Positive Support Transition Plan (PSTP) Instructions

Templates:

Positive Support Transition Plan, DHS-6810 (PDF)
or https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810-ENG

Positive Support Transition Plan Review, DHS-6810A (PDF)
or https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810A-ENG

Behavior Intervention Reporting Form (BIRF), DHS-5148
or https://edocs.dhs.state.mn.us/lfserver/Secure/DHS-5148-ENG

Additional details about the development of a PSTP:

Guidelines for Positive Supports in DHS-Licensed Settings, DHS-6810C (PDF)
or https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810C-ENG

The following instructions provide the requirements for the creation, review and reporting of PSTPs as identified in Minnesota Statutes, section 245D.06, subdivision 8 and Minnesota Rules, part 9544.0070, subpart 3.

These instructions are effective Dec. 18, 2017.

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Chapter 1: Getting started

What is a Positive Support Transition Plan (PSTP)?
A person’s expanded support team develops a PSTP to implement positive support strategies to:

- Eliminate the use of prohibited procedures as identified in Minn. Stat. §245D.06, subd. 5
- Avoid the emergency use of manual restraint as identified in Minn. Stat. §245D.02, subd. 8(a)
- Prevent the person from physically harming self or others.

The PSTP identifies baseline, trigger, escalation, crisis and recovery stages for a person and contains positive, person-centered strategies to intervene during each stage of crisis. The PSTP directs the actions of a person’s provider and their staff. A PSTP primarily is constructed from information provided by a functional behavior assessment (FBA), person-centered service planning and data.

When must a PSTP be developed?
The following are some examples when a PSTP must be created:

- Within 30 calendar days after service initiation when an expanded support team determines the need to therapeutically phase out a procedure used before service initiation
- Before requesting approval from the commissioner for the use of a procedure
- Within 30 days of the third emergency use of manual restraints (EUMR) in 90 days or the fourth use of EUMR in 180 days.

PROCEDURES REQUIRING PHASE-OUT

Minnesota Rules, Chapter 9544.0060 prohibits use of aversive or deprivation procedures:

- As a substitute for adequate staffing
- For a behavioral or therapeutic program to reduce or eliminate behavior
- As punishment
- For staff convenience.

Any use of the following procedures beyond the initial 11-month phase-out period must be reviewed by the External Program Review Committee (EPRC) and approved by the commissioner. Please note, this is not a comprehensive list.

- Chemical restraint
- Mechanical restraint
- Manual restraint, except in an emergency
- Time out
- Seclusion
- Aversive procedures
- Deprivation procedures.
Who must participate in the development of a PSTP?

The law requires licensed providers to develop the PSTP in consultation with the person’s expanded support team. An expanded support team includes the following:

- The person who receives services
- The person’s legal and/or authorized representative (if applicable)
- The person’s case manager (if applicable)
- Representatives of any providers of the service areas relevant to the needs of the person
- A licensed health, mental health professional or other licensed, certified or qualified professionals or consultants (e.g., a psychologist, counselor, psychiatrist, etc.) working with the person and included in the team at the request of the person or the person’s legal representative.

Who is qualified to author a PSTP?

The provider may determine who authors the PSTP, however, the person who reviews the PSTP must meet the definition of a qualified professional in Minn. R. 9544.0020, subp. 47. Both the author of the PSTP and the qualified professional must meet the training requirements outlined in Minn. R. 9544.0090.

The expanded support team develops the plan for the PSTP. Input from these members should be incorporated.
Chapter 2: Creation of a positive support transition plan

How to complete the initial PSTP

The author should complete all questions in Parts A-F on the PSTP template. The template has the definitions of important terms within the document. Additional guidance for each part follows:

PART A: BACKGROUND INFORMATION

You must complete all sections of Part A. Under Service(s) and Treatment Provider(s) Involved in the Implementation of Plan, list both the name of the organization(s) and the individual names of the participants.

PART B: TARGET INTERVENTIONS

In Part B, use the functional behavior assessment (FBA) to identify which interventions the staff will target for reduction or elimination (these are called the “target interventions”).

Your steps:

- Describe the target intervention(s), including emergency use of manual restraint and/or the prohibited procedures the team has identified to be phased out. If the team has identified more than one target intervention, number the interventions.
- Identify a data collection method to monitor the incidence of target interventions. Some methods include frequency count, duration recording, time sampling, interval recording, rating scale and permanent product (for more information on data collection methods, see Chapter 3, Data collection).
- Identify the desired and/or alternative positive support strategies or interventions to use in place of each target intervention. If multiple target interventions were identified, identify which alternative intervention replaces which target intervention.
- Identify the positive support strategy objectives. Include measurable criteria. There must be a positive support strategy objective for each target intervention.
- Measure baseline data for reference in the positive support strategy objective. The baseline data must be collected over a period of no less than two weeks and include all target interventions. If unable to acquire baseline data, document why you could not obtain the data.
- Identify alternative intervention(s) that have been attempted, considered and rejected as not being effective or feasible.
PART C: TARGET BEHAVIORS

In Part C, the PSTP must identify the behaviors targeted for elimination (i.e., target behaviors). A target behavior is a specific action the person has exhibited that:

- Has resulted in the need for a behavioral intervention
- Is identified for elimination concurrently with a target intervention.

How to complete:

- Include any comments that will assist in defining the target behavior. If the team has identified multiple target behaviors for elimination, number the target behaviors.
- Identify the objective data collection method staff will use to monitor the incidence of the target behavior (i.e., frequency count, duration recording, time sampling, interval recording, rating scale, permanent product or other). For more information on data collection methods, see Chapter 3, Data collection.
- Identify a desired alternative action for each target behavior. Describe the instructional methods for teaching the person about alternative actions that can replace target behaviors. If the team identifies multiple desired alternative actions, the PSTP must identify which alternative desired action replaces which target behavior.
- Using information provided by the functional behavior assessment (FBA), identify the hypothesized purpose of the target behavior. To avoid the need for future PSTPs, the plan must work to eliminate the underlying cause of the target behavior.
- Measure baseline data for each target behavior. The baseline data must be collected over a period of no less than two weeks and include all target behaviors in the PSTP. If unable to acquire baseline data, document why you could not obtain the data.
- Describe the reported and/or observed impact the target behavior has had on the person’s quality of life.

PART D: CRISIS SUPPORT PLANNING AND RESPONSE

In Part D, the PSTP must describe the five stages of crisis framework:

- Calm/ideal
- Trigger
- Escalation
- Crisis
- Recovery
Figure 1: The five stages of crisis framework

For the purposes of the PSTP, “crisis” refers to situations that:

- Exceed the person’s resources and coping mechanisms
- Have the potential to endanger the health and safety of the person or others.

The framework also assists expanded support teams to perform their own preliminary analysis of reoccurring crises.

Not every crisis follows this set pattern. Some crises move straight from a trigger phase to a crisis stage. Sometimes a recovery phase can escalate back into another crisis. Every crisis can be unique.

Part D of the PSTP identifies ways to support the person in each phase. Strategies will vary from person to person, as different intervention methods will work for some people and not for others. Information provided in this portion of the PSTP should identify what the person typically “looks” like in each stage. This could include information about the person’s typical affect, behaviors, expressions, sounds or words they typically exhibit in each stage.

**Stages**

**The calm or ideal stage:** This stage indicates what normal or calm functioning would look like for the person. “Calm or ideal” varies for every individual. In this stage, teams identify the person’s affect and typical behavior in an optimal state. The teams also identify the strategies or methods they use to support the person to help the person maintain a calm or ideal state. Some strategies or methods that support the person may include the use of psychotropic medication, counseling, emotional regulation training, skill building and participation in preferred activities.

**The trigger stage:** This stage describes the identified triggers or antecedents (i.e., situations, words, people, decisions, critical periods, etc.) that set the person toward a crisis. The idea behind crisis prevention is that a team should assist the person to either avoid or cope with triggers. The PSTP must identify proactive strategies to support the person so they can cope with or avoid triggers or antecedents. Proactive strategies focus on strategies to use before the person encounters a known trigger or antecedent. The PSTP also must identify reactive
strategies that staff will use after the person has encountered a trigger or antecedent. Reactive strategies focus on methods to use after encountering a trigger/antecedent.

**The escalation stage:** This stage refers to the happenings, events and/or behaviors that typically occur after a trigger and before a crisis. Describe the support or intervention strategies staff will use during the escalation stage. This could include de-escalation techniques, counseling strategies, PRN medication, crisis lines, etc., which may be effective for the person in this stage. This is a critical period in which there is an opportunity to assist the person and avoid a crisis.

**The crisis stage:** This is the stage when things are at their worst. Because the person in this stage may endanger the health and safety of themselves or someone else, some sort of behavioral intervention often is necessary. Describe the intervention methods staff will use when the person is in the crisis stage. These intervention methods could include calling 911 or the emergency use of manual restraint.

**The recovery phase:** This is the period just after a crisis. This is when the person is on their way back to the calm or ideal phase but emotions and behavior may remain heightened. The person may also experience ‘low’ emotions such as remorse or depression during the recovery phase. Describe strategies or methods to support the person in the recovery phase. These may include debriefing the person, suggesting the person call a friend or ally, giving the person space, etc. The goal of the recovery stage is to assist the person toward the calm or ideal stage.

**PART E: QUALITY OF LIFE**

In Part E of the PSTP, you must identify a minimum of two quality of life indicators. The two quality of life indicators must be chosen from two of the domains of a meaningful life (e.g., one quality of life indicator from community membership and one quality of life indicator from control over supports).

Quality of life indicators are reportable or observable outcomes that are measurable and important to the person. Use quality of life indicators to assess beneficial changes the person wants that enrich his/her life experiences. When possible, choose quality indicators that reflect things the person’s target behaviors prevent them from accessing or achieving.

Providers must identify how staff will collect data on each quality indicator.

*Domains of a meaningful life*

The domains of a meaningful life are:

- Community Membership
- Health, wellness and safety
- Own place to live
- Important Long-term relationships
- Control over supports
- Employment earnings and stable income.
PART F: AUTHORSHIP AND CONSENT

The PSTP must include:

- The name and position or title of the author of the PSTP
- The dated signature of the qualified professional who contributed to the development of the PSTP
- The dated signature of the person or their legal representative.

By signing the PSTP, the person or his/her legal representative provides consent to the intervention(s) described in the PSTP. The person or representative can withdraw consent at any time. The consent will expire and a new consent must be obtained on an annual basis. For purpose of consent, annual means before or within the same month of the subsequent calendar year.

A provider must obtain written informed consent from the person who receives services or the person’s legal representative, acting within the scope of their authority, before:

- Initially implementing a PSTP
- The initial consent expires (if the provider intends to continue with the implementation of the PSTP after the expiration date)
- A substantial change is made to the PSTP. (Chapter 6, Revising the PSTP has guidance on how to determine if a substantial change has happened).

You must send completed PSTPs to DHS. Find instructions under Chapter 8: External reporting.
Chapter 3: Data collection

Parts B, C and E of the positive support transition plan require the identification of a data collection method. Data collection is important for determining the success of any plan. Resources for best practices on data collection can be found under Minn. R. 9544.0030, Subp. 4. Examples of data collection methods are identified on form DHS-6810; below is a description of those methods:

**Frequency count**
A method of counting the number of times an event occurs during a given period. Frequency count is the most common measure utilized for tracking events. Each time an event occurs, it is recorded on a data sheet. Frequency counts work well for measuring low-to-medium rates of interventions, behaviors and quality of life indicators, but not as well for high frequency or long-lasting events.

**Duration recording**
Measures the length of time an event occurs. This method works well when the length of an intervention, behavior or quality of life indicator is a primary concern (i.e., low frequency behaviors that are displayed more than momentarily, interventions that occur less frequently but for long durations or quality of life indicators that occur less frequently but for long durations). The onset and offset need to be clearly defined.

**Time sampling**
A method of spot-checking to determine if an event is occurring at specific times. This method is suited for times when continuous observation is not possible or feasible or when an event occurs so frequently that it is difficult to track using frequency count. It is used by recording the presence (+) or absence (-) of an intervention, behavior or quality of life indicator at specific points in time. Time periods should be divided into equal intervals.

**Interval recording**
Divides the observation time into equal intervals and the event is recorded as either occurring (+) or not occurring (-), at any time during each interval. Similar to time sampling, interval recording is suited for high frequency event recording during continuous observation periods.

**Rating scale**
Measures the intensity of an event. When using the rating scale method, the observer selects a numerical rating representing the level of intensity from a series of defined values such as 0 (calm), 1 (agitated), or 2 (aggressive).

**Permanent product**
Measures the outcome or product of an event. This method is used for times when it is not easy or possible to observe an event, but the outcome or product can be observed. Examples of permanent products include taking out the trash, making a bed, refraining from self-injury (no visible marks) or receiving a paycheck, etc.

**NOTE**
If you have a difficult time accurately recording the intensity, duration or incidences of a target intervention, target behavior or quality of life indicator, consider changing your data collection method.
Chapter 4: Conditions for the use of procedures

Providers must meet the following conditions for each of the listed types of procedures incorporated in the PSTP. These procedures must comply with other standards in Minn. Stat., §245D.06 and §245D.061 and must be used only when less restrictive interventions are determined to be ineffective.

- **Mechanical restraint:**
  - A member of the expanded support team must consult with the person's primary care physician to determine whether implementing the procedure is medically contraindicated
  - Use of mechanical restraint that results in restriction of two or fewer limbs or that does not restrict the person's movement from one location to another requires the following procedures:
    1. The person must be given an opportunity for release from the mechanical restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes that the mechanical restraints are used
    2. A staff member must check on the person and make efforts to lessen or discontinue the mechanical restraint at least every 15 minutes. The time each effort was made and the person's response to the effort must be noted in the person's permanent record
  - Use of mechanical restraint that results in restriction of three or more of the person's limbs or that restricts the person's movement from one location to another must meet the conditions of items (1) and (2) and the following additional conditions:
    3. A staff member must remain with the person during the time the person is in the mechanical restraint
  - NOTE: Mechanical restraint includes the use of restraints that prevent/impair a person’s ability to remove a seat belt during transport in a motor vehicle. However, this specific type of mechanical restraint is exempt from item (2).

- **Manual restraint:**
  - The person's primary care physician must be consulted to determine whether implementing the procedure is medically contraindicated
  - The person must be given an opportunity for release from the manual restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes
  - Staff must make efforts to lessen or discontinue the manual restraint at least every 15 minutes, unless contraindicated. Staff must note the time each effort was made and the person's response to the effort in the person's permanent record.

- **Time out procedures:**
  - When possible, staff must implement time out procedures in the person's own room or other areas commonly used as living space, rather than in a room used solely for time out
  - When possible, the person must be returned to the activity from which he/she was removed when the time out procedure is completed
  - People in time out must be continuously monitored by staff
- Release from a time out is contingent on the person's stopping or bringing under control the behavior that precipitated the time out. It must occur as soon as the behavior that precipitated the timeout abates or stops. If the precipitating behavior has not abated or stopped, staff members must attempt to return the person to an ongoing activity at least every 30 minutes.
- If staff implements time out contingent on repeated instances of the target behavior for longer than 30 consecutive minutes, the person must be offered access to a bathroom/drinking water.
- Placement of the person in a room for time out must not exceed 60 consecutive minutes from the initiation of the procedure.
- Must use rooms/spaces that:
  1. Provide a safe environment for the person.
  2. Have an observation window or other device to permit continuous visual monitoring of the person.
  3. Measure at least 36 square feet and be large enough to allow the person to stand, to stretch the person's arms and to lie down.
  4. Be well lighted, well ventilated and clean.

- **Seclusion**
  - The use of seclusion must end when the threat of harm ends.
  - The person must be constantly and directly observed by staff during the use of seclusion.
  - The use of seclusion must be used under the supervision of a mental health professional, qualified professional or external qualified professional.
  - Staff must contact the mental health professional, qualified professional or external qualified professional to inform them about the use of seclusion and to ask for permission to use seclusion as soon as it may be done safely, but not later than 30 minutes after initiating the use of seclusion.
  - When the use of seclusion ends, staff must assess the person to determine if the person can be safely returned to ongoing activity.
  - Staff must treat the person respectfully throughout the procedure.
  - The staff person who implemented the emergency use of seclusion must document its use immediately after the incident concludes.
  - The room for seclusion must be well lighted, well ventilated, and clean. It must have an observation window which allows staff to directly monitor a resident in seclusion, fixtures that are tamperproof, electrical switches located immediately outside the door and doors that open out and are unlocked or locked with keyless locks, that have immediate release mechanisms; and.
  - Staff must remove objects that the person could use to injure his/her self or others from the person and the seclusion room before the person is placed in seclusion.

- **Any other aversive or deprivation procedure (including penalty consequences such as the loss of points or tokens):**
  - The use of aversive or deprivation procedures must be used under the supervision of staff who have been trained on the procedure.
  - Staff must treat the person respectfully throughout the procedure.
  - Each implementation of the procedure must be documented in the person's record.
Chapter 5: Positive support transition plan review

Expanded support teams must review the progress of the PSTP no less than every quarter. The provider must complete the Positive Support Transition Plan Review Form, DHS-6810A (PDF) at each formal review. The expanded support team should document the review frequency in Part A of the PSTP. Send completed PSTP reviews to DHS according to the submission instructions in Chapter 8: External reporting.

The purpose of a PSTP review is to determine if the positive support strategies are improving the person’s quality of life. If the strategies are not positively affecting the person, changes should be made to the PSTP.

A good way to determine if changes are needed is by looking at data and identifying trends or patterns. If the incidence of target interventions has not decreased within the past six months, providers must request help from an external qualified professional.

To receive assistance with identifying an external qualified professional, DHS recommends that providers contact the person’s case manager or send an email request to PositiveSupports@state.mn.us.

Chapter 6: Revising the positive support transition plan

An expanded support team may revise or update a PSTP. Teams should consider revising the plan when data indicates an increase in target behaviors or to reflect changes in a functional behavior assessment (FBA). At a minimum, the expanded care team must update the PSTP on an annual basis and record the update under Part A.

DATE PLAN UPDATED.

Guidelines

Guidelines for revising PSTPs are as follows:

- Substantial changes in the PSTP require a revised plan and consent from the person or their legal representative. Substantial changes include:
  - Changes to frequency of the PSTP review (Part A)
  - Changes to target interventions (Part B)
  - Changes to target behaviors (Part C)
  - Addition of a prohibited procedure to the plan
  - Changes to quality indicators (Part E).

The following items are not considered substantial changes and may be revised either with or without consent:

- Updating medication information (Part A)
- Changing data collection methodology (Parts B, C or E).

- The revision of a PSTP must be documented. Record the date the plan was revised in Part A and complete all parts, including Part F, for consent.
Chapter 7: Positive support transition plan termination

The team must determine timelines for the termination of a PSTP.

**Procedures used at the time of service initiation**

For procedures used at the time of service initiation, expanded support teams must fade out the use of a prohibited procedure as soon as possible and no more than 11 months after the creation of the PSTP.

If the team is unable to phase out a prohibited procedure by the 11-month deadline due to a safety concern, the provider must request approval from the commissioner, via the External Program Review Committee, to extend the use of the procedure (see the [DHS —Request prohibited procedure extension page](#) for more information).

**New procedures**

For new procedures implemented after service initiation and other procedures that have been approved by the commissioner, providers must follow the timeframes set by the commissioner’s approval letter.

**Emergency use of manual restraint (EUMR)**

If EUMR is listed as the target intervention, the provider may terminate the PSTP when there have been less than three uses of EUMR in the past 90 days or four uses in the past 180 days. In the event that a provider terminates a positive support transition plan and staff implement EUMR, the team must create a new PSTP if it is the third EUMR in 90 days or the fourth use of EUMR in 180 days.

**Termination**

The provider may terminate a PSTP before the initial 11-month phase-out period or timeframe set by the commissioner’s approval letter if the procedure has been phased out successfully. Termination of the PSTP signals the end of a target intervention, not necessarily a target behavior. It is expected that the provider will continue to use positive support strategies to:

- Support the person
- Maintain their safety, independence and freedom
- Reduce the instance of identified target behaviors.

The provider must receive the person’s (or their legal representative’s) consent if the plan is to be terminated before it automatically expires. Providers must send notification to DHS via the [Positive Support Transition Plan Review Form, DHS-6810A (PDF)](#) when they terminate a positive support transition plan.
Chapter 8: External reporting

The provider must send copies of the person’s PSTP (and any revisions) to the following:

- The person’s legal guardian/authorized representative
- The person’s case manager
- Service providers involved in the implementation of the strategies in the PSTP
- The Minnesota Department of Human Services (DHS).

To send PSTPs and PSTP reviews to DHS:

- **Preferred method:** Attach a copy to a [Behavior Intervention Reporting Form (BIRF), DHS-5148](#) or
- **Alternative method:** Start a secure email thread with DHS:
  1. Send a blank email to positivesupports@state.mn.us with the subject: Requesting a secure email string
  2. DHS will reply with the title: [SECURE]
  3. Open the message with a one-time passcode
  4. Click reply
  5. Attach the private information (make sure to keep [SECURE] in the title, which will automatically prompt DHS’s system to password protect the documents)
  6. Send the reply.

**Behavior Intervention Reporting Form (BIRF)**

License holders must complete a [BIRF](#) to report the use of any prohibited procedure or emergency use of manual restraint, within the timelines provided on the following page. If the procedure is not listed on Table 1, the expanded support team must determine if the reports will be submitted in aggregate (weekly) or after each incident.

When providers complete a BIRF, they must ensure that the behavior intervention is reported to the expanded support team.

- A behavior intervention(s) that is listed within a current PSTP (targeted for elimination) must be shared with the expanded support team on a quarterly basis: An acceptable format is a frequency count within the PSTP review. However, the provider must comply with any written requests from members of the expanded support team to receive full copies of each BIRF form (Minn. Stat. §245D.04, subd. 3(a2)).
- A behavior intervention(s) that is not listed within a current PSTP must be reported to the person’s legal guardian/authorized representative and case manager within the timeframes listed on the following page. The acceptable format is a copy of the BIRF.
Table 1: Reporting frequency and timelines

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Reporting frequency via the BIRF (DHS-5148)</th>
<th>Must be reported to DHS within:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency use of manual restraint (EUMR), manual restraint/physical holding</td>
<td>Each incident</td>
<td>See reporting EUMRs for details</td>
</tr>
<tr>
<td>Mechanical restraints/devices that constrain the person</td>
<td>Weekly (every 7 days)</td>
<td>15 working days after weekly reporting period</td>
</tr>
<tr>
<td>Wearing of self-harm/self-injury protection equipment</td>
<td>Weekly (every 7 days)</td>
<td>15 working days after weekly reporting period</td>
</tr>
<tr>
<td>Wearing of seat belt restraints</td>
<td>Weekly (every 7 days)</td>
<td>15 working days after weekly reporting period</td>
</tr>
<tr>
<td>Time out</td>
<td>Each incident</td>
<td>15 working days after incident</td>
</tr>
<tr>
<td>Seclusion</td>
<td>Each incident</td>
<td>15 working days after incident</td>
</tr>
<tr>
<td>Penalty consequences</td>
<td>Weekly (every 7 days)</td>
<td>15 working days after weekly reporting period</td>
</tr>
<tr>
<td>Crisis respite placement due to restrictive intervention</td>
<td>Each incident</td>
<td>15 working days after incident</td>
</tr>
<tr>
<td>Call to mental health mobile crisis intervention services</td>
<td>Each incident</td>
<td>15 working days after incident</td>
</tr>
<tr>
<td>PRN psychotropic medication administered, when used to avert or in response to a target behavior</td>
<td>Each incident</td>
<td>15 working days after incident</td>
</tr>
<tr>
<td>Called 911 for law enforcement or other first responder involvement</td>
<td>Each incident</td>
<td>15 working days after incident</td>
</tr>
<tr>
<td>Emergency psychiatric hospitalization</td>
<td>Each incident</td>
<td>15 working days after incident</td>
</tr>
</tbody>
</table>
Example for aggregate (weekly) reporting: Multiple uses of mechanical restraint between the dates of Jan. 1 and Jan. 7 are to be reported on one BIRF and must be submitted to DHS within 15 working (business) days after Jan. 7.

Example for each incident reporting: The emergency use of manual restraint on Jan. 1 and Jan. 3 must be recorded on two separate BIRFs.

**Reporting the emergency use of manual restraint (EUMR), manual restraint/physical holding**

- Within three calendar days of the EUMR, the staff person who implemented the EUMR must submit a written report to the designated coordinator
- Within five working days of the EUMR, the provider must complete and document an internal review of the restraint
- Within five working days after the completion of the internal review, the license holder must consult with the expanded support team
- Within five working days of the expanded support team review, the license holder must submit the BIRF to DHS ([Minn. Stat. §245D.061](https://www.revisor.mn.gov/statutes/text/245D/s245D.061))
Appendix

Definitions

**AVERSIVE PROCEDURE**

The application of an aversive stimulus contingent upon the occurrence of a behavior for the purposes of reducing or eliminating the behavior (Minn. Stat. § 245D.02, subd. 2b).

**AVERSIVE STIMULUS**

An object, event or situation presented immediately following a behavior in an attempt to suppress the behavior. Typically, an aversive stimulus is unpleasant and penalizes or confines (Minn. Stat. § 245D.02, subd. 2c).

**BASELINE**

An initial set of critical observations or data used for comparison or as a control.

**CHEMICAL RESTRAINT**

The administration of a drug or medication to control the person’s behavior or restrict the person’s freedom of movement and is not a standard treatment or dosage for the person’s medical or psychological condition (Minn. Stat. § 245D.02, subd. 3b).

**COORDINATED SERVICE AND SUPPORT PLAN**

“Coordinated service and support plan” has the meaning given in Minn. Stat. § 256B.0913, subd. 8; Minn. Stat. § 256B.0915, subd. 6; Minn. Stat. § 256B.092, subd. 1b; and Minn. Stat. § 256B.49, subd. 15, or successor provisions.

**CRISIS**

A situation perceived or experienced by the person that exceeds the person’s resources and coping mechanisms and has the potential to endanger the health and safety of an individual.

**DEPRIVATION PROCEDURE**

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 the response. Oftentimes the positive reinforcer available 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 (Minn. Stat. § 245D.02, subd. 5a).

**DOMAINS OF A MEANINGFUL LIFE**

Community membership; health, wellness, and safety; own place to live; important relationships; control over supports; and employment earnings and stable income.

**EMERGENCY SAFETY INTERVENTION**

The act of interceding in a situation to prevent death or injury to the person or others.
EXPANDED SUPPORT TEAM
The members of the support team defined in Minn. Stat. §245D.02, subd. 34 and a licensed health or mental health professional or other licensed, certified, or qualified professionals or consultants working with the person and included in the team at the request of the person or the person's legal representative (Minn. Stat. §245D.02, subd. 8b).

LEGAL REPRESENTATIVE
The parent of the person who is under 18 years of age, a court-appointed guardian or other representative with legal authority to make decisions about services for the person. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney (Minn. Stat. §245D.02, subd. 12).

MANUAL RESTRAINT
Physical intervention intended to hold the person immobile or limit the person’s voluntary movement by using body contact as the only source of physical restraint (Minn. Stat. §245D.02, subd. 12).

MANUAL RESTRAINT – EMERGENCY USE
Using a manual restraint when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person’s refusal to receive or participate in treatment or programming on their own do not constitute an emergency (Minn. Stat. §245D.02, subd. 8a).

MENTAL HEALTH
A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community (definition taken from the World Health Organization).

MOST INTEGRATED SETTING
A setting that enables people with disabilities to interact with people without disabilities to the fullest extent possible (Minn. Stat. §245D.02, subd. 20a).

OUTCOME
The behavior, action, or status attained by the person that can be observed, measured and determined reliable and valid (Minn. Stat. §245D.02, subd. 21a).

POSITIVE SUPPORT STRATEGY
A strengths-based strategy based on an individualized assessment that emphasizes teaching a person productive and self-determined skills or alternative strategies and behaviors without the use of restrictive interventions (Minn. R. §9544.0020, subp. 41).
POSITIVE SUPPORT TRANSITION PLAN (PSTP)

The plan required by Minn. Stat. §245D.06, subd. 8 and Minn. Rules, Minn. R. §9544.0070, subd. 3 to be developed by the expanded support team to implement positive support strategies to:

- Eliminate the use of prohibited procedures as identified in Minn. Stat. §245D.06, subd. 5(a)
- Avoid the emergency use of manual restraint as identified in Minn. Stat. §245D.061
- Prevent the person from physically harming self or others as in Minn. Stat. §245D.02, subd. 23b.

The plan will identify baseline, triggers, escalation, crisis and recovery stages for a person and contain positive, person-centered strategies to intervene during each stage of crisis. The positive support transition plan replaces behavior support plans and/or individual program plans that contain the use of a controlled procedure under Rule 40.

PSYCHOTROPIC MEDICATION

Any medication prescribed to treat the symptoms of mental illness that affect thought processes, mood, sleep or behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder. Other miscellaneous medications are considered a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior (Minn. Stat. §245D.02, subd. 27).

PUNISHMENT

Type I or Type II action as described below:

- Type I action means the contingent application of an aversive stimulus.
- Type II action means the contingent removal of a positive reinforcer. "Positive reinforcer" means a consequence or stimulus that is presented following a behavior and that causes the behavior to increase (Minn. R. §9544.0020, subp. 46).

QUALITY OF LIFE INDICATORS

Reportable or observable outcomes that are measurable and important to or for the person. Quality of life indicators are used to assess beneficial changes desired by the person that enrich the person's life experiences (Minn. R. §9544.0020, subp. 48).

QUALIFIED PROFESSIONAL

The term “qualified professional” is defined separately for each type of service and license. Please refer to Minn. R. §9544.0020, subp. 47 and Minn. R. §9544.0090, subp. 2.

QUARTERLY OR QUARTER

Quarterly or quarter means at least every three calendar months.
SECLUSION

Removing a person involuntarily to a room from which exit is prohibited by a staff person or a mechanism such as a lock, device, or object positioned to hold the door closed or otherwise prevent the person from leaving the room; or involuntarily removing or separating a person from an area, activity, situation, or social contact with others and blocking or preventing the person's return (Minn. Stat. §245D.02, subd. 29).

SUPPORT TEAM

The service planning team identified in section Minn. Stat. §256B.49, subd. 15; the interdisciplinary team identified in Minn. R. §9525.0004, subp. 14; or the case management team as defined in Minn. R. §9520.0902, subp. 6 (Minn. Stat. §245D.02, subd. 34).

TARGET INTERVENTIONS

Behavioral interventions targeted for elimination.

TARGET BEHAVIOR

An observable behavior identified in the person's individual plan as the object of efforts intended to reduce or eliminate the behavior (Minn. R. §9544.0020, subp. 54).

TEAM

See Expanded Support Team.

TIME OUT

The involuntary removal of a person for a period of time to a designated area from which the person is not prevented from leaving. For the purpose of this chapter, "time out" does not mean voluntary removal or self-removal for the purpose of calming, prevention of escalation, or de-escalation of behavior; nor does it mean taking a brief break or rest from an activity for the purpose of providing the person an opportunity to regain self-control (Minn. Stat. §245D.02, subd. 34a).

WORKING DAYS

Working days mean Monday, Tuesday, Wednesday, Thursday and Friday, excluding legal holidays.