included in the following this list.

1. Overarching process
2. Creating culture change
3. Offering resources, training and technical assistance to providers
4. Providing incentives to providers, persons served and family members
5. Setting expectations
6. Process values
7. Timing
8. Evaluation

Overarching process. The advisory committee recommends using legislation, rulemaking, a manual and waiver amendments to establish new standards. The remainder of the overarching process is evident in the following processes and elements.

The work group and advisory committee recommend that preparations start immediately by communicating the new standards, particularly the shift from restraint, seclusion and aversive techniques. The advisory committee recommends starting those conversations in the community with providers, family members, persons served, advocates and other stakeholders.

Creating culture change. Advisory committee members see these standards as the foundation for creating a necessary and profound culture change. The culture change must be widespread; it includes providers, persons served, families, the department and communities.

Self-advocates, families and community members play a crucial role in successful culture change. This includes engaging parents and guardians early in the process and throughout the process to address their concerns. This includes utilizing the expertise of parents and guardians who already have these processes in place.

External experts Michael Mayer and Derrick Dufresne prepared a document for the Rule 40 Advisory Committee to use titled "Considerations for Committee Work Regarding Minnesota Rules 9525.2700-9525.2810 (known as Rule 40): A Review of the States and Related Resources."[16] Among other things, Mayer and Dufresne recommended applying all related rules to all settings that are designated for the support of people who have developmental disabilities, creating a technical assistance and training network to assure that staff are competent and ongoing training requirements that include demonstrations of competency. Mayer and Dufresne emphasized the importance of training, technical assistance and oversight.

Sustainability of the culture shift will require continued funding and valuing training and positive support strategies.

Offering resources, training and technical assistance for providers. More than anything, this advisory committee wants to see providers succeed with these new standards and sees the widespread availability of resources, training and technical assistance for providers as a key component to support culture change. The advisory committee wants to demonstrate the desired values by offering resources and technical assistance before applying sanctions.

The advisory committee recommends that implementation address providers at all stages of readiness for change. That is, some providers are already aligned with these new standards; some providers think they are already aligned but misapprehend the standards; and some providers have little alignment.

Providing incentives to providers, persons served and family members. The advisory committee realizes there are many challenges in some of the incentive ideas they recommend. Committee members recommend that the department offer incentives to providers to spur compliance. Possible incentives include:

1. Rewards
2. Honors or recognition
3. Financial incentives
4. Certification
5. Pay for performance

The advisory committee further recognizes that this culture change extends beyond the providers. Everyone involved, including family members, persons served and guardians, will be affected by the change and might need incentives to make this shift.

[16] This document was commissioned by the Minnesota Governor's Council on Developmental Disabilities for use by the Rule 40 Advisory Committee.

Setting expectations. The advisory committee specifically addresses the need to be prepared for glitches and problems during implementation. Most importantly, the advisory committee recognizes that implementation must be graduated and will take time. The advisory committee recommends:

1. A graduated, ramping-up approach;
2. Providers and staff must know what the new requirements are and the deadlines for the implementation process; and
3. The implementation deadlines will be based on facts and will not be arbitrary

Implementation process values. The advisory committee recommends these values be upheld in the implementation process planning, design and execution:

1. Transparency
2. Alignment of values
3. Collaboration
4. Flexibility
5. Recognition of varied levels of provider competencies
6. Oversight and accountability
7. Providing technical assistance to providers rather than punishing them
8. Acknowledge and address real-world challenges including limited funding
9. Statewide and system-wide training of providers on permitted techniques, including teaching alternate behaviors, before enforcement of the new standards

A recurring theme throughout the discussions, particularly in regard to implementation, was togetherness and support. The work groups and committee members value partnering with providers to ensure success. They recognize and appreciate the service that providers offer and the challenges in providing that service. Committee members are not looking to sanction providers but rather to enable providers to offer excellent service for everyone's benefit.

Timing options. The advisory committee recommends a phased approach to implementation. The phased implementation would be completed before the established end date when all the new standards are in full enforcement. Advisory committee members recommend:

1. Passage of legislation followed by stages of implementation and enforcement of the new standards in which all providers must come into compliance by a given date
2. Phases of implementation in which different providers have staggered dates of enforcement.

Some committee members believe that providers unable to meet their enforcement date would have to request and receive a temporary authorization to continue current practices beyond their enforcement date. Each request would include a plan to successfully move into compliance as quickly as possible and would be subject to renewal every 90 days.

During the initial implementation period, a provider would be held to existing standards until enforcement of the new standards applies to them. Some committee members recommend an overall implementation time period of eighteen months.

Evaluation. The advisory committee recommends evaluation of the implementation process based on formative data to make changes where necessary and to use implementation science findings and experts.

Interdisciplinary team. Committee members suggest a team that may include interagency members or interdepartmental members could be useful. The interdisciplinary team would guide the implementation of the new standards by focusing on language and terminology used in conversations but also researching other states' approaches to large-scale culture change.

The advisory committee recommends the person's team design a transition plan for each person who currently engages in self-injurious behavior for which mechanical or manual restraint is used or who have a plan that includes programmatic use of restraints in place. Data collection and monitoring of the person's progress would be reported to DHS licensing, the Ombudsman for Mental Health and Developmental Disabilities and any external review entity.

After the initial implementation period when all providers are subject to the new standards, persons new to licensed services and programs, such as those coming from a family home, who are dependent on mechanical or manual restraint will need a plan like the Temporary Use of Mechanical Restraint for Self-Injurious Behavior plan described above. Again, data would be collected, analyzed and shared publicly while in compliance with HIPAA privacy. The provider would then have one year to successfully complete the program and would be prohibited from using manual restraints.

Sustaining the Changes

The advisory committee specifically addressed sustaining the changes after the initial rollout and implementation of the new standards. This is an essential part of "implementation" and is consistent with the overarching goal to see success and not citations. The advisory committee recommends:

1. Continue providing resources and technical assistance;
2. Consider the future roles of Community Support Services (CSS), Metro Crisis Coordination Program (MCCP), Community Outreach for Psychiatric Emergencies (COPE) and Adolescent Crisis Services;
3. Continue to build capacity of an array of competent providers throughout the state;
4. Persons, self-advocates, family members, guardians, conservators and community members should continue to have an active role in sustaining the changes as referenced in the above "creating culture change" section;
5. Continue to use and update best practices as they change over time; and

6. Michael Mayer and Derrick Dufresne recommended[17] establishing ongoing training requirements that include competency demonstrations in specified areas such as:
    a. Primary preventative measures rather than restraint;
    b. Interventions that are less intrusive than restraints;
    c. Effective ways to de-escalate situations to avoid restraints; and
    d. Crisis intervention techniques that utilize alternatives to restraint.
7. Examine the need for additional professionals including behavior analysts, mental health professionals, and rehabilitative therapists to effectively implement the policies, assessments, service provision, technical assistance and evaluation recommended.
8. Recommend that the Commissioner pursue changes necessary to assure health care coverage including Medicaid payment for the services and professionals needed to implement the Committee's recommendations.

Providing resources and technical assistance. Committee members want to see the new service standards implemented successfully. It is their belief and value that success can be achieved if the providers are supported. This means continuing to provide resources and technical assistance. Resources may include, but not limited to, written materials or training courses. Technical assistance may include 24-hour hotline, access to clinical experts or crisis services such as CSS and MCCP.

Future roles of CSS, MCCP, COPE and Adolescent Crisis Services. Because of the heavy emphasis on training and technical assistance, we need to consider the future role of some of the crisis services. CSS is a part of State Operated Services and provides decentralized clinical consultation and technical assistance. MCCP works interdependently with individuals, private providers and public agencies in the Twin Cities metropolitan area to prevent crises that affect the residential or work (educational) placements of persons with developmental disabilities or related conditions and reduce the use of hospitalizations and civil commitments resulting from crisis situation. COPE is a Hennepin County program whose professionals are available to go where the person is, handle the immediate crisis and provide a clinical assessment. Adolescent Crisis Services is similar to COPE but for the adolescent population.

Building capacity. The discussions yielded anecdotal conclusions that capacity to build to this higher level of service will be a challenge. As with many new initiatives, available qualified professionals will be few in number in the beginning. To sustain the new standards and way of providing services, the community will need to grow the number of qualified professionals who can deliver and oversee the new service standards are met correctly.

Building capacity will entail training the trainers and coordinating with educational institutions on courses and degrees to create a new generation of professionals aligned with the needs of the new standards in Minnesota.

[17] Please see recommendation number six on page of their document "Considerations for Committee Work Regarding Minnesota Rules 9525.2700-2810 (known as Rule 40): A Review of the States and Related Resources". The underlining indicates this is a link to a Web site page.

Advisory Committee Recommendation Concerns

Concerns. These are some overarching concerns that some committee members have expressed in regard to establishing new service standards and how committee members have decided to address them.

1. Concern that providers will exit the system and new providers will not replace them and there will not be enough competent providers to meet the demand for services. Committee members discussed that with change, this is always a concern. Proper training of providers will alleviate some of this concern because once providers are trained on the new standards, there will be less fear that results in providers exiting the system.
2. The challenges of funding and resource limitations. Committee members discussed that this is always a concern as well. One way to address this is to stage implementation in phases and spread the demand on resources out while building capacity to provide services that meet the new best practices standards. Of course, finding the most efficient ways to deliver services and be in compliance will aid in meeting the funding limitations.
3. Concern about keeping persons safe and the increased cost of regulation. Committee members discussed that the whole point of the new standards is to keep persons safe. The increased cost of regulation can be handled much like the funding challenges raised above; spreading the costs out over time and finding efficient ways of doing things will mitigate concerns.
4. Concern about the current lack of data. Committee members requested a survey of current providers to gather some data about the use of restraints in licensed facilities. Although the results were disappointing, the Advisory Committee and the Department were both able to gain some useful information. In particular, data reporting must be quick, easy and affordable for the provider to report.[18]

[18] The Department is looking at an abbreviated interim data collection method while more permanent structures, which take more time, are being established.

Closing Words from the Department

The Department is committed to a set of actions that will create the culture we seek of positive approaches that respect the individual strengths, needs, and preferences of those receiving services and help them achieve a high quality of life. Based on the recommendations from the committee, the Department will take the following actions:

- Incorporate principles and key parameters from the recommendations into the proposed legislative language for the provider standards in section 245D that will apply to DHS licensed or certified providers who deliver home and community based services, Intermediate Care Facility for Persons with Developmental Disabilities program services, day training and habilitation, or semi-independent living services to persons with disabilities.
- Seek legislative authority to expand rule making authority more broadly than the Rule 40 Modernization Advisory Committee, and continue the rule making process to result in a rule that provides additional stakeholder input into the implementation of recommendations.
- Consult with people who use services, their families, case managers, advocates, providers and consultants who have demonstrated success and expertise on best practices through the rule making process, and in the development of policy and procedure manuals.
- Develop an implementation plan that adopts the recommendations of the Advisory Committee, including a phased implementation plan that provides for the necessary training and technical assistance to support best practices, and a plan for the oversight, and monitoring of provider practices and any emergency use of restraint or seclusion
- Develop a means to collect data on use of restraint or seclusion and begin collecting information from providers during 2013.
- Make available training and technical assistance on person centered approaches and best practices to those who conduct assessments, provide case management and provide services.
- Determine what changes are necessary after evaluating regulations for other services that the Department regulates, beyond those covered by the 245D home and community-based services standards, against the recommendations in this document to assure consistency with the principles adopted by DHS.

The Department thanks the members of the Rule 40 Advisory Committee, for their diligence and dedication to completing their charge of recommending changes to modernize Rule 40. They put in significant time, and through thoughtful discussion and debate developed a roadmap to a future that will better support people with disabilities as they live, work and play in our communities. Thanks also go to the many people who attended the meetings, followed the progress of the committee and provided their perspectives and suggestions to the recommendations.

Lastly, we acknowledge and thank the many staff from across the different administrations of the Department and other state departments who participated and supported the work of the advisory committee and will continue to work together as we move into developing our implementation plan and bringing the recommendations to reality.

Next Steps for the Department

The Department anticipates the following action items:

1. Propose statutory language
2. Develop an interim data collection process to better understand the current use of all aversive and deprivation procedures currently permitted under Rule 40 while more permanent structures are being proposed to the legislature
3. Continue the rulemaking process
4. Develop a provider manual on positive support strategies
5. Develop statewide training and technical assistance

The Department invites advisory committee members to follow the progress of the new legislation, rulemaking, waiver amendments and positive supports manual that will follow this set of recommendations.

Appendix A – Glossary of Technical Terms

The following terms are technical terms or are used in a technical sense in this document. For clarification, we have provided the following definitions.

1. Adaptive Assessment –An assessment that measures capacity and skills of a person.
2. Chemical restraint **–** This is a prohibited technique. "The administration of a drug or medication when it is used as a restriction to manage the [person's] behavior or restrict the [person's] freedom of movement and is not a standard treatment or dosage for the [person's] condition. Orders or prescriptions for the administration of medications to be used as a restriction to manage the [person's] behavior or restrict the [person's] freedom of movement shall not be written as a standing order or on an as-needed basis (PRN)."[19]
3. Containment without monitoring –This is a prohibited technique. Containing, restricting, isolating, secluding or otherwise removing a person from the stream of daily activities or fully or partially immobilizing a person without being monitored for medical and psychological distress. This includes sending a person to a bedroom to cool off, calm down or relax when there is no plan to monitor the person who has been sent off.
4. Crisis Plan – The written plan developed to provide the service provider with evidence-based techniques to help support a person during a period of crisis.
5. Deprivation - This is a prohibited technique. Removal of or denial of access to a particular reinforcer for a period of time.
6. Designated Coordinator – refers to the designated staff person responsible for evaluating the delivery of services by a license holder. The designated coordinator is responsible for reviewing and evaluating incidents that occur during the delivery of a license holder's services, and creating strategies to prevent incidents in the future.
7. Emergency – A situation when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. A person's refusal to receive/participate in treatment shall not constitute an emergency. Damage to property that does not pose an imminent risk of physical harm to self or others does not constitute an emergency.
8. Emergency Use of Manual Restraint – This is a permitted technique. An emergency in which a manual restraint is used when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. A person's refusal to receive/participate in treatment shall not constitute an emergency situation.
9. Faradic shock **–** Faradic shock is a prohibited technique**. Faradic shock m**eans of or pertaining to a discontinuous, asymmetric, alternating current from the seconding winding of an induction coil.
10. Functional Assessment – Refers to the assessment defined in the Adult Mental Health Act, Minnesota Statute 245.462, subdivision 11a or the Children's Mental Health Act, Minnesota Statute 245.4871, subdivision 18.

[19] This definition is from page three of Attachment A to the Jensen Settlement Agreement. The bracketed portion indicates where terminology was modified for consistency. The Settlement Agreement used "resident" while the recommendation uses the term "person."

11. Functional Behavior Assessment – An assessment that operationally defines the interfering behaviors, identifies the situations in which the interfering behaviors are likely to occur and not occur, and generates a hypothesis of why the behavior occurs.
12. Interfering behavior – Means a behavior or psychiatric symptom that prevents a person from a more integrated setting or from participation in the most integrated setting.
13. Level programs – Level programs are prohibited if they entail a response cost procedure. Level programs means a type of program in which participants move up and sometimes down a hierarchy of levels contingent on meeting specific performance criteria with respect to target behavior. Moving up a level gains access to more privileges and the person is expected to demonstrate more independence. Moving down a level reduces privileges and provides access to a smaller universe of opportunities. Losing privileges and moving down a level is a response cost procedure (i.e., negative punishment). Some level programs are a permitted technique; some
14. Manual restraint **–** Manual restraint is a permitted technique when used in an emergency. Manual restraint means "physical intervention intended to hold a [person] immobile or limit a person's movement by using body contact as the only source of physical restraint. It is any manual method that restricts freedom of movement or normal access to one's body, including hand or arm holding to escort a person over [the person's] resistance to being escorted. The term does not mean physical contact used to: facilitate the person's completion of a task or response when the [person] does not resist or the [person's] resistance is minimal in intensity and duration; conduct necessary to perform medical examination or treatment; response blocking and brief redirection used to interrupt a person's limbs or body without holding a person or limiting [the person's] movement; or holding [a person], with no resistance from that [person], to calm or comfort."[20]
15. Medical restraint – Medical restraint is a permitted technique. Medical restraint means when devices are used to treat a person's medical needs to protect a person known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a person with physical disabilities in a manner specified in the person's treatment plan. Medical restraint and psychotropic and/or neuroleptic medications shall not be administered to clients for punishment, in lieu of adequate and appropriate habilitation, skills training and behavior supports plans, for the convenience of staff and/or as a form of behavior control.
16. Negative reinforcement – The removal of a stimulus or consequence that results in a behavior increasing. For example, if a person pretends to be sick to get out of having to complete their house chores, they may be negatively reinforced because they avoided having to do chores. If they pretend to be sick in the future to avoid chores, we can assume that getting out of chores negatively reinforces pretending to be sick.
17. Pain – Pain is a prohibited technique. Pain includes physical pain, mental pain, or emotional distress**.**
18. Person Centered Planning – A family of approaches to organizing and guiding community change in alliance with people with disabilities and their families and friends; a strategy used to facilitate

[20] This definition is from page 2 of Attachment A to the Jensen Settlement Agreement. The bracketed portions indicate where terminology was modified for consistency. The Settlement Agreement used "client" and "individual" and pronouns while the recommendation uses the term "person."

team-based plans for improving a person's quality of life as defined by the person, their family and other members of the community and that focuses on the person's preferences, talents, dreams and goals.

19. Positive Reinforcement – Positive reinforcement is a permitted technique. Positive reinforcement is a procedure in which a consequence or stimulus is presented following a behavior and the behavior increases. For example, a person completes their chores and is immediately given monetary reward or allowance. If that person does their chores more often, we can assume that the monetary reward was a positive reinforcer.
20. Positive Strategies section – the section of the person's plan that fills the role of an "intervention plan" that equips and prepares providers to positively and effectively help the person make progress in their personal repertoire towards the life they desire to live.
21. Prone restraint – Prone restraint is a prohibited technique**.** Prone restraint is **a**ny manual restraint that places the person in a face-down position. Prone restraint does not include brief physical holding of a person who, during the emergency use of a manual restraint, rolls into a prone or supine position as long as staff restore the person to a standing, sitting or side-lying position as soon as possible. [21]
22. Punishment – This is a prohibited technique. A procedure used to reduce or stop a target behavior.
    a. **Positive or Type I punishment.** Decreasing the rate or future likelihood of a target behavior by applying an aversive. Type I punishment includes overcorrection techniques.
        i. **Positive practice overcorrection**. The use of a behavioral change tactic based on positive punishment in which, contingent on the selected target behavior, the learner is required to engage in effortful behavior directly or logically related to fixing the damage caused by the selected target behavior. Example: A person failed to make his bed when asked to do so. The person is required to make his bed ten times or to make his bed and all of his housemates' beds.
        ii. **Restitutional overcorrection**. A form of overcorrection where contingent on the selected target behavior, the person is required to clean, repair, or correct the damage or return the environment not only to the original state but to bring the environment to a condition vastly better than it was prior to the selected target behavior. Example: A person spills a cup of milk. Not only is the person required to clean up the milk and safely dispose of the broken glass, but is required to vacuum and mop the entire house (the overcorrection).
    b. **Negative or Type II punishment.** Decreasing the rate or future likelihood of a target behavior by removing a positive reinforcer. Negative punishment includes but is not limited to:
        i. **Response Cost.** The use of negative punishment in which, contingent on a behavior, a specific amount of a reinforcer is removed.
        ii. **Loss of privileges**. Reduction in status and/or access to reinforcers due to a levels change in a token economy or another levels-based program.
23. Qualified Developmental Disability Professional (QDDP) - An individual who meets the qualifications specified in Code of Federal Regulations, title 42, section 483.430.
24. Response Blocking – Response blocking is a permitted technique. Response blocking is the use of physical means to temporarily block a physical blow or to physically intervene as soon as the person

[21] This definition is from page two of Attachment A to the Jensen Settlement Agreement.

begins to emit the selected target behavior to prevent or "block" the completion of the response. Response blocking does not involve immobilizing a person in any manner.

25. Restriction of rights – This is a prohibited technique. The removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Often times the positive reinforcer is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer.
26. Rights –The controlling rights afforded to a person in a licensed setting and includes the right to privacy from visual and audio taping unless a signed consent form is completed and room monitors and door alarms.
27. Seclusion – This is a prohibited technique. "The placement of a person alone in a room from which egress is:
    a. noncontingent on the person's behavior; or
    b. prohibited by a mechanism such as a lock or device or by an object positioned to hold the door closed or otherwise prevent the person from leaving the room."[22]
28. Target behavior –A response that is made the object of analysis.
29. Time out and room time out – Time out and room time out are prohibited techniques. Time out and room time out means "removing a person from the opportunity to gain positive reinforcement and is employed when a person demonstrates a behavior identified in the [individual program plan] for reduction or elimination. Room time out means removing a person from an ongoing activity to a room (either locked or unlocked)."[23]
30. Token reinforcement programs that require the person to earn normal goods and services – This is a prohibited technique. Token reinforcement programs that deprive the person of normal goods and services such as phone use, normal access to food, water, outings into the community, privacy and movement.
31. Trauma-informed care –An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. (SAMHSA definition)
32. Use of mechanical restraint – Use of mechanical restraint is a prohibited technique. Mechanical restraint means the use of a device to limit a person's movement or hold a person immobile as an intervention precipitated by the person's behavior."[24] "The term does not apply to devices used for medical restraint. Mechanical restraint includes the use of metal handcuffs, shackles, leg hobbles, cable tie cuffs, PlastiCuffs, FlexiCuffs, posey cuffs, Velcro soft cuffs, fabric straps, and any other mechanical means to restrain a person. Use of mechanical restraint is a prohibited technique.
33. Use of painful techniques – Use of painful techniques is prohibited. Painful techniques **m**eans the use of any technique that induces pain, causes damage, illness or injury or restricts breathing. This

[22] This definition is from page three of Attachment A to the Jensen Settlement Agreement.
[23] This definition is from page three of Attachment A to the Jensen Settlement Agreement. The bracketed portion indicates a term that might not be consistent with the remainder of the document or direction of the new standards.
[24] This definition is from page two of Attachment A to the Jensen Settlement Agreement.

includes intentional infliction of pain or injury, intentional infliction of fear of pain or injury, dehumanization and degradation.

34. Use of punishment of any kind – Use of punishment of any kind is prohibited. This means any aversive technique that punishes in any form. Examples of punishment includes revocation of a planned outing as a consequence of a person's behavior, hitting, pinching, or slapping, water misting, overcorrection, withholding money, deprivation of meals, sleep, clothing, medications, medical treatments, or therapy.

Appendix B – Jensen Settlement Agreement

Click the link to see the entire Jensen Settlement Agreement.[25]

[25] The underlining indicates this is a link to a Web site page.

Appendix C – CMS Waiver Instructions

Section G-2: Safeguards Concerning Restraints and Restrictive Interventions

Section G-2 "concerns the use of restraints and/or restrictive interventions during provision of waiver services. When either is permitted, the state must specify the safeguards that it has established concerning their use and how the state ensures that such safeguards are followed. Providing effective safeguards in the use of restraints and/or restrictive interventions is integral to assuring the health and welfare of waiver participants. When restraints and/or restrictive interventions are not permitted, the state must have a means to detect unauthorized use."

Click the underlined link to see the detailed instructions for completion of section G-2.

Appendix D – Positive Support Strategies Summary (REVISED 8.6.12)

Minnesota Department of **Human Services**

Rule 40: Positive Support Strategies

Revised following August 6, 2012, Advisory Committee Meeting

Attended one, two, or three work group meetings:

Rick Amado, DHS-SOS; **Maria Anderson,** DHS-AMH; **Jane Brink**, LTC Ombudsman**; Stacy Danov**, DHS-SOS; **Renee Jensen**, Barbara Schneider Foundation; **Jill Johnson,** DHS-CMH; **Bob Klukas**, DHS-Rules; **Sue McGuigan,** TBI Advisory Council; **Tim Moore,** Rule 40 Advisory Committee; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz,** Rule 40 Advisory Committee; **Lauren Siegel**, DHS-DSD; **Mike Tessneer,** DHS-Office of Compliance; **Suzanne Todnem**, DHS-DSD; **Cheryl Turcotte**, MH-DD Ombudsman; **Charles Young**, DHS-DSD; **Gail Dekker**, DHS-DSD, facilitator;

I. *Context and reminders*
   A. The charge of the work group was to recommend standards that will apply to persons with disabilities
   B. The standards will be expressed in statute, rule, and manual

II. *Terminology*
   A. Use the term "positive strategies" which is broad and can apply to multiple populations rather than "positive behavior supports" which is most often used with people with developmental disabilities. This is to contrast with and veer away from any use of aversive procedures, deprivation or punishment.
   B. Do not use "intervention plan" but no replacement terminology suggested. Will use "intervention plan" until a replacement term established in order to distinguish from other plans.

III. *Positive Strategies Framework has these components:*
   A. Contextual values (person-centered values)
   B. Assessment
   C. Bridge between assessment and intervention plan

D. Intervention plan: one plan across disciplines; plan focuses on skill building across disciplines
E. Data, reporting and monitoring
F. Consultation support for providers
G. Professional credentials
H. Reference to manual for guidelines and standards

IV. Functional Behavior Assessment Components

A. Undertake a medical, dental, and mental health diagnostic assessment to rule out those causes. However, do not wait for a mental health diagnostic assessment to begin a functional behavior assessment (can be concurrent).
B. The mental health assessment:
    1. Should be completed by a mental health professional.
    2. Mental health history and trauma history should be included, not just a current mental health assessment.
    3. Should assess for chronic stressors that do not rise to the level of trauma, such as economic stress and family dysfunction.
    4. Should include a functional or adaptive assessment.
    5. Genetic symptoms of mental illness should be treated with appropriate medications along with positive strategies. When working with people with mental illness, there is a role for a plan that builds skills.
C. The medical assessment:
    1. Must assess for the presence of pain or discomfort.
    2. Must be related to the challenging behavior or symptom. It is not sufficient simply to refer to a prior physical.
    3. Must include a dental exam.
D. Need to integrate all findings.
E. Assume challenging behavior is intended to control the person's environment or to communicate something. The assessor must go further and hypothesize about what specifically is being controlled or communicated and then develop a plan to address that.
F. Regarding the current Rule 40: Maintain section 5 of current Rule 40 that speaks to keeping person's records, medical and other histories for five years.

V. When would a functional behavior assessment (FBA) be needed or triggered?

A. When emergency restraints are used.
B. When someone has a history of having restraints used on them.
C. When a person is asked to leave the place they're living in due to challenging behaviors or if this is being considered.
D. When a person is asked to leave a day program or service due to challenging behaviors or if this is being considered.
E. When a person has a history of behaviors of concern.
F. When a decision has been made on a person's behalf that gets in the way of the person's ability to live their life.
G. When a person engages in criminal conduct or potentially criminal conduct.
H. When a person is taking psychotropic medications.

1. Upon admission to a new provider, if the person is taking psychotropic medications, or
2. If the person is taking psychotropic medications to manage behavior
3. To assure person still building capacity where possible

I. At the person's annual review.
J. At the time of a MnCHOICES annual reassessment
K. If an FBA is done by a school, it needs to be comprehensive, not just for school.
    1. And/or this should be done when the person is at risk of or is suspended from school
L. Incidents are defined in Licensing standards. A pattern of incidents could be one trigger for an FBA.
M. Give providers a screening tool. There are, for example, known behaviors with certain conditions like brain injury.
    1. It would be case managers' responsibility to use the screening tool at annual review to ask about behaviors.
N. The 245B risk management assessment could be another trigger to ask whether an FBA is needed.
O. Consider the community's response to any behavior as part of the norm. What is a reasonable person's view of a certain behavior? For example, is a thrown plate always a crisis?
P. Pattern of incidents (to be defined) – for early detection of need
Q. Checklist – providers could possibly use a checklist/flow chart that would determine when an FBA or other diagnostic is necessary as a screening tool.

VI. The assessment and positive strategies plan must include:

A. The FBA must be done with a team.
B. There are five components of a positive strategies plan:
    1. Contextual strategies
    2. Antecedent strategies
    3. Prompting and instructional strategies
    4. Reinforcement strategies
    5. Positive responses to problem behavior
        1. Note that a crisis plan is separate from the positive support plan.

C. Desired outcomes should drive the intervention plan.
D. A clear and measurable description of the challenging behavior, description of events, times and situations that predict the occurrence and non-occurrence of the challenging behavior, and a description of consequences that maintain the challenging or problem behavior: reinforcement, punishment.
E. The planner must develop a hypothesis about why this behavior happens and what sustains it.
F. Through direct observation, the planner identifies and confirms the function of the challenging behavior. It is assumed that the person uses the challenging behavior to control their world or to communicate something. The planner must get to specifics

about what is being controlled and/or what is being communicated and the function of the challenging behavior.

G. Others, in addition to the planner, can be trained to gather the data that either supports or does not support the hypothesis.
H. The plan must use person-first language.

VII. What positive support strategies look like:

A. Training for case managers and providers – e.g., de-escalation, crisis services instead of calling 911
B. Quality of life improvement; not just whether target symptom alleviated
C. Not disability-specific language or approach
D. Providers and counties need screening tool or checklists to determine the need for functional behavior analysis (FBA). Considered in the development of the intervention plan.

VIII. *Credentials of person doing assessment and creating plan*

A. Both formal training and experience. Person must have training in behavior analysis by a recognized training group. The person must also adopt the philosophy.
B. Person must have competency to develop and implement a plan. It's more important to have quality checks than qualifications.
C. Concern about bleed-over from other professionals who claim the qualification with little training or experience.
D. Credentials are needed to prevent harm.
E. Question: Who will determine or assess the competency of competency assessors if not professional boards or associations?
F. Note: The waiver provider standards initiative has defined several levels of behavior workers as described below. The more comprehensive the FBA needs to be and the more intense the behavior strategies plan needs to be, the more qualified the behavior worker needs to be.
    1. A behavior specialist may assist in providing observations for an FBA and implement a behavior plan under the supervision of a behavior analyst or behavior professional;
    2. A behavior analyst may conduct an FBA and develop a behavior plan under the supervision of a behavior professional and may supervise the work of a behavior specialist;
    3. A behavior professional, who is licensed, may review behavior plans developed by others as well as develop behavior plans him/herself and supervise behavior analysts and behavior specialists.

G. Note that some credentials don't fit will with all disciplines and populations.. For example:
    1. Mental health uses peers with mental illness to create peer-developed plans (wellness reaction plan).

2. How well does this approach apply to crisis respite providers or residential providers?

H. Be thoughtful about the cost factor of these requirements: training, experience, ability to pass a competency test, level of person who can conduct an FBA.

IX. Outcomes and Evaluation

A. Use evidence-based practices
B. The person is growing and developing/gaining skills
C. Implement changes one at a time and evaluate outcome
D. Note that an FBA and positive strategies plan is not a one-time event, but a process that must be reviewed (and possibly on-going) and outcomes evaluated to measure progress toward plan goals.
E. Use MnCHOICES annual reassessment as a way to conduct such a review and evaluation.

X. Crisis response

A. Remember that CSS and MCCP provide crisis services in Minnesota. A lot of funding goes into this. We should use the existing structure.
B. But we need to make sure they collect data to ensure their plans are working.

XI. External review (for monitoring, reporting, etc. work group)

A. When and to whom?
B. Recommendation or mandatory instruction from external reviewer
C. Reporting – what, when and to whom?
D. Look at required credentials and experience for an FBA and to develop and monitor and evaluate a positive supports plan.

XII. Concern about similar terms, which need to be defined

A. Mental Health: Functional Assessment
B. Developmental Disabilities: Functional Behavior Assessment
C. Education: Behavior Plan for IEP school services
D. Minnesota Health Care Programs (MHCP): Individual Behavior Plan (IBP)

XIII. Comments and Concerns following 8/6/12 Advisory Committee Meeting

A. Re: scope of this effort: Great concern about how this approach might be integrated into the Elderly Waiver (EW) and apply to people with dementia.

Appendix E – Person-centered Planning Summary (REVISED 8.6.12)

Rule 40: Person-Centered Planning- July 16th and 27th

Revised following August 6, 2012, Advisory Committee Meeting

Attending one or both work group meetings:

Rick Amado, DHS-State Operated Services; **Maria Anderson**, DHS-Adult Mental Health; **Mark Anderson**, Barbara Schneider Foundation; **Erwin Concepcion**, DHS-State Operated Services; **Stacy Danov**, DHS-State Operated Services; **Sue McGuigan**, Traumatic Brain Injury Advisory Committee; **Sandra Newbauer**, Office of Ombudsman, Long-term Care; **Brad Hansen**, ARC (by phone); **Renee Jensen**, Barbara Schneider Foundation; **Jill Johnson**, DHS-Children's Mental Health; **Bob Klukas**, DHS-Rules; **Lauren Siegel**, DHS-DSD; **Bonnie Jean Smith**; Rule 40 Advisory Committee**; Gloria Steinbring,** self-advocate and Rule 40 Advisory Committee; **Cheryl Turcotte**, Office of Ombudsman DD/MH; **Mike Tessneer**, DHS-Compliance **Jill West**, People, Incorporated (by phone); **Suzanne Todnem**, DHS-DSD; **Gail Dekker**, DHS-DSD, facilitator;

I. Context and reminders
   A. The charge of the work group is to recommend standards that will apply to persons with disabilities.
   B. The standards will be expressed in statute, rule and manual.

II. Components of a Person-Centered Plan (PCP)
   A. Facilitation of a Person-Centered Plan
      1. The person's voice is most important. The person must be involved and at the center of the planning process, as well as invited to identify their circle of support to also be included in the process.
      2. The PCP facilitator must be independent (meaning the facilitator has no other role in the person's life unless chosen to play this role by the person) and certified by a recognized professional group such as MAP, ELF, etc This facilitator must use agreed-upon, evidence-based PCP tools and keep documentation of the PCP process. The county case manager would have a list of certified facilitators.
         a. The provider should not facilitate the creation of a PCP because it is the PCP is broader than a care plan, it is not the provider's role and it would be a conflict of interest.

b. See the Michigan document on the independent, external facilitator. (See July advisory committee meeting handout #13)

B. Indicators that the plan is person-centered: The plan must:
1. Encompass the person's quality of life, not just quality of care.
2. Gather and consider history of the person from family, friends and certain professionals, as well as by truly listening to the person and their needs.
3. Be individualized based on the person's strengths, needs, culture, and preferences.
4. Build on the person's natural skills, talents and interests.
5. Be reflective of the person's goals (e.g., at one year, five years, and beyond), and dreams for the future, as well as written in first-person.
6. Address skill development to achieve the person's goals in the PCP; skill development is tied to the person's valued outcomes.
7. Take into account what should be avoided/what the person doesn't want in their life.
8. Collectively find a balance between the person's desires and safety concerns.
9. Be an action plan with steps to be taken, along with realistic timelines and measurement for goals.
10. Have "dignity of risk"
    a. Identify the supports needed to accomplish the PCP.
    b. Refer to Michigan document section on "Wellness and Wellbeing" as resource.

11. Move toward an individualized budget controlled by the person that recognizes and includes important informal supports.
    a. Note that counties are developing the option of creating unlicensed person support plans, similar to CDCS.

C. Review/Evaluation of Person-Centered Plan
1. The provider would translate how they express the values of choices from the PCP in any of the other plans for that individual.
2. There would be a checklist for the PCP facilitator with PCP elements/values, complete with a list of minimum requirements.
3. The person is interviewed by the PCP facilitator to see if they feel respected, satisfied with the outcomes so far, engaged in planning, happy, and if there need to be changes made to the plan.
4. Routinely measure the progress made on the plan's goals and adjust the plan's goals based on the person's development.
5. Kansas has a process satisfaction survey that can guide evaluation of a PCP meeting process; this can be done by a third party or as a facilitator self-check.

D. The Role of the Case Manager and Provider in Person-Centered Planning
1. It is most important to respect the person's preferences about who is involved in creating the PCP.
2. The PCP is a tool offered to a person by their case manager in the case of challenging behavior, but not just for a behavior crisis. The case manager would contract out for creation of a PCP.
3. Think of the PCP as similar to an advanced directive—just as an advanced directive belongs to the person and is shared with all medical providers, a PCP belongs to the

person and is shared with the case manager and all providers to direct their planning on behalf of the person.
    a. The person decides what in the PCP to share and with whom.

4. There should be a checklist for providers. It should ask whether a new client has a PCP. If not, the provider's role is to notify the case manager so one can be arranged. If yes, the question for the provider is how did the provider apply the PCP to the ISP (Individual Service Plan)?
    a. See the Michigan document on how to integrate the PCP into the ISP.
    b. Add to ISP checklist: Did the team offer the person a PCP? Then describe what action was taken.

5. Training will be needed for case managers and providers on PCP and their roles.
6. Because of the crisis prevention component of a PCP, if a person doesn't want a PCP, there should be another plan that addresses crisis prevention that is person-centered.
7. All other plans should be person-centered; if a PCP is not done, there are other plans that will ensure the quality of life for the person. Ideally, the PCP is the contextual representation of the lifestyle of the person that guides other plans and leads to better outcomes.
8. If the person refuses to have the provider involved in the PCP process, it is the provider's responsibility to honor that wish and utilize the PCP when creating all other required plans.
9. The planning process and an established grievance and dispute resolution process must be communicated to the person in a way they can understand.
10. The case manager and providers need to check that the PCP is current, because it may need to be updated. The person's goals may have changed but the PCP doesn't reflect that.
11. Consider using informal supports as a way to get a PCP done.

III. Rejections

A. Broaden the definition of "medically necessary" to encompass person-centered planning. The Michigan document definition is a good resource. There was consensus as to the absolute importance of a person-centered approach to all service and lifestyle planning.

IV. Recommendations

A. All persons receiving services covered by this rule have or have available a person-centered plan (Yes-8, No-0, Person's Choice-1)
    1. A person-centered lifestyle plan is less expensive than a crisis intervention, so there is value in suggesting that all clients have a PCP, complete with a crisis prevention plan.
B. All person receiving services covered by this rule have or have available a person-centered program plan and a person centered service plan, both guided by the PCP, if one is available. (Yes-10, No-0, Maybe-1).
C. The PCP directs all legally required plans.
D. There need to be safeguards to protect against provider/system takeover and to ensure that an individual knows their rights regarding the PCP.
E. Default is that a person with a guardian would receive a PCP.

V. Special Considerations for Further Discussion

A. What safeguards can be put into place to ensure a balance of what the person wants and what the provider sees as important for the person?
B. There are special considerations when it comes to civil commitment and criminal sanctions. How do you do a PCP when there is a guardian? There is a possible conflict of interest here.
   1. If a person isn't verbal, does the guardian speak for the person? Response: People who care about the person describe a good day for the person and a bad day.
   2. If rights have not been taken away by a court, the person retains those rights.
C. How do you measure values and client satisfaction as outlined? Michigan has created a checklist of indicators that may be helpful.
D. The above recommendations have not yet been differentiated based on "essential components" versus "recommended components."

VI. Concerns from Advisory Committee Meeting on 8/6/12

A. If the PCP includes risks, etc., but does not have to do with the person's desires, then the risks should not be in the PCP.
B. This is a rule for providers and if they can't be involved in the plan creation, how would they be able to provide the best care and utilize the plan appropriately?
C. Concern about integrating a PCP into the new CSP instead of having separate plans.
D. Concern about how to pay for this. The Michigan document has found a way to have Medicaid pay for this planning if the person is eligible for Medicaid.
E. There are multiple acceptable person-centered planning approaches

Appendix F – Emergency Use of Manual Restraint Summary (REVISED 9.7.12)

Rule 40: Emergency Use of Restraints – REVISED

Rule advisory committee's recommendation to DHS

Attended one or both work group meetings:

Rick Amado, DHS-SOS; **Maria Anderson,** DHS-AMH; **Steve Anderson**, Rule 40 Advisory Committee; **Jane Brink**, LTC Ombudsman**; Stacy Danov**, DHS-SOS; **Alicia Donahue**, MH-DD Ombudsman; **Kay Hendrickson,** Rule 40 Advisory Committee; **Anne Henry**, Rule 40 Advisory Committee; **Dan Hohmann**, MSOCS; **Renee Jensen**, Barbara Schneider Foundation; **Jill Johnson,** DHS-CMH; **Barbara Kleist**, Rule 40 Advisory Committee; **Bob Klukas**, DHS-Rules; **Annie Mullin**, Rule 40 Advisory Committee; **Michelle Ness,** MN Dept. of Health; **Dean Ritzman**, DHS-DSD; **Lauren Siegel**, DHS-DSD; **Mike Tessneer,** DHS-Office of Compliance; **Suzanne Todnem**, DHS-DSD; **Cheryl Turcotte**, MH-DD Ombudsman; **Charles Young**, DHS-DSD; **Gail Dekker**, DHS-DSD, facilitator

I. Context and reminders
   A. The charge of the work group is to recommend standards that will apply to persons with disabilities
   B. The standards will be expressed in statute, rule, and manual
   C. The department presented a preliminary rule draft at the July Advisory Committee meeting that included this definition of emergency based on the Jensen Settlement definition: "Emergency" means situations when the person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. Person's refusal to receive and participate in treatment shall not constitute an emergency
   D. This work group discussed techniques and methods in two contexts:
      1. Emergencies
      2. Non-emergencies
   E. The non-emergency discussion was limited to a few select topics at these work group meetings; other non-emergency recommendations and standards discussed at other meetings remain part of the whole recommendation but are not repeated in this summary.

II. Main discussion points

A. Definition of emergency – in addition to "imminent danger to self or others"
    1. Whether to include property damage
    2. Only unpredicted events or include "somewhat predictable" situations?
    3. Customized "emergency" definition for each individual – personalized crisis plan
    4. Narrow view (danger to self or others) vs. broad view (includes property damage, risk of criminal repercussions, and risk of loss of housing)
    5. Includes modifying usual use of equipment such as slowing down a person's electric wheelchair
    6. Replace with other terminology such as "behavioral crisis" to coordinate with 245D
    7. Not left to individual staff discretion
    8. If provider calls for police assistance in a situation, then it must be treated as any other emergency that triggers reporting, documentation, review, etc.

B. Emergency techniques permitted, criteria
    1. Not medically contraindicated
    2. Proven to be safe and effective (data required)
    3. Short period of time; not necessarily based on "when person is calm"
    4. First-time event for the person with that provider, then the provider must create a plan to address the type of incident in the future.

C. "As approved by the commissioner" to keep standards current
    1. This would be a list of permissible emergency techniques referred to in rule or statute; would be updated and maintained to keep standards current
    2. Would entail a process for standard review and updating
    3. Concern: too loose a standard? Sufficient transparency?

D. Emergency deprivation, permitted?
    1. Maybe (4 yes, 1 no, 8 maybe)
    2. Should be temporary
    3. For person's safety

E. Role of crisis plan
    1. Broader than use of restraints; should restraints (last resort) be part of a crisis plan?
    2. Slippery slope?
    3. When must a provider develop a crisis plan for a person?
    4. Should follow the person to new providers

F. Non-emergency techniques permitted
    1. Voluntary participation, e.g., person chooses to go to his room, provider engages the person in a new activity, conversation, questions about what would be helpful
    2. Redirection, de-escalation, teaching, temporary interruption without the use of force (and well defined)
    3. Standards must include process to reintroduce the person into regular activities

G. Non-emergency techniques prohibited
    1. Involuntary participation, e.g., person sent to room (room time out)

H. Other definitions
    1. Deprivation
    2. Blocking apparatus (and its use) – prohibited but needs to be well-defined

3. Seclusion, time out, etc. must be better defined; and allows a provider to separate two residents who are attacking each other or a resident who is attacking others

III. Rejections

A. Risk of criminal repercussions not involving physical danger to self or others
   1. Not an emergency
   2. Concern: would require staff to know what constitutes criminal behavior

IV. Recommendations – **Emergency context**

A. Definition of emergency – from Jenson settlement: situations when the person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. Person's refusal to receive and participate in treatment shall not constitute an emergency; property damage is an emergency only if it poses imminent danger to self or others
B. New standards should specifically list the permitted techniques
C. No mechanical restraints in emergencies
D. No deprivation of basic rights in any situation
E. No seclusion and time outs in emergencies (vote 0-13)
F. Only correct use of blocking apparatuses for safety and protection of self or others

V. Recommendations – **Non-emergency context**

A. No use of negative punishment as a consequence to behavior
   1. E.g., person refuses to clean his room so can't go to the movie that night = not acceptable practice
B. No use of positive punishment
   1. i.e., presenting an unfavorable outcome or event following an undesirable behavior; an aversive stimulus is added to the situation
   2. e.g., being scolded for doing something; e.g., spanking, corporal punishment
C. No deprivation that requires the person to earn everything
   1. Including token and level programs
D. No deprivation of basic rights in any situation
E. No new mechanical restraints for SIB; plus interim process to move persons away from existing mechanical dependencies (or variance with a plan), with oversight and monitoring; no new mechanical restraint use for persons with a history or restraints used on them in the past.

VI. Other work groups

A. Training
   1. Crisis intervention training – need more/better
   2. Trauma-informed care – should be required training
   3. Requirements should apply to night staff and relief staff
   4. Providers need more training to reduce or eliminate the need to call law enforcement

Note
There are additional comments and additional recommendations below from the September advisory committee meeting. Additional Recommendations include new items to the recommendations of the work groups. Sometimes Comments are repeated as Additional Recommendations; this is intentional. The requested changes to the summary and recommendation document dispersed at the September meeting have already been implemented and reflected above.

VII. Additional comments from the September advisory committee meeting

A. Clarify terms:
    1. Deprivation means removing or denying something from someone before a person's behavior happens. Example: Depriving a person of food.
    2. Negative punishment means removing something from someone after a person's behavior happens. Example: Removing a person's dinner plate after they throw food.
B. However, if a person uses a crutch to hit another person, this is an emergency, and temporary removal is not a punishment but an issue of safety.
    1. Return the crutch when the person is calm.
    2. Report the incident.
    3. This should be a critical incident that is subject to review.
C. Distinguish between protective equipment used for medical conditions and restraints used for behavior "management."
D. Note that the term "emergency" in Minn. Stat. 245D is defined more broadly than this committee has been talking about. It refers to a situation that affects a provider, such as a tornado, rather than a situation that affects a person receiving services. We need a different word for what this committee means, "situations when the …[person's] conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety." The term "emergency" in this document will refer to the committee's meaning.
E. If a person will not leave a public place, even though the place is closing: It is not an emergency according to the definition in #4 when a person will not leave a public place. The person is not harming himself or another, but the situation must be addressed because, for example, the public place is closing. The person cannot stay. The rule should permit physical escort or broaden what is permitted in such situations.
F. It would help if emergency techniques or crisis techniques are defined so people know what their options are.
G. Physical escort:
    1. Distinguish provider's convenience vs. legal trespass.
    2. Recognize that if provider abandons a person-centered approach to deal with this situation there will be costs, including erosion of trust, therapeutic setbacks, and so on. Options include:
        a. Re-direction or de-escalation techniques
        b. Seeking consultation
        c. Determine reason for resistance
        d. Recognize that over time, staff will learn new skills.

3. Define physical escort and guidance and put these in the context of a hierarchy of prompts. Delineate when restraint begins.
4. Recognize that when police are called, they have weapons and the provider loses control of the situation.
5. Define protective equipment. Separate from mechanical restraint; provide examples and non-examples.
6. It is an industry standard that guidance, whether physical escort or hand-over-hand guidance, is never used against a client's resistance; otherwise it is force and a manual restraint.

H. Use of blocking apparatus: Use of pillow for self-protection or to protect another person
   1. Use of a pillow for self-protection or to protect another person is not the use of a restraint. When a blocking apparatus is used to isolate or seclude a person, it is used as a restraint. The former is for self-protection, the latter is to control or restrain a person.

I. Are all emergencies unpredictable and unforeseen? Should the definition of emergency be tightened? The intent is to lead to the development or refinement of the person's crisis plan.
   1. You simply cannot anticipate all behaviors in all situations for all causes. But you can require providers to plan and revise plans as needed.
   2. Change the circumstances to avoid recurrence.
   3. Conduct a functional behavior assessment (FBA).
   4. Provide examples and non-examples in a manual along with the definition. For example, context is important; a swing is not always a hit or an emergency.

J. Concern about programs that use levels:
   1. Many youth corrections programs use these and there is concern about absolute bans. This is not an emergency. Simply eliminating this approach could result in loss of providers.
   2. They should be prohibited because they are punitive and are often used as a substitute for treatment.
   3. They can also provoke an outburst.
   4. The members present agreed that level programs should be prohibited.

K. However, members agreed that token economies are not the same as level programs and should not be prohibited.

VIII. Additional Recommendations from the September advisory committee meeting

A. Use Jensen Settlement Agreement language to define emergency.
B. Distinguish between protective equipment for medical conditions (such as a seizure disorder) and use of restraints for behavior "management."
C. Only manual restraints are permitted to be used in emergencies.
D. Expand Item G on Summary. It applies to more than self-injurious behavior. It applies also to persons who have a history of restraints used on them and any use of restraints.
E. Refer to the Monitoring work group: Address training response to emergency—systems response.

F. Describe what can be done in an emergency besides resorting to a restraint, such as de-escalation techniques.
G. Describe which manual restraints may be used and which are prohibited.
H. Provide examples of emergencies and non-emergencies, perhaps in the manual.
I. Include definitions.

Appendix G – Training Notes and Additional Recommendations (Added 9.7.12)

Training Work Group
Meeting Notes
August 17, 2012

Attending
Rick Amado, DHS-SOS; **Steve Anderson**, Advisory Committee Member and Mt. Olivet & ARRM Rep; **Renee Jenson**, Barbara Sneider Foundation; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz**-Advisory Committee Member and Dakota County; **Lauren Siegel**, DHS-DSD; **Gail Dekker,** DHS-DSD, facilitator; **Charles Young**, DHS-DSD; **Suzanne Todnam,** DHS-DSD

Purpose
Develop content for training on the new standards

Product
Recommendations to be presented to the Rule 40 Advisory Committee for their consideration at the October meeting.

Givens
1. We will recommend standards that will apply to people with disabilities.
2. Standards will be expressed in statute, rule and manual.

Resources
1. "Monitoring, Reporting and Training the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas" (August advisory committee meeting handout #5)

Questions for the Group

A. *What are the goals of training?*

Comments
1. To support a safe environment- safety should be a top priority.
2. Allow for the evolution of practice, as best practices are always changing. This is done by continually evaluating the training and changing it as needed.
3. Should be accessible to all people that support individuals with developmental disabilities that live in all applicable geographic locations. For this to occur the training must be person-centered and have the appropriate IT resources.
4. Should be available in multiple formats, as people learn in different ways. The emphasis should be on hands-on training as actually practicing and applying skills is the most direct way of learning methods of quality care.
5. To impact people's culturally ingrained beliefs about the value of punishment.
6. To be collaborative- in more ways than one. First, people need to learn to work together in these communities. Second, for buy-in from all levels of service, providers, staff and governing entities need to be involved in the creation and implementation of the training.
7. To benefit the individuals served. People should be trained on human relations for better service and an overall understanding that the people they are serving are just like them in many ways.

8. To be efficient and effective. An efficient and effective training will better prepare and equip someone to do their job and the subsequent feelings of competence will contribute to less staff turnover.
9. To provide people with common, industry standard language to support the entire field with more universally competent employees.
10. Support the value of training with the appropriate certifications, so those being trained are made to feel like a valued professional that is on a track to achieving more. Pay should reflect the advancement in training/certification.
11. To use what is already working, but make it more user-friendly.
12. Must have clear objectives for each training.

B. *In one or two sentences, say what a successful training system looks like. Example: "Provider staff at all levels receive training in person-centered planning and positive support strategies."*

Comments

1. Is available 24/7, has multiple approaches and is asynchronous.
2. The content and language is accessible so that people with less previous knowledge of the field are able to understand the material.
3. The training should be affordable.
4. The modules should have very clear objectives that subsequently build off each other to exemplify the progress an individual has made.
5. Stream-lined to be achievable, but also comprehensive.
6. The training should have tiers based on previous knowledge, but with the same overall message. The early stages could be online, but the later stages should include demonstration.
7. The training should include a competence assessment.
8. Training should take place within each org to create-buy in and should have the ability to be sustainable and grow within that organization. Somehow incorporating people from other organizations in some of the trainings would be beneficial for idea-sharing.

C. *What are the main components of a new training system?*
(Participants wrote comments on post-its and clustered post-its into categories. DSD staff named each category, which is underlined.)

1. Broad goals of the training

h. Quality assurance
i. Culturally competent and responsive
j. Training recognizes the wide diversity of people protected by these standards
k. Builds capacity and community (McKnight)
l. Demonstrated competency-based
m. Training professionalizes participants
n. Leads to certification levels
o. Training incorporates the practices we are teaching (use PBS in training approach)

2. Developing the training
   a. Identify who will be developing the training
   b. Communication systems

3. Delivery
    a. 24/7, a synchronized, multi-media presentation
    b. Synchronized vertical and horizontal delivery
    c. Multiple formats
    d. Core vs. Advanced
    e. Time/Hours (how much?)
    f. Reference material
    g. Regional hubs foster sharing, support and continuous development
    h. Mentoring, supervised practice, OJT Coaching
    i. Time to practice learned techniques
    j. 24 hour consultation after training
    k. Behavior staff (i.e. BHs) need to model for and mentor staff who implement plans in community settings

4. Accessibility
    a. Initial training PCP and PBS for all caregivers
    b. All training must be affordable and available

5. Topics of focus within the training
    a. Crisis/de-escalation
        i. Identification of crisis.
        ii. What does it feel like to be disabled and in crisis
        iii. How to maintain safety in a crisis
        iv. De-escalation techniques
        v. Verbal and non-verbal ways to de-escalate a crisis situation
        vi. Proactive vs. reactive strategies
    b. Prohibited techniques/punishment and use of restraints in an emergency
        i. Understanding of punishment
        ii. Changing culturally ingrained beliefs about the value of punishment
        iii. Reasons why prohibited techniques are prohibited
        iv. Use of manual restraints in an emergency
    c. Rights of the Person
        i. Rights of persons being served
        ii. Understanding regulatory obligations
        iii. Identify all levels-macro-standards to micro-person
    d. Basics of behavior change
        i. The steps to take to achieve behavioral change
        ii. Understanding of FBA
        iii. Training specific to person with regard to function of behavior and recommendations
    e. Trauma informed care

*A special note about measuring something such as a training curriculum:

What is being measured:	Input (Easiest to Measure)	Output	Outcome (Hardest to Measure)
Description of Category:	• The number of hours of training	• Competency test and credential	• Measured by person satisfaction and demonstrated choice activity. • Identify the most competent and ask them to evaluate others less advanced, can be observation, checklists and written tests. • Some providers set up a system that supports success but checks to make sure that people are accumulating the knowledge that they are supposed to be accumulating. Need a level of management to ensure the provision of services. The outcomes for workers should be individually assessed. • Use a pre-test, post-test and 6-month test (to see what they have used) to demonstrate competencies and supplement that with client satisfaction, the amount of sick time and workers comp, reduced use of restraints. Highlight skills demonstration and strengths.

D. *Who or what are the qualified training resources or systems- recognizing that more training resources may be developed as time goes on?*

Comments

1. The Kansas PBS System is used at SOS and stored at the U of M within the College of Direct Supports. There are 16 people in a cohort, 8 students are affiliated with SOS and 8 are affiliated with private providers. This is a free program and it is not board certified. However, this program has more supervised practice and is very similar to board certification. At the end of this program, students are able to: complete competent and comprehensive FBAs, use the competing behavior model in intervention, collect reliable data, get a brief introduction to PCP and facilitate a strong team through collaborative group work. There are 9 modules in this course and class meets one time a month from 9 am to 4 pm. This curriculum can be modified as it is implemented and critiqued.
2. South Carolina has a similar system as Kansas, but it has an additional system that is focused on implementers. This system is similar to the one used at Cambridge, as it is three days, has lots of practice and the professional training is long term and comprehensive.
3. MCCP and CSS (Metro Crisis Coordination Program and Community Support Services) are currently the primary receivers of referrals for training in the counties, as money is already allocated to these programs for that purpose. To train providers outside of the county system, there would need to be contracts to pay independently. **MCCP** receives calls if

people are dealing with challenging behavior. MCCP has a Behavior Analyst on staff that has the capacity to do an FBA and create plans for the individual. The trained county case managers within this system understand these behaviors to make better referrals. There are additional trainings available for specific populations. **CSS** is 65 to 70 hours for a case work up. CSS has more time to train, but is very similar to MCCP and it would be a good model to follow.

4. The Institute for Applied Behavior Analysis (IABA) is based in Los Angeles, California. The program is two weeks and 100 hours. Students learn about positive support strategies, FBAs (and actually complete one and evaluate another) and person-centered assessments. On the down side, we would have to buy the system and continuously pay them to have that training come here.
5. Mount Olivet Rolling Acres and Meridian both have good entry-level training on PSS.
6. The Barbara Sneider Foundation offers an 8 hour de-escalation training that is non-violent and has lot of practical application. This training includes individuals from law-enforcement, family and people with mental illness. Barbara Sneider also has a 40 hour Crisis Intervention Team (CIT) training (a SAMHSA best practice) to prepare trainers within other organizations. This training is meant to create a culture change away from the use of seclusions and restraints. The training was a partnership with Northwestern University and there are CEUs available for those in the nursing, law enforcement and education fields.
7. Brih Design creates custom behavioral training, as does Behavioral Dimensions.
8. The Lovaas Institute does training for providers to children with autism. The Midwest location, located in Minneapolis, is equipped to do the trainings.
9. David Mandt does regional training, which will most likely cost money. He has trainings on topics such as trauma informed positive behavior support and complex behaviors.
10. Crisis Prevention Intervention (CPI) training with the Crisis Prevention Institute- is a lot like the Mandt training. There is on-site training as well as seminars and workshops of various lengths.
11. Disability Support Organizations have trainings that are related to the types of disabilities in which they specialize, but these are not as comprehensive.
12. The person-centered thinking initiative was started by SOS at the U of M and teaches person-centered lifestyle planning. Coaches are trained to work with people, supervisors are trained to oversee direct care and managers are trained to oversee the organization.

E. What should be the focus of training for different roles in the system and where are credentials needed?

1. Direct care staff who implement positive support plans, behavior staff who create positive support plans and behavior staff who oversee positive support plans are the three positions listed within the new waiver provider standards. We need to identify what these three positions need and what other types of positions need (including the advanced positions in an organization as well as family members and state agency staff).
2. The desire for staff to be creating PSS plans and the supervisors to oversee that process was expressed.
3. (This question may be revisited at the next meeting due to time)

F. Who is responsible to pay for which training?

1. SAMHSA has grants available for training

2. (Paying for training will most likely be revisited at the next meeting)

G. *What is a model for providing certification and credentials to providers?*
   1. On the first page of the NADD.org page there is a link for a credential page. These credentials are competency-based, there are multiple levels with multiple disciplines.

Next meeting

Wednesday, August 29, 1:00-3:00 in Lafayette 4146.

Training Work Group
Meeting Notes
August 29, 2012

Attending
Rick Amado, DHS-SOS; **Mark Anderson**, Barbara Schneider Foundation; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, OMHDD; **Dan Hohmann**, DHS-SOS; **Bob Klukas**, DHS-rules; **Pat Kuehn**, Rule 40 Advisory Committee Member; **Sue McGuigan,** TBI Advisory Committee; **Tim Moore**, Rule 40 Advisory Committee Member; Genie Potosky, DHS; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz,** Advisory Committee Member; **Lauren Siegel**, DHS-DSD; **Charles Young,** DHS-DSD; **Suzanne Todnem,** DHS-DSD, project lead; **Gail Dekker,** DHS-DSD, facilitator; **Dan Chandler**, DHS-SOS; **Chris Michel**, OMHDD; **Mike Tessneer**, DHS-Compliance

Purpose
This is the second meeting of this work group to develop content for training on the new standards.

Product
Recommendations to be presented to the Rule 40 Advisory Committee for their consideration at the September 7 meeting.

Givens
3. We will recommend standards that will apply to people with disabilities.
4. Standards will be expressed in statute, rule and manual.

Resources
2. "Monitoring, Reporting and Training the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas" (August advisory committee meeting handout #5)

Questions for the Work Group

A. What should be the focus of training for different roles in the system, and where are credentials needed? What training should everyone have and what training would apply based on position or certification?

1. What training should everyone receive?

Comments

a. De-escalation training (such as avoiding power struggles, minimizing negative attention, redirection). Must include practice/demonstration of competence, not just theory.
b. Why aversives, deprivation, and punishment are not effective or safe.
c. Person-centered planning, including practice/demonstration of competence, not just theory.
d. Positive support strategies, including practice/demonstration of competence, not just theory.
e. Organizing principle for training:
    i. Framework: Includes intro to the changes, rationale, evidence. Method of training can be online.
    ii. Strategies and Tactics: Includes functional behavior analysis (FBA), person-centered planning (PCP), positive support strategies, de-escalation strategies, etc. Method of training requires competency demonstration.

iii. Policy: Includes requirements of statutes, rules, VAA, MOMA, rights, etc. Method of training can be online.

f. Training on trauma-informed care
g. Personal accountability of staff person, i.e., a change from blaming person or fixing person to approach that considers environments we create around the person being served. Developing a reflective or introspective approach where staff person asks, "What can I do differently?"
h. Person's rights, patients' bill of rights. Address and correct assumptions about what laws require because there is much misinformation out there.
i. Cultural competency, diversity understanding. Staff person should understand their own culture and its assumptions, the culture of the person being served, the culture of the service environment, such as the medical culture, the DD culture, the mental health culture, etc.
j. Acceptable physical restraints that can be used in emergencies with medical monitoring, including practice/demonstration of competence, not just theory.
   i. Definition of emergency
   ii. What procedures are prohibited
k. Vulnerable Adult Act (VAA), Maltreatment of Minors Act (MOMA)
l. Systems awareness, organizational awareness and its contributions to aggression and other challenging behaviors.
m. Reporting requirements, documentation requirements.

2. *What training for direct care staff who implement positive support plans, in addition to above?*

Comments
a. More emphasis on Strategies and Tactics from 1.e Organizing Principle for Training above, such as positive supports, de-escalation, etc.
b. Concern about general level of competence of direct care staff. The need good interaction skills and skills need to be measured by outcomes—how they treat people. Includes human relations, respectful communications.
c. Client-specific knowledge and competence.
d. Strategies/skills specific to set of clients and setting
   i. There was discussion about whether there could be general competency standards or whether competency must be person-specific.

e. Understanding of relationship between behavior and environment.
f. Employee self-care
g. Collegial care, for example, debriefing with each other after a crisis.
h. Understanding of diagnoses, medications
i. Staff members' documentation and reporting requirements
j. When to communicate with the person's family or person's emergency contact(s)
k. When to call 911.

3. *What training for behavior staff that create positive support plans/QDDP in addition to above?*

Comments

1. More theory than for general training
2. More demonstrated competence for all requirements
3. Real experience and demonstrated competence in developing behavior plans under supervision, not just mock-ups or school assignments.
4. Real experience and demonstrated competence in doing an FBA appropriate for your level and situation.
5. Know how to research literature
6. Resources in their communities
7. Know how to train and coach direct care staff
8. Know how to evaluation the services they provide
9. Know how to communicate effectively
10. Know the limits of their knowledge, when to ask for help, and whom to ask.
11. Continuing education to stay current in field

4. *What training for behavior staff who oversee positive support plans/masters' or doctoral level?*

Comments

a. Real experience and demonstrated competence in doing an FBA.
b. Tools to know relationship between behaviors and conditions under which it occurs.
c. Know how to apply person-centered planning principles
d. How biology affects behavior
e. More theory of other disciplines, such as biology, neurology
f. How to integrate disciplines to develop plans
g. How to design and use data system to measure effectiveness of care
h. Understand resources of human services system, its procedures, and people in your local system.
i. Know how to build capacity of employee and of organization ("Lead and teach")
j. Know how to and conducts periodic supervision/consultation/mentoring of behavior professionals.

5. *What training for provider executives, managers, owners (non-clinical persons)?*

Comments

a. Outcomes that they and their staff are responsible to achieve.
b. What they can hold clinical people accountable for.
c. Know how to include your staff in organizational decisions. The concern is that as owner or manager of business makes administrative, organizational, or financial decisions, this will have an impact on the people you serve, so you must consult with your staff to understand what those impacts will be and take them into account.
d. Know where you can get help.
e. Management best practices
f. Continuing education
g. Competency in person-centered thinking at the organizational level and the ability to address this in their organization.
h. Ability to create a person-centered environment for their staff.

6. *What training for case managers?*

Comments
a. Case managers do not need to know how to do an FBA.
b. CEUs to keep current on innovations and evolving knowledge.
c. Know what is possible: resources about the system because they are pivot point for accountability, they sign off on plans, etc.
d. Training in their monitoring and oversight roles and responsibilities, as well as these responsibilities for other parties they work with, such as providers, Licensing, etc.
e. More in-depth knowledge of person-centered planning, ability to talk teams through it. Knowledge of four primary approaches of PCP.

7. *What training for professional guardians (paid for their services)?*

Comments
a. Training for everyone (All items in A.1)
b. Training for direct care staff (All items in A.2)
c. Case manager training (All items in A.6)

8. *What training for Families (recommended, not required; not subject to this rule)?*

Comments
a. Know what is possible (similar to case managers)
b. Know about voluntary informed consent, difference between substitute decision making vs. making a decision in person's best interests.
c. Person-centered planning
d. Positive support strategies
e. De-escalation strategies
f. If person is on consumer-directed community support (CDCS), person and/or their family should receive info on consumer support grants (CSG), fiscal support entities (FSEs)

9. *What training for persons in consumer-directed community services option (CDCS)? Recommended, not required; not subject to this rule.*

Comments
a. What they can expect from providers
b. What they can hold providers accountable for
c. Appeals, grievance rights and procedures
d. Training for everyone (All items in A.1)
e. How to self-advocate
f. Consumer support grants, fiscal support entities.

10. *What training for persons receiving services? (Recommended, not required; not subject to this rule.)*

Comments
a. Training for everyone (All items in A.1) as the person can understand
b. Information on their rights

c. Information on person-centered planning.

11. *What training for DHS policy staff?*

Comments
a. Training for everyone (All items in A.1)
b. Case manager training (All items in A.6)
c. In-depth training on:
   i. Person-centered planning for individuals and organizations
   ii. Annual training in evolution and innovations and best practices in their field, whether DD, Aging, Mental Health, etc.
d. Field trips, field work, spend time in counties, service settings.
e. Training on how to evaluate success and effectiveness of state policies.

B. If we need to stage training (due, for example, to a limited number of qualified trainers), what are your training priorities? Who should be trained first? In what topics?

Comments
1. Set standards, let providers include required training in their orientation and continuing training.
2. Determine what is needed annually by employee role and add in to requirements.
3. Train trainers who can train others. Options recommended:
   a. Start with master's level and go down.
   b. Start with direct care staff because they have so much contact with persons being served.
   c. Start by region or by system and train all levels simultaneously so everyone in an area or system are getting the same messages and aligning the same way.

4. Train DHS policy staff early.
5. Train case managers early.
6. Train crisis providers. Be clear about what we expect of them.

C. What are acceptable training delivery methods? What methods are less effective and for what types of training?

Comments
1. All training must have a product that the trainee must produce whether it is to pass a competency test or to demonstrate a skill.
2. Guideline: If you touch a person, you must demonstrate skills. If you don't touch a person, you can rely on monitoring or online training.
3. Mentoring should be available for owners, managers, executives.

D. What do you recommend to make training feasible across all provider types?

Comments
1. Use online subscription
2. Minimize travel for providers.
3. DHS should have a training group that can travel and offer regional workshops.

   a. Use provider associations, such as ARRM, and other conferences for cost-effectiveness.

4. Marketing is needed to emphasize reasons to buy in, such as effectiveness, improved safety, prospect to save money.
5. Discuss with colleges and licensing boards ways to revise curriculum to bring along next generation of professionals.
6. Purchase copyrights of existing training and make widely available.

Minnesota Department of **Human Services**

Rule 40: Training Work Group Summary

Attended one or both work group meetings:
Rick Amado, DHS-SOS; **Mark Anderson**, Barbara Schneider Foundation; **Dan Chandler**, DHS-SOS**;** **Stacy Danov**, DHS-SOS; **Alicia Donahue**, OMHDD; **Dan Hohmann**, DHS-SOS; **Bob Klukas**, DHS-Rules; **Pat Kuehn**, Rule 40 Advisory Committee Member; **Sue McGuigan,** TBI Advisory Committee; **Chris Michel**, OMHDD**; Tim Moore**, Rule 40 Advisory Committee Member; **Genie Potosky**, DHS-Performance Measurement & Quality Assurance (PMQI) Division; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz,** Advisory Committee Member; **Lauren Siegel**, DHS-DSD; **Mike Tessneer**, DHS-Compliance**;** **Charles Young,** DHS-DSD; **Suzanne Todnem,** DHS-DSD, project lead; **Gail Dekker,** DHS-DSD, facilitator

I. Context and reminders
   A. The charge of the work group was to recommend standards that will apply to persons with disabilities
   B. The standards will be expressed in statute, rule, and manual

II. Recommended components of a successful training system
   A. Training organizing principles are:
      1. Framework: Introduction to the changes, rationale for changes, evidence for changes, main concepts. Method of training can be online (for greater flexibility, access anytime, and lower cost). Proof of learning can be a knowledge test.
      2. Strategies and Tactics: Includes functional behavior assessment, person-centered planning, positive support strategies, de-escalation strategies, etc. Method of training is in-person and proof of learning requires a skills demonstration by trainee.
      3. Policy: Includes the requirements of statutes, rules, Vulnerable Adult Act (VAA), Maltreatment of Minors Act (MOMA), protection of rights. Method of training can be online. Proof of learning can be a knowledge test.
   B. These organizing principles provide a basis for all elements of the training system. For example, training topics would fit into one of the three organizing principles. Whatever role a person plays, they will receive training in all three principles but with differing emphasis based on their role. For example:
      1. Direct service staff might receive more training on strategies and tactics than provider executives.
      2. DHS staff and provider executives might receive more training in policies than the direct service staff.
   C. Underlying goals of the training include:
      1. Quality assurance
      2. Culturally competent and responsive services
      3. Demonstrated learned competencies
      4. Training results in certification and professionalization of participants.

D. **Training Development**: Who will develop the training? What training already exists? For example, the Kansas Positive Behavior Supports System is already being used by State Operated Services and is administered by the Institute on Community Integration of the U of M. There is a need to evaluate the costs, subject matter and logistics of the proposed trainings (See training work group meeting notes from 8/17 on Pages 4-6 to see possible training resources.)

E. **Delivery**: Training should encompass:
   1. Multiple formats
   2. Asynchronous delivery, that is, online training available 24/7
   3. Core and advanced tracks
   4. Specific time requirements
   5. Reference material
   6. All training must require proof of competency. For some topics, proof of competency can be demonstrated by a knowledge test. For other topics, such as skills and strategies, competency cannot be demonstrated by passing a knowledge test; instead the staff person must practice the skills during training and show the skills in a demonstration.

F. **Mentoring**: This should be available for direct care staff, owners, managers and executives. There should be:
   1. Regional hubs for development and support
   2. Time to practice the learned techniques (including some supervised time)
   3. 24-hour consultation.

G. **Accessibility:** Initial training on PCP and PBS should be available to all caregivers.
   1. All of the required or desired trainings must be affordable and available.
   2. Because these trainings will need to be accessible to providers throughout the state, minimize travel for providers with online training. Create a DHS training group that can travel and offer workshops.

H. **Specific training topics include:**
   1. Crisis management and de-escalation techniques
   2. Review of prohibited techniques and why punishment/aversive procedures are not effective or safe for person or staff
   3. The legal and safer ways to use restraints in an emergency
   4. Creating buy-in for the theoretical/cultural changes inherent in these changes
   5. Rights of the person
   6. Basics of behavior change
   7. Trauma-informed care
   8. Relevant policies such as VAA and MOMA
   9. Cultural competency, that is increasing one's ability to work effectively with people from diverse racial and ethnic backgrounds, as well as developing awareness of the culture of the service delivery system, the work culture of the provider organization, and one's own cultural assumptions.

III. Additional Recommendations on Training

A. Measuring outputs and outcomes: While the measuring of inputs (such as the number of hours of training offered) and outputs (such as number of competency tests passed) is relatively easy, measuring outcomes is more difficult, but more important because improved service outcomes is the reason for the training. Providers should have a system that supports success and highlights strengths but also accurately ensures the required knowledge and skills are being accumulated.

B. Mandated, but differentiated, training for providers and provider staff, county and state agency staff, and others, depending on their roles

1. **1.** Everyone who works in an organization that serves individuals that fall under this rule/statute will receive a baseline set of trainings (See the 8/29 Training Work Group meeting notes, Pages 1-4.)
2. **2.** Roles that have greater responsibility will have broader and deeper training requirements. See the 8/29 Training Work Group meeting notes.
3. **3.** Exposure to new topics is important, even if that topic is considered to be higher level than necessary. Exposure increases the trainee's competence and promotes more interest in advancing further in the field.
4. **4.** Optional training will be made available to parents, family members and unpaid guardians, and to persons using consumer-directed care options.
5. **5.** Paid, professional guardians must take required training.

C. **Training priorities when limitations are present**:

1. Prioritize training trainers that can train others.
2. Prioritize setting standards so that providers can include those specific trainings in their orientation and continuing education trainings.
3. Train all people within an organization or within a region at the same time so the entire organization or region is using the same approach. Then move on to other organizations or regions.
4. DHS policy staff, case managers, and crisis providers were indicated as being a priority for training these concepts first.

D. Creating buy-in: Because these trainings will reflect some substantial changes in the system, convey:

1. **1.** The reasons to buy-in to all of these changes.
2. **2.** The benefits the new approach will offer: efficacy, efficiency and improved safety, among others.

Minnesota Department of **Human Services**

Rule 40 Advisory Committee
Meeting Notes – Training
September 7, 2012

Note
These are comments and additional recommendations gathered at the September advisory committee meeting. Additional recommendations include new items to the recommendations of the work groups. Sometimes comments are repeated as additional recommendations; this is intentional. The recommendations below together with the training work group notes from 8.17.12 and 8.29.12 make up the advisory committee's recommendation to DHS.

Training

Comments on Recommendation

1. Decide what types of training in manual restraints is acceptable, including acceptable approaches and acceptable providers of training.
2. Provide training on how to use manual restraints most safely.
3. When hiring, assess or screen the potential staff person's ability to work with people with challenging behaviors.
4. Effective training requires:
   A. Trainees must demonstrate competency.
   B. Conversion of material into multiple formats.

5. Direct service staff need training on how to collect data/record observations accurately.
6. Focus on protection of rights training, Vulnerable Adult Act and Maltreatment of Minors Act, should be on the connection between the ways challenging behavior can lead to rights violations.
7. Recognize the need for continuing education for everyone.
8. Can parents, guardians, families be incented to participate in training?
   A. Also reach out to others in the community to encourage their participation in training, such as first responders.
9. Add to manual and add risk management and risk assessment to training for direct service staff and for parents and families, because these people are often poor at assessing risk.
10. Add motivational interviewing, active listening, LEAP, collaborative problem solving, and other tools, approaches and methods to training.
11. Add sensory integration to the manual.
12. The steering committee or a training review panel reviews acceptable training curricula and/or providers and updates this list in the manual each year.
13. Training will be led (designed and implementation lead) by a qualified professional.

Additional Recommendations

1. Training for everyone must include training in person-centered planning (PCP) and positive support strategies.
2. There must be a policy and practices manual as a reference for providers.
3. Use Donald Kirkpatrick's model to evaluate training effectiveness. It has five levels:
   A. Participant's satisfaction with the training.
   B. Competency demonstration by trainee, whether a test or skills demonstration
   C. Measurement of behavior change as a result of training
   D. Measurement of improved outcomes for persons as a result of training
   E. Measurement of return on investment for training: Do outcomes make training sustainable?

4. Add to goals of training:
   A. Quality of life
   B. Increase in person-centered services

5. Direct service staff need training on how to collect data/record observations accurately.
6. Focus on protection of rights training, Vulnerable Adult Act and Maltreatment of Minors Act, should be on the connection between the ways challenging behavior can lead to rights violations.
7. Recognize the need for continuing education for everyone.
8. Add to manual and add risk management and risk assessment to training for direct service staff and for parents and families, because these people are often poor at assessing risk.
9. Add motivational interviewing, active listening, LEAP, collaborative problem solving, and other tools, approaches and methods to training.
10. Add sensory integration to the manual.
11. The steering committee or a training review panel reviews acceptable training curricula and/or providers and updates this list in the manual each year.
12. Training will be led (designed and implementation lead) by a qualified professional.

Appendix H – Monitoring, Reporting and Oversight Summary (REVISED 10.22.12)

Minnesota Department of **Human Services**

Rule 40: Monitoring, Reporting, Oversight Work Group Summary-REVISED
Revised as of 10.22.12 advisory committee meeting
Rule advisory committee's recommendation to DHS

Attended some or all work group meetings:
Rick Amado, DHS-SOS; **Mark Anderson**, Barbara Schneider Foundation; **Steve Anderson,** Rule 40 Advisory Committee Member, Mt. Olivet; **Rick Cardenas,** ACT; **Don Chandler**, DHS-SOS; **Erwin Concepcion**, DHS-SOS; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, OMHDD; **Katherine Finlayson,** DHS – Licensing; **Brad Hansen**, Arc Greater Twin Cities; **Anne Henry**, Rule 40 Advisory Committee Member, Minnesota Disability Law Center; **Kay Hendrikson,** Rule 40 Advisory Committee Member, OMHDD; **Dan Hohmann,** DHS – MSOCS; **Renee Jenson**, Barbara Schneider Foundation; **Jill Johnson**, DHS-CMH; **Barb Kleist,** Rule 40 Advisory Committee Member, Arc; **Bob Klukas**, DHS-rules; **Pat Kuehn**, Rule 40 Advisory Committee Member, Ramsey County; **Jim Leibert,** DHS-DSD; Dr. **Gail Lorenz,** Barbara Schneider Foundation; **Chris Michel**, OMHDD; **Tim Moore**, Rule 40 Advisory Committee Member, U of M; **Michelle Ness,** MDH/OHFC; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz,** Rule 40 Advisory Committee Member, Dakota County; **Lauren Siegel**, DHS-DSD; **Mike Tessneer**, DHS-Compliance **Charles Young,** DHS-DSD; **Suzanne Todnem,** DHS-DSD, project lead; **Gail Dekker,** DHS-DSD, facilitator

This summary is intended to reflect the work group's recommendation to the advisory committee in regard to monitoring, reporting and oversight. Not all specific ideas discussed are included; please refer to each work group meeting date notes for greater detail. Rather, multiple suggestions are represented here with broader concepts statements.

IX. Context and reminders

A. Givens
   1. The charge of the work group was to recommend standards that will apply to persons with disabilities
   2. The standards will be expressed in statute, rule, and manual

B. Resource: "Monitoring, Reporting and Training on the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas" (August Advisory Committee meeting handout #5)

C. Purpose
   1. Develop content for monitoring, documentation, reporting, review, and oversight of new standards.

D. Product
   1. Recommendations to be presented to the Rule 40 Advisory Committee for their consideration at the October 22 meeting.

X. Goals of successful monitoring, reporting and oversight
   A. Ensure persons progress/improve/grow
      1. Provide resources, non-punitive support to providers
   B. Improve person's lives across settings and populations
   C. Improve the safety of all persons
   D. Reduce the use of emergency restraints

XI. Successful process has:
   A. Data reported and available on a website that is properly maintained and updated
      1. Of each provider, and
      2. Aggregate data
   B. Clear and transparent standards and process
   C. Timely
   D. Efficient yet recognized each person
   E. Meaningful
   F. User-friendly
   G. Satisfied persons
   H. High-quality services

XII. Values
   A. Improvement; not punishment
      1. Re: services
      2. Re: standards
      3. Re: resources
      4. Incentivizes desired outcomes
   B. Growth of
      1. Provider (competency)
      2. Persons (e.g., skill building, satisfaction)
   C. Individualization, person-centered services
   D. Resources
   E. Responsive

XIII. Comprehensive monitoring
   A. High-level for trends, patterns
   B. Including positive indicators
   C. Outcomes
   D. And comprehensive triggers
      1. E.g., various reviews, training, early intervention/support to provider, access to timely triage after a restraint incident, etc.

XIV. Restraint monitoring
   A. Of person and process during a restraint
   B. Of techniques used by provider

XV. Reporting and notifications
   A. Of use of restraint in an emergency (a.k.a. "incident"; incident reporting – process already in place, we can model after or piggyback on existing process such as to ombudsman office)
      1. Process
         a. Online, computer-based
         b. Notifications to:
            a. Administration of the organization (owner, manager, etc.)
            b. Designated internal reviewer within the organization
            c. Person's family or guardian
            d. Person's case manager
            e. External reviewer

f. DHS
c. Verbal reports
d. Written reports
e. Aggregate reports
f. Reviews (see below)
g. Debrief of all staff involved in an incident and the person before staff leave at the end of the shift; debrief is intended to address any trauma, feelings or immediate emotional needs of person and staff involved.

B. Of other options used
1. Hospital usage
2. 911 calls

C. Of other techniques used by providers
1. E.g., Permissible token programs that do not take back tokens

D. What is reported:
1. All people involved (staff, person, etc.)
2. Start and end time of restraint
3. What measures were taken to avoid restraint (what, when, how long)
4. What was learned
5. Any injury to staff or person
6. Etc.

XVI. Reviews

A. Internal review (see 8.31.12 notes)
1. Purpose: to determine what happened and what can be learned from the situation; focus on the incident context and antecedent circumstances
2. Trigger for internal review: every emergency use of restraint
3. Who: designated staff member will lead; review will include all staff involved with the restraint or on their shift when the restraint occurred, the person when possible
4. When: during the staff's shift, and no later than when staff leave at the end of the shift

B. Debrief (see 8.31.12 notes, page 3)
1. Different from the internal review
2. Purpose: to address any trauma, feelings or immediate emotional needs of persons and staff involved in the restraint

C. External review
1. Purpose:
a. to provide outside, non-punitive clinical technical assistance for quality improvement
b. to look at the provider's system/program level of issues, trends, processes and competencies that may feed into the emergency use of restraints
c. to determine if person/provider is a good fit
2. Trigger for external review: every emergency use of restraint
3. Who: Ombudsman for MHDD would house the external review panel or clinical experts
a. Would need funding for this responsibility.
4. When: TBD – but more than a monthly meeting of the review panel
5. What: flexible – every use of restraint would be reported to the review panel; the review panel decides how it will respond – review would be proportionate with situation reported.
6. Recommendation issued, copy sent to:

        a. License holder
        b. Person, family/guardian (HIPAA compliant)
        c. Ombudsman's office
        d. DHS – policy area (possibly licensing but triggers regulation of recommendation)
        e. Counties/case managers
    D. Processes policies
        1. DHS will create a process flowchart for providers, case managers, and others to know what needs to happen when restraint occurs.

XVII. DHS Oversight

A. Regulatory (licensing)
    1. Use of prohibited techniques
    2. Restraint use
        a. Type
        b. Duration
        c. Number of incidents
        d. Person and staff involved
        e. Context (e.g., alternatives/de-escalation tried, person-centered plan, etc.)
        f. Etc.
B. Data
    1. Demographic information of persons restrained (aggregate, anonymous)
    2. Data collection has consistent standards from individual, provider, provider type, to statewide so data can be aggregated consistently at all levels
    3. Provider statistics:
        a. Number of restraints
        b. Number of person-centered plans (ratio with number of persons)
        c. Number of person-centered plan goals met (ratio?)
        d. Client satisfaction (a rating system?)
        e. Staff satisfaction (rating system?)
        f. Calls to law enforcement, hospital use, etc.
C. Interdisciplinary teams / regional committees
D. Statewide review board
E. Outcomes

XVIII. Feasibility – recommendations to create wide applicability (see 10.15.12 notes, pg. 3-4)

A. provide templates, standardize processes and documentation; use technology (e.g., online reports)
B. build on existing infrastructure
C. make things quantifiable, transparent, clear

Note

There are additional comments and additional recommendations below from the October advisory committee meeting. Additional Recommendations include new items to the recommendations of the work group. Sometimes Comments are repeated as Additional Recommendations; this is intentional. The requested changes to the summary and recommendation document discussed at the October meeting have already been implemented and reflected above.

Comments from Advisory Committee Members on October 22

1. Who monitors use of prohibited techniques?
    A. Response: DHS Licensing Division under the Vulnerable Adult Act.

2. What is the family's role in internal and external reviews? What is the community's role?
3. Internal review documents following the emergency use of restraints should be sent to Licensing Division, Ombudsman, and External Review Panel.
4. Note that the Office of Health Facility Complaints (OHFC located in the Health Department) has authority over MDH-licensed programs only, a limitation on this office's ability to be the location for the external review panel.
5. There should be ongoing stakeholder review of the implementation of these recommendations. Volunteers could be part of another existing group like the Minnesota Council on Quality or the State Quality Council.
6. Reporting, monitoring, internal review, debriefing of staff must accommodate organizations with one or two staff or one or two staff on duty. Allow more time for internal review and debriefing, perhaps 24 hours (not just until the end of a shift).
7. A debriefing of the emergency use of restraints with the person on whom the restraints were applied may occur too soon if it is required before the end of a shift. Instead follow the person's plan to determine timing or type of debriefing, or if there is no plan, do this within 24 hours.
8. Do all clients need a debriefing? It may provide the wrong kind of attention.
9. Direct care staff need training and a model for how to do a debriefing and an internal review.
10. Over time, the debriefing of the person on whom restraints have been used should occur more and more frequently within the context of the individual's person-centered plan.
11. Does the person's plan address the crisis that occurred? An internal review should ask this.
12. These recommendations require the provider to act—this is good.
13. Where there are multiple providers serving a client, one of them may be doing less well than the others. What should be done then?
14. There may be a problem with a lack of system resources, such as the availability of people qualified to conduct sensory integration assessments. What should be done in these cases?
    A. The external review panel can be charged to advocate for system-wide resources where these are under-developed.
    B. Where does a recommendation about system resource needs go? Response: To the ongoing stakeholder group for faster response. And to regional quality councils.
15. The internal review process will look at individual incidents of the emergency use of restraints. This will be followed by the external review.
16. The person being served must have input into reviews, whether individually, in the review itself (a group setting), or by conversation or interview, whatever the person prefers.
17. Distinguish between debrief of staff and debrief of person following emergency use of restraints.
18. Add to data collected information on training: Who has been trained? What topics have they been trained on?
19. Ensure that original reports are preserved.
    A. Disagree-don't require this. First draft may be emotional and unclear. This document has legal implications.
    B. Follow-up reports can include additions but not changes to the original reports
    C. Provide best practices guidelines through training and in a manual for what should happen in a crisis.
    D. Yet, investigators do need to be trained.
    E. Favor first blush, raw feeling. This is important information to know.
    F. Dealing with the emotional content of a report is a provider training issue.
    G. The first person's comment is not a full report, but important.

H. Notification/reporting requirements can affect a report's comprehensiveness. If the first person sends something without the provider's review, this can cause problems. Process and timing matter.
I. This is an internal operations issue for the provider/manager.

20. The incident report and internal review should be submitted within 24 hours. The incident report is available for internal review.
    A. Can an incident report be verbal? Response: No, the provider should submit it online, use an online form.
    B. Providers still make phone calls as needed.
    C. The provider organization may need more time to review a person-centered plan than 24 hours so that the external reviewer can have the benefit of these observations.
    D. This can be addressed in the internal review as "follow up as needed" where the provider says what steps they intend to take and their implementation timeline. This is what would be sent to the External Review Panel.
    E. Is it redundant to have both progress notes and an incident report?

21. When a staff member applies hands to a person multiple times in a few minutes, is each application of hands a separate incident requiring multiple incident reports?
    A. Response: An "episode" or incident describes all uses of manual restraints and how long each use of manual restraints lasts. The provider defines the episode or incident, which is then reviewed internally and externally.
    B. The design of the reporting form permits full description of each use of restraints during an incident.
    C. Internal review is done when the incident (or episode or crisis) is over.

22. The steps taken to reintegrate the person back into their environment following the emergency use of restraints must be part of the incident report.
23. The incident report must include the person's assessment of what happened and what should happen next. Consider the SOAP Note model or another similar model that includes the person's view of what happened. (SOAP = person's *subjective* experience, provider's *objective* note , *assessment*, and *plan*).
24. The provider should consult with the Interdisciplinary Team as part of the internal review process.
    A. Concern about mandating a meeting of the team for every incident.
    B. This consultation could be done by phone.
    C. The policy and practices manual should list the best practices re: the interdisciplinary team and internal review.
    D. Every person does not have an interdisciplinary team. We need a broad term.
    E. Include other providers, too.
    F. Include families, too.

25. The incident report should contain:
    A. Information on the person's goals and progress toward them, to be used by both the internal review and external review.
    B. Positive indicators (See 9-12-12 Meeting Notes, page 5)
    C. Whether the person has a case manager.

26. Add to Goals of Successful Monitoring, Reports and Oversight (Section I of recommendation)
    A. Promote recovery and wellness
    B. Eliminate use of restraints
    C. Monitor effectiveness of training
    D. Monitor adequacy of resources

27. Training of providers should include training on trauma-informed care.
28. Will external review panel follow up with provider to see the results of the provider's implementation plan following the internal review of the emergency use of restraints?
    A. Response: The external review panel has flexibility to determine how it will respond, and may choose to do this.
    B. The provider should report on the implementation of any plan to the external review panel and to Licensing and to the Minnesota Council on Quality and the State Quality Council.
    C. The case manager must follow up with the provider on provider's implementation plan. If the case manager is not getting provider follow-up, then Licensing staff can go out.
    D. If the person has no case manager, but restraints are being used, this suggests the person may require a case manager.

29. We need to build more expertise in the crisis system.
30. The external review panel provides technical assistance (TA); it does not delivery training. It does not monitor the implementation of plans.
31. Who monitors at the provider level?
    A. Response: This is part of DHS oversight.

Additional Recommendations

These recommendations were added by the Advisory Committee to the Summary of the Monitoring Work Group's recommendations.

1. Internal review documents following the emergency use of restraints must be sent to Licensing Division, Ombudsman, and External Review Panel.
2. There should be ongoing stakeholder review of the implementation of these recommendations. Volunteers could be part of another existing group like the Minnesota Council on Quality or the State Quality Council.
3. Reporting, monitoring, internal review, debriefing of staff must accommodate organizations with one or two staff or one or two staff on duty. Allow up to 24 hours for internal review and debriefing, not just until the end of a shift.
4. When debriefing the person on whom the emergency use of restraints was applied, follow the person's plan to determine the timing or type of debriefing, or if there is no plan, hold the briefing within 24 hours.
5. Direct care staff must have training on how to conduct or participate in a debriefing and an internal review following the emergency use of restraints.
6. The internal review must ask whether person's plan addresses the crisis that resulted in the emergency use of restraints and the staff must revise the plan, if needed.
7. The external review panel is responsible to advocate for system resources. The external review panel's recommendation about the need for system resources will be forwarded to the ongoing stakeholder group (Refer to Item #2 above) and to regional quality councils, too.
8. The person being served must have input into both the internal and external review. This input must be offered in a way the person prefers, whether at the reviews, by individual interview or conversation, and with the people present that the person wants present to support him or her.
9. DHS, as part of its oversight role, must collect data on training related to emergency use of restraints, monitoring, reporting, reviews, including who has been trained and what topics they have been trained on.
10. Ensure that original reports on the emergency use of restraints are preserved.
    A. Follow-up reports can include additions but not changes to the original reports
    B. Provide best practices guidelines through training and in a manual for what should happen in a crisis.
    C. The incident report must be completed online and submitted within 24 hours of the emergency use of restraints. The incident report must be used in the internal review, which must also occur within 24 hours.

11. The provider must indicate in the internal review documents what the plan of action is and the timetable. This information must also be sent to the external review panel.
12. An incident describes all uses of manual restraints and how long each use of manual restraints lasts. The provider defines the incident, which is then reviewed internally and externally.
13. The design of the reporting form will permit a full description of each emergency use of restraints during an incident.
14. The steps taken to reintegrate the person back into their environment following the emergency use of restraints must be part of the incident report.
15. The incident report must include the person's assessment of what happened before and during the emergency use of restraints and what should happen next.
16. The policy and procedures manual will include best practices regarding consultation with the Interdisciplinary Team for the internal review process.

17. Included in the internal review process:
    A. If the person has one, the provider should consult with the Interdisciplinary Team as part of the internal review process. The consultation may be done by phone or electronically.
    B. If the person uses other providers, the provider should consult with other providers.
    C. The person's family or guardian.

18. The incident report must contain:
    A. Information on the person's goals and progress toward them, to be used by both the internal review and external review.
    B. Positive indicators
    C. Whether the person has a case manager and must list the case manager's name and contact information.

19. Add to Goals of Successful Monitoring, Reports and Oversight (Section I of recommendation)
    A. Promote recovery and wellness
    B. Eliminate use of restraints
    C. Monitor effectiveness of training
    D. Monitor adequacy of resources

20. Training of providers must include training on trauma-informed care.
21. The provider must send regular reports on its implementation of its plan following its internal review to the external review panel and to the appropriate regional or state body responsible for quality reviews.
    A. The external review panel has flexibility to determine how it will respond, and may choose to follow up on how well the provider has carried out its implementation plan following the internal review of the emergency use of restraints.
    B. The case manager must follow up with the provider on provider's implementation plan. If the case manager is not getting provider follow-up, then Licensing staff can cite the provider.

Appendix I – Implementation Summary (REVISED 9.7.12)

Minnesota Department of Human Services

Rule 40: Implementation Work Group Summary – REVISED
Rule advisory committee's recommendation to DHS

Attended one or both work group meetings:
Rick Amado, DHS-SOS; **Mark Anderson**, Barbara Schneider Foundation; **Don Chandler**, DHS-SOS; **Erwin Concepcion**, DHS-SOS; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, OMHDD; **Brad Hansen**, Arc Greater Twin Cities; **Anne Henry**, Rule 40 Advisory Committee Member, Minnesota Disability Law Center; **Renee Jenson**, Barbara Schneider Foundation; **Jill Johnson**, DHS-CMH; **Bob Klukas**, DHS-rules; **Pat Kuehn**, Rule 40 Advisory Committee Member, Ramsey County; **Chris Michel**, OMHDD; **Tim Moore**, Rule 40 Advisory Committee Member, U of M; **Dean Ritzman**, DHS-DSD; **Lauren Siegel**, DHS-DSD; **Mike Tessneer**, DHS-Compliance **Charles Young,** DHS-DSD; **Suzanne Todnem,** DHS-DSD, project lead; **Gail Dekker,** DHS-DSD, facilitator;

I. Context and reminders
   A. The charge of the work group was to recommend standards that will apply to persons with disabilities
   B. The standards will be expressed in statute, rule, and manual

II. Initial implementation – the process and key elements
   A. Overarching process
      1. Preparations – now, getting the conversations started
      2. Legislation, rulemaking, manual, waiver amendments
      3. Pre-implementation
      4. Adherence to new standards
      5. Evaluation
      6. Maintenance
   B. Getting culture change buy-in from all parties including: (who)
      1. Agency
      2. Provider executives and owners
      3. Provider management
      4. Direct care staff
      5. Persons, families, guardians, parents
      6. Counties
      7. Community, including advocacy groups, psychiatrists, medical doctors
   C. Culture change – how and why we get it
      1. Communicate with II.B.1-7:
         a. What is permitted under the new rule or statute
         b. What is prohibited under the new rule or statute
         c. Dates/deadlines for implementing the transition, based on data and evidence
         d. Benefits of the change (including financial, moral, professionalism, etc.)
      2. Emphasize the purpose of implementing the new policy is to increase safety for everyone involved in crisis situations

3. Provide a historical perspective to explain why this change is necessary
4. Change the conversations in the industry; use precise and careful language
    a. E.g., eliminate the phrase “inappropriate behavior” to recognize the function of ALL behavior
5. Change the service framework (from paternalistic to choice)
6. Use stages of change model: Pre-contemplation, Contemplation, Preparation, Action, Maintenance, Relapse Prevention
7. Emphasize skill building and creation; replacement of current tools
8. Share success stories – including the most challenging situations
9. Use and align funding with goals of the change
10. Promote and encourage organizational development

D. Provide resources and technical assistance
    1. Crisis resources
    2. On-site mentors
    3. Telepresence, online training and other technology utilized
    4. Functional Behavior Assessment
    5. Experts available to work through individual cases (not just hotline access)

E. Incentives – for the provider and the person served
    1. Rewards
    2. Honors
    3. Money
    4. Certification
    5. Based on outcomes; pay for performance

F. Expectations
    1. Ramp-up approach, graduated implementation process
    2. Be prepared for imperfect implementation; “hiccups”
    3. Providers and staff must know:
        a. New requirements
        b. Deadline(s) for implementation (process)
    4. Implementation deadline dates will be informed by data and not arbitrary

G. Implementation process values
    1. Transparency – the process should be transparent to providers, persons, stakeholders, the public, etc.
    2. Alignment – use positive practices with the providers
    3. Collaboration; team approach; avoid “us-them” atmosphere; DHS helps providers and persons
    4. Flexibility, including accommodating different learning styles and access needs
    5. Recognize varied levels of provider competencies
    6. Oversight and accountability
    7. Attainable while continuously striving to outperform previous accomplishments
    8. Teaching – provide resources in a way where the provider learns, gains competence

H. Timing options
    1. Various delay/gap approaches between implementation of new standards and enforcement of new standards
    2. Stages by provider; providers develop implementation plan for themselves:
        a. State sets deadline for systems change
        b. Baseline data from providers to DHS by Date A
        c. Provider creates their own implementation plan by Date B, includes a plan for each person in care and what training is necessary

d. All plans must be implemented by Date C unless provider asks for and receives a variance

I. Evaluation
   1. Use formative data to make changes
   2. Use implementation science experts

III. Sustaining the changes
   A. Provide resources and technical assistance
   B. Define future role of CSS, MCCP, COPE and Adolescent Crisis Services
   C. Building capacity
      1. Train trainers
      2. Coordinate with educational institutions on courses and degrees to create a new generation of professionals aligned with the needs of the new standards in Minnesota

Note

There are additional comments and additional recommendations below from the September advisory committee meeting. Additional Recommendations added new items to the recommendations of the work groups. Sometimes Comments are repeated as Additional Recommendations; this is intentional. The requested changes to the summary and recommendation above have already been directly implemented above.

IV. Additional comments on recommendation summary
   A. Committee is making large, expensive recommendations. Among all your recommendations, what is non-negotiable vs. nice to have? What are the costs/fiscal note of these recommendations?
      1. Response: Difficult to respond to this, because changing a culture does take resources.
      2. Response: When comparing costs, remember to include not just direct costs, but also downstream costs, such as fewer emergency hospital admissions.
   B. There should be an interdisciplinary steering committee to guide the implementation of these changes.
      1. The steering committee should focus on language and terms to be used in conversations to change culture.
      2. Yet, practices must change, not just conversations. Our approach to change doesn't have to be sequential; we can promote change on multiple levels at the same time.
      3. Research other states' approach to large-scale culture change.
   C. Address safety concerns.
   D. Consider the readiness of providers to make change. Types may include:
      1. "We are there already!" (Early adopters)
      2. "We work with people with challenging behaviors and do Rule 40 plans. We do it right and don't need to change anything." (Yet this is a real change that they may not accept the need for.)
      3. "This change doesn't affect us because we don't serve people with challenging behaviors." (This group may not realize that the people they serve, even if they are not challenging, are not getting the supports they need.)
   E. Concern about reaction from parents and guardians. Communicate with them about the change early and often.

        1. What is the family's incentive to adopt the changes? Does any incentive to change go only to providers? Can some incentives go to the person? Incentives would help the family.
    F. Transparency requires data. We need to know how many people are having restraints used on them, how often restraint is used, where it's happening, what injuries are caused by restraint, etc.
        1. We also need to know about the person's plan, positive and negative impact of changes.
    G. Establish a way for providers to mentor providers. Create a technical assistance (TA) team. Highlight providers who do well.
    H. Incentives need to reach direct service staff. It's not okay for any financial incentive to go only to the pocket of the CEO.
    I. DSD should have someone lead the implementation of these changes that has experience managing large system change and social policy implementation.
    J. Community buy-in must include psychiatrists and MDs regarding the use of medications.

V. Additional recommendations
    A. DSD and the steering committee should look to other states for implementation approaches.
    B. DSD should have help developing a data and research design to measure its success as it implements the new policies.
    C. Providers' organization implementation plans must include how they will transition persons from Rule 40 programmatic use of restraints.
        1. There needs to be oversight of providers' plans.
        2. There needs to be support for providers who currently use Rule 40s.
    D. Engage parents, guardians early and ongoing to address concerns that some parents may have about these changes. See II.B.5. above
    E. Engage advocacy groups, too. See II.B.7. above
    F. Community education and outreach must include psychiatrists and MDs regarding the use of medications.
    G. Implementation must address providers at all stages of readiness for change.

Appendix J – Rule 40 Advisory Committee Meeting Summary 6.20.13

Rule 40 Advisory Committee Meeting Summary: 6.20.13

Attending:

Committee Members: Kay Hendrikson, Bonnie Jean Smith, Anne Henry, Patricia Kuehn, Kelly Ruiz, Steve Anderson, Tracy Lisowski, Shamus O'Meara, Leanne Negley, Colleen Wieck, Barbara Kleist

DHS Staff: Alex Bartolic, Stacy Danov, Mike Tessneer, Bob Klukas, Dean Ritzman, Rachel Tschida, Loren Colman, Gregory Gray

Other Organizations and Guests: Rick Cardenas (Advocating Change Together), Joe Fuemmeler (Chrestomathy, Inc.), Kelly Ryan (Chrestomathy, Inc.)

Summary of Meeting

- DHS Deputy Commissioner Anne Barry convened the final The Rule 40 Advisory Committee meeting on 6-20-13.

- The Committee reviewed the attached "Abbreviated version" of the recommended language modifications and voted on each section.

- Shamus O'Meara, Class Counsel in the *Jensen v. Minnesota Department of Human Services* requested the following statement be included after each recommendation.

  "Regarding the revised draft narrative document, the *Jensen* Settlement Class reiterates its previously stated position (*see, e.g.,* e-mail correspondence dated April 2, 17, May 4 and 6) that the Settlement Class does not support any provision of the Rule 40 Committee narrative that is inconsistent with, or in violation of, the Settlement Agreement. The revised draft narrative continues to include exceptions for the use of mechanical restraint with erroneous statements that the "advisory committee members recommend" the temporary use of mechanical restraints, that "the advisory committee acknowledges" situations allowing for temporary use of mechanical restraints, and that "the advisory committee recommends" that providers may continue temporarily using mechanical restraints. *See* Draft Narrative at pp. 20, 23. We have never agreed to such provisions. Rather, the parties to the *Jensen* Settlement Agreement, including the State of Minnesota and Department of Human Services, agreed to eliminate the use of mechanical restraint for the Facility as defined in the Settlement Agreement. As we have

repeatedly conveyed, the definition of Prohibited Techniques in the Settlement Agreement was reached by consensus between the parties with active assistance from the consulting experts. The Prohibited Techniques section, like other sections of the Settlement Agreement, are best practices provisions that should be present throughout all State of Minnesota facilities.

The Settlement Class expressly preserves, and does not waive, all of its rights and positions."

- All modifications were made and are reflected in the Final 7-2-13 final document.

Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40

ABBREVIATED Version for use at Meeting on 6/20/13

(Page Numbers) noted in this document provide a reference to the page number that item/topic can be found in the 93 page Narrative version (June 2013).

Overview of Advisory Committee Recommendations (page 14)

Scope (page 14)

The advisory committee recommends its recommendations be placed in Minnesota Statute chapter 245A so that it will have broad application to all DHS-licensed services and programs. These recommendations focus on positive support practices, person-centered planning and the most integrated setting and will apply to children and adults.

The advisory committee recommends repeal of the current Rule 40 and that these recommendations manifest in rule, statute, and a positive support practices and policy manual.

General Recommendations (page 15)
There are some recommendations that the advisory committee makes that applies generally and is not limited to just one work group topic.

1. The positive practices manual should provide examples to illustrate what the standards mean and intend. The examples should include application of the standards in mental health situations.
2. The Plan - Advisory committee members discussed and decided that instead of creating confusion over different plan names and what elements would go in which plans, they recommend one plan for each person. Throughout this document, you will see references to different plan sections, all of which may be part of the one plan for each person. All plans and sections would be developed using positive approaches and be person-centered. Within each plan, there will be different sections that address the individual needs and desires of the person for whom the plan is designed. Each plan will be comprised of, among other things, the following required components :
    a) Person's goals – lists the person's goals
    b) Positive strategies – describes what positive strategies will be used with the person, describes what is important to the person
    c) Person's needs – describes what is important for the person
    d) Intervention – describes what to do in a crisis short of emergency use of manual restraint
3. Some committee members recommend the Department establish a small group of stakeholders to review the Georgia and Vermont positive support manuals and recommend adoption with modifications of other states' work.

Positive Support Strategies (page 17)
Advisory committee members recommend:

1. Requiring providers to be trained, competent and use positive support strategies;
2. Proper screening tools or checklists be used to determine when functional assessments are necessary;
3. Using the existing mental health crisis services for children and adults and mobile crisis teams

Assessment. This includes medical, dental and mental health diagnostic assessments. These assessments may be concurrent with a functional assessment or a functional behavior assessment.

Advisory committee members recommend DHS develop criteria for providers to use to help the provider determine when a functional behavior assessment is necessary. (page 17- Details are not repeated here)

Committee members recommend a positive strategies section: (page 19)

1. Accommodate the need for rapid and persistent changes;
2. Focus on quality of life improvement and not just whether target symptoms are alleviated;
3. Based upon best practices across disciplines; and
4. A screening tool or checklist for providers and counties to determine when there is a need for functional behavior assessment as considered in the positive strategies plan.

The advisory committee recommends a non-exhaustive list of permitted positive support strategy examples be provided in the forthcoming positive support manual.

Person-centered Planning (page 19)
The advisory committee recommends that person-centered planning begin as early as possible. (pg 20)

The advisory committee recommends a separate person-centered section in each person's plan.(pg 20)

The advisory committee further recommends that person-centered planning be done with a competent facilitator who has been trained in person-centered planning tools and be available to everyone who wants it. (page 20)

Permitted Techniques (page 20)
Advisory committee members recommend that the following techniques, although they might entail some physical contact with the person, should be permitted. They are not considered an emergency use of manual restraint or any other kind of prohibited restraint. This is not an exhaustive list of permitted techniques. (Page 20)

1. Positive behavioral support
2. Emergency use of a manual restraint
3. Temporary use of mechanical restraints for persons with serious self-injurious behavior coming from unregulated settings to DHS-licensed services with a plan designed to eliminate the use of mechanical restraints and overseen by professional staff and subject to reporting requirements
4. Physical guidance such as hand-over-hand contact to facilitate a person's completion of a task or response that is directed at learning a skill when the person does not resist or the resistance is minimal as determined by the support team. The support team is the service planning team identified in Minnesota Statute section 256B.49, subdivision 15, or the interdisciplinary team identified in Minnesota Rules, part 9525.0004, subpart 14, whichever applies (page 21)
5. Token reinforcement programs that do not permit removal of tokens from persons once they have been earned
6. Corrective verbal feedback
7. Physical contact, with no resistance from the person, to calm or comfort the person in distress
8. Minimal physical contact or physical prompt necessary to redirect a person's behavior when the behavior does not pose a serious threat to the person or others AND the behavior is effectively

redirected with less than 60 seconds of physical contact by staff OR the physical contact is used to conduct a necessary medical examination or treatment by a licensed health professional

9. Response blocking
10. Mechanical devices for medical conditions
11. Temporary withholding or removal of objects being used as a weapon (page 21)

The advisory committee recommends that use of permitted techniques be tied to notifications and reporting. (page 21)

Advisory committee members were not able to come to consensus on some permitted techniques such as the use of seat belt restraints and guided escort. Some committee members recommend seat belt restraints be permitted with a plan in place to move away from the dependency; they consider seat belt adapters to be different from mechanical restraints. Other committee members consider seat belt restraints like any other mechanical restraint that will be strictly prohibited with the exception of use during an implementation period. (page 21)

Some committee members raised concern about guided escort and are unclear whether consensus was met. The example shared involved a person who wanted to stay at a public recreation center past open hours. The person was forced to leave the center by staff as an alternate to police intervention. (pg 21)

Best practices are a complete ban on all use of mechanical restraints. (page 21)

Some committee members recommend permitting brief, five-second or less holds. The concern is that if every single hold, even for a few seconds, is reported that the more concerning restraints will be lost in the sheer number of reports being made. (page 21)

Prohibited Techniques (page 21)
For further explanation of items listed below, please see the Glossary in Appendix A. Advisory committee members recommend the following techniques be prohibited:

1. Use of mechanical restraint
2. Prone restraint
3. Manual restraint except in the case of emergency
4. Seclusion
5. Time out and room time out
6. Chemical restraint
7. Use of painful techniques
8. Use of faradic shock
9. Deprivation or restriction of rights
10. Use of punishment of any kind
11. Token reinforcement programs that require the person to earn normal goods and services
12. All level programs that move a person down the hierarchy of levels or use a response cost procedure.
13. Speaking to a person in a manner that ridicules, demeans, threatens, or is abusive or other inappropriate vocalizations;

14. Requiring a person to assume and maintain a specified physical position or posture as an aversive procedure, for example, requiring a person to stand with the hands over the person's head for long periods of time or to remain in a fixed position;
15. Totally or partially restricting a person's senses, including a pillow or blanket over a face;
16. Presenting intense sounds, lights, or other sensory stimuli as an aversive stimulus;
17. Using a noxious smell, taste, substance, or spray, including water mist, as an aversive stimulus;
18. Forced exercise;
19. Using a person receiving services to discipline another person receiving services;
20. Physical crisis management techniques;
21. Any hyperextension or twisting of body parts;
22. Tripping or pushing;
23. Any exacerbation of any medical or physical issue;
24. Containment that is medically contraindicated; and
25. Containment without monitoring (page 22)

The recommended prohibitions above represent the advisory committee's understanding of current best practices on which there was consensus except where explicitly noted. (page 22)

There is a lot of concern around the definition of "chemical restraint." Some committee members wish to clarify their intent that PRN use to treat a psychiatric symptom or disorder must: (page 22)

- Be within the person's prescribed use of the medication;
- Be given to the person at the person's request;
- Be taken voluntarily; and
- "Standard treatment" may include PRN use of medication. (page 22)

It must be noted that these standards allow for accommodations. For example, certain therapies (deep pressure interventions) for persons with disabilities may appear as manual restraint but are not. (pg 23)

Lastly, some committee members recommend allowing the use of arm limiters when such use is under the care of a highly qualified mental health professional and used to prevent serious self-injurious behavior. The highly qualified mental health professional would develop and oversee the positive strategies used to wean the person's use of the arm limiters. The use of arm limiters would not be subject to an arbitrary time limit. Permitted use would be based on the person's progress. If progress plateaus, then additional mental health professionals should be consulted. The minimum professional level required to use arm limiters with a person would be a staff person subject to the third tier of the recommended staff training. (Page 23)

Emergency Use of Manual Restraint (page 23)
The Advisory Committee recommends that a provider may apply only manual restraint against a person in an emergency, which is defined as a situation where the person's actions:

- pose imminent risk of physical harm to the person or others, and
- less restrictive strategies will not achieve safety.
- a person's refusal to receive or participate in treatment does not constitute an emergency. (page 23)

Advisory committee members feel that the costs of restraint to the person are too high to include damage to property as the sole basis for restraint or refusal to participate in treatment or take medications. However, property destruction that poses an imminent risk of physical harm to the person or others when less restrictive strategies will not achieve safety meets the definition of an emergency that warrants emergency use of manual restraint. (page 23)

The manual restraint techniques that will be permitted in an emergency cannot restrict the person's breathing, must not be medically contraindicated or apply pressure to the person's chest. (page 23)

Temporary Use of Mechanical Restraint for Self-Injurious Behavior (page 23)
The advisory committee acknowledges that sometimes, albeit rarely, situations arise where temporary use of mechanical restraints for self-injurious behavior should be permitted. The advisory committee recommends that a provider may temporarily continue the use of mechanical restraints when:

- The person exhibits serious self-injurious behavior;
- The person comes from an unregulated setting into a DHS-regulated setting;
- Immediate removal of the mechanical restraints cannot be safely accomplished without significant risk to the person;
- Application of mechanical restraint has been initiated and was routinely used in the unregulated setting; and
- Positive behavioral support strategies have been tried.(page 23-24)

The advisory committee acknowledges that although the use of mechanical restraints needs to be eliminated, when an individual coming from an unregulated setting has become dependent on the use of mechanical restraints, immediate cessation may present an unwarranted risk to the person. (page 24)

The advisory committee recommends all of the same notifications, reporting requirements and monitoring as the Emergency Use of Manual Restraint section. Some committee members recommend that data be collected, analyzed and shared publicly while in compliance with HIPAA privacy. (page 24)

Staff Training (page 24)
The committee recommends the effectiveness of training be measured through demonstrated competency of the skills in the setting in which services are provided. (page 24)

In addition to core training, the advisory committee recommends additional tiered training requirements for people based on the level of responsibility and qualifications. (page 24 -training topics on pages 25-27 –details are not repeated here.)

Some advisory committee members recommend twenty hours of annual training. (page 24-25)

The advisory committee recommends hands-on training including mentoring of staff. As noted above, the advisory committee values demonstration of competency and not just knowledge acquisition. (page 25)

Some committee members recommend that training on person-centered planning be on an as-needed basis or subject to competency testing in lieu of an annual training requirement. (page 26)

Some committee members recommend combining the training in tiers two through four for Designated Coordinators and Qualified Developmental Disability Professionals into an interactive online curriculum. (page 26)

Some committee members also recommend increasing compensation to providers to cover the extensive training recommended for staff. (page 27)

The advisory committee recommends evaluation of training. (page 28)

Committee members discussed and recommended using the Donald Kirkpatrick five levels of evaluation. (page 28)

Reporting and Notifications (page 28)
The advisory committee recommends an electronic format for reporting including the ability to request additional help and reporting of all permitted and unpermitted use of restraints.

Emergency use of manual restraints (page 28)
The advisory committee makes a detailed recommendation about what should be reported to the department's licensing division and to whom additional notifications of use of emergency use of manual restraint should go.

First, the advisory committee recommends that reporting should either work in conjunction with an existing process or be modeled after an existing incident reporting process. The initial report on the emergency use of restraint should be preserved as an original document and additions can be made as a follow up to the original report. (page 28)

Process. (page 28)
The advisory committee recommends that reports be filed online and be computer-based. The advisory committee also recognizes the role of oral reports, written reports, aggregate reports, reviews and debriefing.

Notifications. (page 28-29)
The advisory committee recommends notifications go to (list not repeated here)

What is reported. (page 29)
The advisory committee recommends the following information be reported to members on the notification list above:

1. All the people involved in the emergency use of restraint (e.g., staff, person, other clients, etc.)
2. Types of restraint used
3. Start and end time of restraint, including back-to-back uses of one or more restraints and when release attempts were made
4. What de-escalation measures were taken to avoid the restraint

    a. What techniques tried
    b. When were they tried
    c. How long were they tried
5. What was learned
6. Outcome of the restraint including:
    a. Any injury to staff or person and if so, provide a description
    b. Whether any medical diagnostic or treatment occurred
    c. How the persons involved were reintroduced into their environment (p. 29)

Temporary Use of Mechanical Restraints for Self-Injurious Behavior (page 29)
The advisory committee recommends that the same reporting and notification requirements for Emergency Use of Manual Restraints apply to the Temporary Use of Mechanical Restraints for Self-Injurious Behavior.

Other events (page 29)
Advisory committee members recommend reporting requirements for other events in addition to emergency use of manual restraint. These other events are:

1. The person's hospitalization
2. Emergency responder/law enforcement/911 calls regarding a person
3. Any violations of the new standards such as use of a prohibited procedure with a person
4. PRN use of medications (p. 29)

Although committee members acknowledge that some PRN use of medications is appropriate, some committee members recommend reporting all PRN use. The committee recommends that PRN administration must be voluntary by the person. (p. 29)

There is general consensus that a person's hospitalization should be reported but inquiry was made about whether all hospitalization should be reported or just unplanned hospitalization. (p.30)

Monitoring (page 30)
Restraint monitoring (page 30)
Advisory committee members recommend monitoring persons during the emergency use of manual restraint to ensure the restraint is done in the safest way possible and to reduce risk of injury.

Internal review (page 30)
The advisory committee recommends an internal review process following every emergency use of manual restraint to determine what happened and what can be learned from the situation. The internal review would focus on the emergency use of manual restraint context and antecedent circumstances.

External review (page 31)
The advisory committee recommends an external review process following every emergency use of manual restraint.

The advisory committee recommends the external reviewer be resourced effectively.

Oversight (page 31)
The advisory committee recommends that the following outcomes and indicators be measured and reported. (List not repeated here)

Data (page 31)
Advisory committee members recommend the oversight entity gather and maintain data sufficient to conduct trend analysis on a system-wide level and to detect potential problems at the provider level. The data should include all the restraint data above as well as data about training related to emergency use of restraints, monitoring, reporting, reviews and who has been trained and on what topics they have been trained.

Committees and teams (page 32)
For example, during implementation discussions, some committee members suggested an interdisciplinary team / steering committee to guide implementation of the changes.

The advisory committee recommends a state level committee could serve in one or multiple capacities such as:

1. Performance reporting system and checking on the reliability, validity, and timeliness of data including emergency use of restraint, injuries, deaths, and not to prevent restraint, injuries and deaths
2. Review and advise on biennial review of positive practices manual
3. Make recommendations regarding resources (p. 32)

The advisory committee recommends formation of regional committees comprised of members from multiple disciplines and clinical expertise to participate in oversight, implementation and evaluation of practices. (p. 32)

Implementation (page 32)
Initial implementation (page 32-33)
The advisory committee recommendation addresses the following key processes and elements, which are included in the following this list. (not repeated here)

Overarching process (page 33)
The advisory committee recommends using legislation, rulemaking, a manual and waiver amendments to establish new standards.
The work group and advisory committee recommend that preparations start immediately by communicating the new standards, particularly the shift from restraint, seclusion and aversive techniques.

The advisory committee recommends starting those conversations in the community with providers, family members, persons served, advocates and other stakeholders.

Offering resources, training and technical assistance for providers (page 33-34)

The advisory committee recommends that implementation address providers at all stages of readiness for change. That is, some providers are already aligned with these new standards; some providers think they are already aligned but misapprehend the standards; and some providers have little alignment.

Providing incentives to providers, persons served and family members (page 34)
Committee members recommend that the department offer incentives to providers to spur compliance.

Setting expectations (page 34)
The advisory committee recommends:

1. A graduated, ramping-up approach;
2. Providers and staff must know what the new requirements are and the deadlines for the implementation process; and
3. The implementation deadlines will be based on facts and will not be arbitrary

Implementation process values (page 34)
The advisory committee recommends these values be upheld in the implementation process planning, design and execution (not repeated here)

Timing options (page 35)
The advisory committee recommends a graduated approach to implementation. The graduated implementation would be completed before the established end date when all the new standards are in full enforcement.

Advisory committee members recommend:

1. Passage of legislation followed by stages of implementation and enforcement of the new standards in which all providers must come into compliance by a given date (one size fits all approach)
2. Stages by providers where different providers will have different enforcement dates.

Some committee members recommend an overall implementation time period of eighteen months.

Evaluation (page 35)
The advisory committee recommends evaluation of the implementation process based on formative data to make changes where necessary and to use implementation science findings and experts.

Interdisciplinary team (page 35)
Committee members suggest a team of interdisciplinary membership that may include interagency members or interdepartmental members as useful. The interdisciplinary team would guide the implementation of the new standards by focusing on language and terminology used in conversations but also researching other states' approaches to large-scale culture change.
The advisory committee recommends that providers design a transition plan for each person who currently engages in self-injurious behavior for which mechanical or manual restraint is used or who have a plan that includes programmatic use of restraints in place. Data collection and monitoring of the person's progress would be reported to DHS licensing, the Ombudsman for Developmental Disabilities and Mental Health, and an external review entity.

Sustaining the changes (page 36)
The advisory committee recommends:

1. Continue providing resources and technical assistance;
2. Consider the future roles of Community Support Services (CSS), Metro Crisis Coordination Program (MCCP), Community Outreach for Psychiatric Emergencies (COPE) and Adolescent Crisis Services;
3. Continue to build capacity of an array of competent providers throughout the state;
4. Persons, self-advocates, family members, guardians, conservators and community members should continue to have an active role in sustaining the changes as referenced in the above "creating culture change" section;
5. Continue to use and update best practices as they change over time; and
6. Michael Mayer and Derrick Dufresne recommended establishing ongoing training requirements that include competency demonstrations in specified areas such as:
    a. Primary preventative measures rather than restraint;
    b. Interventions that are less intrusive than restraints;
    c. Effective ways to de-escalate situations to avoid restraints; and
    d. Crisis intervention techniques that utilize alternatives to restraint. (p.36)

Advisory Committee Recommendation Concerns (page 37)

Concerns. These are some overarching concerns that committee members have expressed in regard to establishing new service standards and how committee members have decided to address them.

1. Concern that providers will exit the system and there will not be enough competent providers to meet the demand for services. Committee members discussed that with change, this is always a concern. Proper training of providers will alleviate some of this concern because once providers are trained on the new standards, there will be less fear that results in providers exiting the system.

2. The challenges of funding and resource limitations. Committee members discussed that this is always a concern as well. One way to address this is to stage implementation in phases and spread the demand on resources out while building capacity to provide services that meet the new best practices standards. Of course, finding the most efficient ways to deliver services and be in compliance will aid in meeting the funding limitations.

3. Concern about keeping persons safe and the increased cost of regulation. Committee members discussed that the whole point of the new standards is to keep persons safe as well as safe. The increased cost of regulation can be handled much like the funding challenges raised above; spreading the costs out over time and finding efficient ways of doing things will mitigate concerns.

4. Concern about the current lack of data. Committee members requested a survey of current providers to gather some data about the use of restraints in licensed facilities. Although the results were disappointing, the Advisory Committee and the Department were both able to gain some useful information. In particular, data reporting must be quick, easy and affordable for the provider to report.

Appendix A – Glossary of Technical Terms (page 40 – 45)

The following terms are technical terms or are used in a technical sense in this document. For clarification, we have provided the following definitions.

1. Adaptive Assessment –An assessment that measures capacity and skills of a person.
2. Chemical restraint **–** This is a prohibited technique. "The administration of a drug or medication when it is used as a restriction to manage the [person's] behavior or restrict the [person's] freedom of movement and is not a standard treatment or dosage for the [person's] condition. Orders or prescriptions for the administration of medications to be used as a restriction to manage the [person's] behavior or restrict the [person's] freedom of movement shall not be written as a standing order or on an as-needed basis (PRN)."[1]
3. Containment without monitoring –This is a prohibited technique. Containing, restricting, isolating, secluding or otherwise removing a person from the stream of daily activities or fully or partially immobilizing a person without being monitored for medical and psychological distress. This includes sending a person to a bedroom to cool off, calm down or relax when there is no plan to monitor the person who has been sent off.
4. Crisis Plan – The written plan developed to provide the service provider with evidence-based techniques to help support a person during a period of crisis.
5. Deprivation - This is a prohibited technique. Removal of or denial of access to a particular reinforcer for a period of time.
6. Deprivation also known as restriction of rights **–** This is a prohibited technique. The removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Often times the positive reinforcer is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer.
7. Designated Coordinator – refers to the designated staff person responsible for evaluating the delivery of services by a license holder. The designated coordinator is responsible for reviewing and evaluating incidents that occur during the delivery of a license holder's services, and creating strategies to prevent incidents in the future.
8. Emergency – A situation when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. A person's refusal to receive/participate in treatment shall not constitute an emergency. Damage to property that does not pose an imminent risk of physical harm to self or others does not constitute an emergency.
9. Emergency Use of Manual Restraint – This is a permitted technique. An emergency in which a manual restraint is used when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. A person's refusal to receive/participate in treatment shall not constitute an emergency situation.
10. Faradic shock **–** Faradic shock is a prohibited technique**. Faradic shock m**eans of or pertaining to a discontinuous, asymmetric, alternating current from the seconding winding of an induction coil.

[1] This definition is from page three of Attachment A to the Jensen settlement agreement. The bracketed portion indicates where terminology was modified for consistency. The settlement agreement used "resident" while the recommendation uses the term "person."

11. Functional Assessment – Refers to the assessment defined in the Adult Mental Health Act, Minnesota Statute 245.462, subdivision 11a or the Children's Mental Health Act, Minnesota Statute 245.4871, subdivision 18.
12. Functional Behavior Assessment – An assessment that operationally defines the interfering behaviors, identifies the situations in which the interfering behaviors are likely to occur and not occur, and generates a hypothesis of why the behavior occurs.
13. Interfering behavior – Means a behavior or psychiatric symptom that prevents a person from a more integrated setting or from participation in the most integrated setting.
14. Level programs – Level programs are prohibited if they entail a response cost procedure. Level programs means a type of program in which participants move up and sometimes down a hierarchy of levels contingent on meeting specific performance criteria with respect to target behavior. Moving up a level gains access to more privileges and the person is expected to demonstrate more independence. Moving down a level reduces privileges and provides access to a smaller universe of opportunities. Losing privileges and moving down a level is a response cost procedure (i.e., negative punishment). Some level programs are a permitted technique; some
15. Manual restraint **–** Manual restraint is a permitted technique when used in an emergency. Manual restraint means "physical intervention intended to hold a [person] immobile or limit a person's movement by using body contact as the only source of physical restraint. It is any manual method that restricts freedom of movement or normal access to one's body, including hand or arm holding to escort a person over [the person's] resistance to being escorted. The term does not mean physical contact used to: facilitate the person's completion of a task or response when the [person] does not resist or the [person's] resistance is minimal in intensity and duration; conduct necessary to perform medical examination or treatment; response blocking and brief redirection used to interrupt a person's limbs or body without holding a person or limiting [the person's] movement; or holding [a person], with no resistance from that [person], to calm or comfort."[2]
16. Medical restraint – Medical restraint is a permitted technique. Medical restraint means when devices are used to treat a person's medical needs to protect a person known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a person with physical disabilities in a manner specified in the person's treatment plan. Medical restraint and psychotropic and/or neuroleptic medications shall not be administered to clients for punishment, in lieu of adequate and appropriate habilitation, skills training and behavior supports plans, for the convenience of staff and/or as a form of behavior control.
17. Negative reinforcement – The removal of a stimulus or consequence that results in a behavior increasing. For example, if a person pretends to be sick to get out of having to complete their house chores, they may be negatively reinforced because they avoided having to do chores. If they pretend to be sick in the future to avoid chores, we can assume that getting out of chores negatively reinforces pretending to be sick.

[2] This definition is from page 2 of Attachment A to the Jensen settlement agreement. The bracketed portions indicate where terminology was modified for consistency. The settlement agreement used "client" and "individual" and pronouns while the recommendation uses the term "person."

18. Pain – Pain is a prohibited technique. Pain includes physical pain, mental pain, or emotional distress**.**
19. Person Centered Planning – A family of approaches to organizing and guiding community change in alliance with people with disabilities and their families and friends; a strategy used to facilitate team-based plans for improving a person's quality of life as defined by the person, their family and other members of the community and that focuses on the person's preferences, talents, dreams and goals.
20. Positive Reinforcement – Positive reinforcement is a permitted technique. Positive reinforcement is a procedure in which a consequence or stimulus is presented following a behavior and the behavior increases. For example, a person completes their chores and is immediately given monetary reward or allowance. If that person does their chores more often, we can assume that the monetary reward was a positive reinforcer.
21. Positive Strategies section – the section of the person's plan that fills the role of an "intervention plan" that equips and prepares providers to positively and effectively help the person make progress in their personal repertoire towards the life they desire to live.
22. Prone restraint – Prone restraint is a prohibited technique**.** Prone restraint is **a**ny manual restraint that places the person in a face-down position. Prone restraint does not include brief physical holding of a person who, during the emergency use of a manual restraint, rolls into a prone or supine position as long as staff restore the person to a standing, sitting or side-lying position as soon as possible. [3]
23. Punishment – This is a prohibited technique. A procedure used to reduce or stop a target behavior .
    a. **Positive or Type I punishment.** Decreasing the rate or future likelihood of a target behavior by applying an aversive. Type I punishment includes overcorrection techniques as well as the simple application of a negative reinforcer (an aversive):
        i. **Positive practice overcorrection**. The use of a behavioral change tactic based on positive punishment in which, contingent on the selected target behavior, the learner is required to engage in effortful behavior directly or logically related to fixing the damage caused by the selected target behavior. Example: A person failed to make his bed when asked to do so. The person is required to make his bed ten times or to make his bed and all of his housemates' beds.
        ii. **Restitutional overcorrection**. A form of overcorrection where contingent on the selected target behavior, the person is required to clean, repair, or correct the damage or return the environment not only to the original state but to bring the environment to a condition vastly better than it was prior to the selected target behavior. Example: A person spills a cup of milk. Not only is the person required to clean up the milk and safely dispose of the broken glass, but is required to vacuum and mop the entire house (the overcorrection).
    b. **Negative or Type II punishment.** Decreasing the rate or future likelihood of a target behavior by removing a positive reinforcer. Negative punishment includes but is not limited to:

[3] This definition is from page two of Attachment A to the Jensen settlement agreement.

iii. **Response Cost.** The use of negative punishment in which, contingent on a behavior, a specific amount of a reinforcer is removed.

iv. **Loss of privileges**. Reduction in status and/or access to reinforcers due to a levels change in a token economy or another levels-based program.

24. Qualified Developmental Disability Professional (QDDP) - An individual who meets the qualifications specified in Code of Federal Regulations, title 42, section 483.430.
25. Response Blocking – Response blocking is a permitted technique. Response blocking is the use of physical means to temporarily block a physical blow or to physically intervene as soon as the person begins to emit the selected target behavior to prevent or "block" the completion of the response. Response blocking does not involve immobilizing a person in any manner.
26. Rights –The controlling rights afforded to a person in a licensed setting and includes the right to privacy from visual and audio taping unless a signed consent form is completed and room monitors and door alarms.
27. Seclusion **–** This is a prohibited technique. "The placement of a person alone in a room from which egress is:
    a. noncontingent on the person's behavior; or
    b. prohibited by a mechanism such as a lock or device or by an object positioned to hold the door closed or otherwise prevent the person from leaving the room."[4]
28. Target behavior –A response that is made the object of analysis.
29. Time out and room time out **–** Time out and room time out are prohibited techniques. Time out and room time out means "removing a person from the opportunity to gain positive reinforcement and is employed when a person demonstrates a behavior identified in the [individual program plan] for reduction or elimination. Room time out means removing a person from an ongoing activity to a room (either locked or unlocked)."[5]
30. Token reinforcement programs that require the person to earn normal goods and services **–** This is a prohibited technique. Token reinforcement programs that deprive the person of normal goods and services such as phone use, normal access to food, water, outings into the community, privacy and movement.
31. Trauma-informed care –An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. (SAMHSA definition)
32. Use of mechanical restraint **–** Use of mechanical restraint is a prohibited technique. Mechanical restraint means the use of a device to limit a person's movement or hold a person immobile as an intervention precipitated by the person's behavior."[6] "The term does not apply to devices used for medical restraint. Mechanical restraint includes the use of metal handcuffs, shackles, leg hobbles, cable tie cuffs, PlastiCuffs, FlexiCuffs, posey cuffs, Velcro soft cuffs, fabric straps,

[4] This definition is from page three of Attachment A to the Jensen settlement agreement.
[5] This definition is from page three of Attachment A to the Jensen settlement agreement. The bracketed portion indicates a term that might not be consistent with the remainder of the document or direction of the new standards.
[6] This definition is from page two of Attachment A to the Jensen settlement agreement.

and any other mechanical means to restrain a person. Use of mechanical restraint is a prohibited technique.

33. Use of painful techniques – Use of painful techniques is prohibited. Painful techniques **m**eans the use of any technique that induces pain, causes damage, illness or injury or restricts breathing. This includes intentional infliction of pain or injury, intentional infliction of fear of pain or injury, dehumanization and degradation.
34. Use of punishment of any kind – Use of punishment of any kind is prohibited. This means any aversive technique that punishes in any form. Examples of punishment includes revocation of a planned outing as a consequence of a person's behavior, hitting, pinching, or slapping, water misting, overcorrection, withholding money, deprivation of meals, sleep, clothing, medications, medical treatments, or therapy.