STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

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October 30, 2013

The Honorable Donovan W. Frank
United States District Court Judge
Warren E. Burger Federal Building & U.S. Courthouse
316 North Robert Street, Suite 724
St. Paul, MN 55101

Re: ***James and Lori Jensen, et al. v. Minnesota Department of Human Services, et al.***
File No. 09-CV-01775 DWF/FLN

Dear Judge Frank:

The Minnesota Department of Human Services is filing a copy of Anne Barry's October 30, 2013 letter to the Court along with the following attachments:

- Rule 40 Implementation Plan (proposed), dated October 30, 2013;
- Rule 40 Implementation Plan Project Staff (proposed), dated October 30, 2013;
- Rule 40 Implementation Plan Acronyms (proposed), dated October 30, 2013; and
- Rule 40 Implementation Plan Chronological Timetable (proposed), dated October 30, 2013.

A copy of these documents were previously hand delivered to the Court this afternoon and copies are being provided by electronic mail to the Court Monitor, David Ferleger, Esq., and Shamus O'Meara, Esq., Attorney for Plaintiffs, as well as Dr. Wieck and Ms. Opheim.

Respectfully,

s/ Steven H. Alpert

STEVEN H. ALPERT
Assistant Attorney General
Atty. Reg. No. 0001351

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Attorney for Defendants

Attachments

Minnesota Department of **Human Services**

October 30, 2013

The Honorable Donovan W. Frank
United States District Court
724 Federal Building
316 North Robert Street
St. Paul, MN 55101

By Hand-Delivery

David Ferleger, Esq.
Independent Consultant and *Jensen* Court Monitor
Archways Professional Building
413 Johnson Street, Suite 203
Jenkintown, PA 19046

By E-Mail

Re: *James and Lori Jensen, et al. v. Minnesota Department of Human Services, et al.*
Court File No.: 09-CV-01775 DWF/FLN

Dear Judge Frank and Mr. Ferleger:

In response to the Court's August 28, 2013, Amended Order and Memorandum, attached please find the following:

1. Rule 40 Implementation Plan (Proposed), dated October 30, 2013; and

2. Rule 40 Implementation Plan Chronological Timetable (Proposed), dated October 30, 2013.

Thank you for your consideration.

Sincerely,

Anne M. Barry
Deputy Commissioner

Enc.

Cc: Shamus O'Meara, Attorney for Plaintiffs
Colleen Wieck, Executive Director for the Governor's Council on Developmental Disabilities
Roberta Opheim, Ombudsman for Mental Health and Developmental Disabilities
Steven Alpert, Assistant Attorney General
Scott Ikeda, Assistant Attorney General
Gregory Gray, DHS Chief Compliance Officer
Amy Kaldor Akbay, DHS Chief General Counsel

Rule 40 Implementation Plan (Proposed), dated October 30, 2013

Part I - Adoption of Advisory Committee Recommendations

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	RESOURCES REQUIRED (with date established or added)	PERSON(S) RESPONSIBLE	ACTIONS TAKEN (with date actions taken)	OBSTACLES (with date established or added)	ACTIONS TO ADDRESS OBSTACLES (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete, Approved Revised Deadline)	Documentation for Verification
	REPORTING, REVIEWS, OVERSIGHT AND QUAILTY ASSURANCE									
EC 1A	**1.0 A Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - *Behavior Intervention Reporting Form (BIRF):*** • *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 the reporting of all permitted and unpermitted use of restraints. A person's voluntary use of restraints must also be reported.(pg.25)* • *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 (pg. 37)* • *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 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. (pg. 26)* • *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* *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 (pg. 26)* • *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 manager; 5. External reviewer; 6. DHS – licensing and policy areas (pg. 26)*	1.1 A Solicit initial stakeholders feedback on BIRF prior to posting on DHS web site (6/1/2013)	7/1/2013	Content SMEs and stakeholders including providers, Rule 40 Advisory Committee members and OMHDD (6/1/2013)	**DSD 245D/Services and Standards Policy Consultants (Lead)**, DSD Community Capacity Team Unit Supervisor, Rule 40 Advisory Committee Members and OMHDD	1. Schedule meetings with stakeholders (6/1/2013) 2. Conduct meetings with stakeholders prior to launch of BIRF - Three separate review meetings occurred before launch of the BIRF with varying Rule 40 Advisory Committee Members in attendance on: 04/26/2013 with Kay Hendrickson (OMHDD); 06/07/2013 with Kay Hendrickson & Roberta Opheim (OMHDD); and 06/20/2013 with Kay Hendrickson and other members of the Rule 40 Advisory Group (Anne Henry, Steve Anderson, Kelly Ruiz and Pat Kuehn). 3. Review feedback received from Colleen Wieck GCDD (6/21/2013)	None	N/A	**Complete**	Meeting notes; e-mail communications
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DHS – licensing and policy areas (pg. 26)*	1.2 A Make available on DHS web site Behavior Intervention Reporting Form (BIRF) and instructions (6/1/2013)	7/8/2013	Content subject matter experts (SMEs), IT technical staff , DSD Management, Ombudsman for Mental Health and Developmental Disabilities(OMHDD) and Rule 40 Advisory Committee members to review/approved BIRF (6/1/2013)	**DSD 245D/Services and Standards Policy Consultants (Lead)** Disability Services Division (DSD) Division Director, , DSD Community Capacity Team Unit Supervisor, DHS Executive Clinical Director, MNITS (Minnesota Information Technology) Technical staff and Rule 40 Advisory Members: • Anne Henry MDLC (Minnesota Disability Law Center) • Kay Hendrickson OMHDD (Ombudsman for Mental Health and Developmental Disabilities) • Steve Anderson (ARRM) • Pat Kuehn Minnesota Association of County Social Service Administrators (MACSSA) – Ramsey County) • Kelly Ruiz (MACSSA – Dakota County) • Colleen Wick - Minnesota Governor's Council on Developmental Disabilities	1. Meet with IT technical staff regarding BIRF purpose and format (4/15/2013) 2. Develop BIRF draft (6/10/2013) 3. Obtain approval of BIRF from DSD Management and Rule 40 Advisory Committee members and Jensen Compliance Committee (7/1/2013) 4. Launch BIRF on the DHS web site (7/5/2013) 5. Meet with IT technical staff regarding minor changes to be made to BIRF to increase functionality based on feedback received from OMHDD, ARRM and providers using the form (8/1/2013) 6. Meet with OMHDD (Kay Henrickson and Roger Schwab) to review changes and obtain approval (8/6/2013) 7. Obtain approval from the Jensen Compliance Team to post BIRF revisions (8/10/2013) 8. Update BIRF on DHS web site (8/13/2013)	None	N/A	**Complete**	URL to BIRF on DHS Web site - https://edocs.dhs.state.mn.us/lfserver/Secure/DHS-5148-ENG (Date submitted 7/24/3013)
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EC 1A	***1.0 A Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Behavior Intervention Reporting Form (BIRF):*** • *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 the reporting of all permitted and unpermitted use of restraints. 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DHS – licensing and policy areas (pg. 26)*	1.4 A Review and analyze BIRF reports to identify trends and develop policy recommendations (6/1/2013)	7/1/2013	Content subject matter experts (SMEs), IT technical staff ,DHS Management, Ombudsman for Mental Health and Developmental Disabilities(OMHDD) and Rule 40 Advisory Committee members (6/1/2013)	**DSD 245D/Services and Standards Policy Consultants (Lead)**, DHS Licensing, MNITS (Minnesota Information Technology) Technical staff DSD Community Capacity Team Unit Supervisor, Rule 40 Advisory Committee Members and OMHDD	1. Develop database to capture BIRF data elements - • # reports received; # unduplicated providers submitting a report; # unduplicated persons receiving services reported on; # unduplicated persons receiving services with Rule 40 plan • Individuals with more than one report & Positive Support Transition Plan • Individuals with more than one report & No Positive Support Transition Plan • # Reports Manual Restraint; # Reports Mechanical restraint; # reports with Self-harm/SIB equipment; # reports seat belt; # reports w/time out ; # reports w/ time out/Seclusion; # reports with penalty consequence; # reports include prone restraint; # reports with PRN; # reports call 911; # reports with emergency hospitalization; # reports include injury to someone; # reports using any procedure > 60 minute; # reports received 21 days after intervention date (7/1/2013) 2. Create report format (10/1/2013);3 Initiate running of reports (9/15/2013) ; 4.Obtain input of OMHDD on the frequency of reports (10/15/2013) 5. Complete analysis of data received from 7/13 - 12/2013 (1/15/2014); 6.Develop policy recommendation for rule writing (1/31/2013) ; 7. Provide on-going reports as part of Oversight and Monitoring Process (**See EC 1C Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Monitoring and oversight)**	None	N/A	**Incomplete**	BIRF reports, Data analysis report and policy recommendations

Rule 40 Implementation Plan (Proposed), dated October 30, 2013

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	RESOURCES REQUIRED (with date established or added)	PERSON(S) RESPONSIBLE	ACTIONS TAKEN (with date actions taken)	OBSTACLES (with date established or added)	ACTIONS TO ADDRESS OBSTACLES (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete, Approved Revised Deadline)	Documentation for Verification
EC 1A	***1.0 A Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Behavior Intervention Reporting Form (BIRF):*** *• 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 the reporting of all permitted and unpermitted use of restraints. A person's voluntary use of restraints must also be reported.(pg.25)* *• 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 (pg. 37)* *• 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 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. (pg. 26)* *• 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* *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 (pg. 26)* *• 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 manager; 5. External reviewer; 6. DHS – licensing and policy areas (pg. 26)*	1.5 A Develop and implement policy to ensure appropriate and timely notification are made	1/1/2014	Content SMEs and stakeholders including providers, IT Technical staff Rule 40 Advisory Committee members and OMHDD, Provider organizations (6/1/2013)	**DSD 245D/Services and Standards Policy Consultants (Lead)**, State Program Administrator Licensing Rule 40 Advisory Committee Members and OMHDD, ARRM, MACASSA(Minnesota Association of County Social Service Administrators)	1. Notifications requirements for providers included in 245D.O6 and 245D.061 and in BIRF	None	N/A	**Incomplete**	DHS Licensing Reports, Licensing Review & Behavior intervention report form
EC 1B	**1.0 B State Reporting Center for Suspected Vulnerable Adult Maltreatment Common Entry Point** *• Advisory committee members strongly value the role of reporting and oversight (pg.25)* *• 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 (pg. 37)* *• 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. (26)*	1.1 B Add to the scope of the Singe Statewide Common Entry Point initiative currently underway behavioral incident reporting as the permanent structure for BIRF reporting (6/1/2013)	12/1/2015	Project Manager, content subject matter experts (SMEs), IT technical staff , CCA Management, Ombudsman for Mental Health and Developmental Disabilities(OMHDD); External Stakeholders , advisory group (6/1/2013	Project Manager for Reporting Center for Suspected Vulnerable Adult Maltreatment Common Entry Point (Lead)	1. Identify project budget to include behavior incident reporting in the Single Statewide common entry point for maltreatment reporting system currently under development (1/1/2014) 2. Request from legislature authority and appropriation to cover additional administrative costs for the expansion of existing project. (2/1/2015) 3. Add inclusion of behavioral incident reporting to the scope of the Single state wide common entry point, Project Charter (**Dependent on cost and/or legislative approval)** 4. Reporting Center including reporting of behavioral incidents operational	Need to identify costs and if necessary request legislative authority (10/15/2013)	DSD Division Director to review division budget against additional cost for expansion to exiting project (1/1/2014)	**Incomplete**	Copy of applicable section of the revised Common Entry Point Project Charter that address inclusion of BIRF; Screen shot of developed portal for BIRF
EC 1C	***1.0 C Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Monitoring and oversight -*** *• 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 (pg. 27)* *• **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. (pg. 27)* *• **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. (pg. 28)* *• **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. (pg. 28)* *• **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 (pg. 28); 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 actively. (pg. 28)*	1.1 C Meet with Subject Matter Expert (Dr. Fredda Brown to discuss best practices for monitoring and oversight (10/1/2013)	11/15/2013	DHS/DSD Management staff, DHS/DSD and licensing content subject matter experts (10/1/2013)	**DSD Division Director (Lead)**, Dr. Fredda Brown, consultant to the court monitor, DHS Executive Clinical Director, DHS Licensing Manager and DSD 245D/Services and Standards Policy Consultants and practitioners who raised issues.	1. Meet with Dr. Brown to provide perspectives of practitioners as she prepares recommendations based on best practice to address areas of dispute. (10/15/2013 - 10/16/2013) 2. Receive recommendations Dr. Brown (11/4/2013) 3. Review recommendations and identify action steps to develop review process (11/15/2013)	N/A	N/A	**Incomplete**	Meeting invitation, e-mails Meeting Notes
EC 1C	***1.0 C Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Monitoring and oversight -*** *• 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 (pg. 27)* *• **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. (pg. 27)* *• **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. (pg. 28)* *• **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. (pg. 28)* *• **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 (pg. 28); 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 actively. (pg. 28)*	1.2 C Based on Dr. Brown recommendations, develop monitoring and oversight process that meets best practice for oversight of use of restraints (10/1/2013)	2/1/2014	DHS/DSD Management staff, DHS/DSD and licensing content subject matter experts recommendations, stakeholders to be a part of the design of the oversight structure (10/1/2013)	**DSD 245D/Services and Standards Policy Consultants(LEAD)**; DSD Division Director, DHS Executive Clinical Director	1. Meet with DHS Licensing, DHS Executive Clinical Director, and identified stakeholders to design structure/process (12/15/2013) 2. Review and seek input from OMHDD and Colleen Wieck on process (12/24/2013) 3. Obtain final approval on review process and implementation plan from DSD Division Director and DHS Jensen Compliance Office (2/1/2014)	N/A		**Incomplete**	Meeting notes, e-mail communication, approved plan for oversight

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	RESOURCES REQUIRED (with date established or added)	PERSON(S) RESPONSIBLE	ACTIONS TAKEN (with date actions taken)	OBSTACLES (with date established or added)	ACTIONS TO ADDRESS OBSTACLES (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete, Approved Revised Deadline)	Documentation for Verification
EC 1C	***1.0 C Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Monitoring and oversight*** - *• 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 (pg. 27)* *• **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. (pg. 27)* *• **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. (pg. 28)* *• **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. (pg. 28)* *• **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 (pg. 28); 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 actively. (pg. 28)*	1.3 C Implement Monitoring Oversight and Process(10/1/2013)	6/1/2014	DHS/DSD Management staff, DHS/DSD and licensing content subject matter experts recommendations, stakeholders to be a part of the oversight process (10/1/2013)	**DSD 245D/Services and Standards Policy Consultants(LEAD)**; DSD Division Director, DHS Licensing Director and Manager and DHS Executive Clinical Director	1. Identify DHS staff and stakeholders to be part of the oversight process (2/1/2014) 2. Review list of identified DHS staff and stakeholders with DSD Division Director, DHS Licensing, OMHDD, Colleen Wieck and Jensen Compliance Office (2/15/2014) 3. Finalize DHS staff and stakeholders to be part of the oversight process (3/1/2014) 4. Implement approved review process (6/1/2014)	May need fiscal resources to implement recommendations	Pending until recommendation identified	**Incomplete**	Meeting notes, review reports
EC 1D	**1.0 D Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Quality of Life** *The advisory committee states that the goals of successful monitoring, reporting and oversight are: 2. Improved quality of life by improving quality of a person's care and support (pg. 27)*	1.1 D Develop and implement strategies to determine if/how changes made regarding policy changes, training, staff, protocols, documentation, etc. impact the quality of life for persons intended to be served.- **Strategy #1 MnCHOICES -** Persons receiving waiver services and PCA services will be assessed annually for quality of life indicators via the MnCHOICES assessment. (7/1/2013)	9/1/2014	DHS/DSD Management staff, DHS/DSD and licensing content subject matter experts, IT support stakeholders to (10/1/2013)	**DSD 245D/Services and Standards Policy Consultants(LEAD)**; State Program Administrator Licensing; Mn CHOICES Lead, DSD Division Director, CCA DHS Fiscal Director, Executive Clinical Director, MNITS staff	1. Launch MnCHOICES in first implementer counties (11/5/2013) 2 Develop report to look specifically at quality of life indicators included in MnCHOICES (6/1/2014) 4. Statewide implementation of MnCHOICES (8/1/2014) 5. Develop process to automate reports to provide to oversight and monitoring team (9/1/2014)	Need additional IT support to develop report	Pending until after MnCHOICES Launch	**Incomplete**	MnCHOICES Quality of Life Indicator Report
EC 1D	**1.0 D Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Quality of Life** *The advisory committee states that the goals of successful monitoring, reporting and oversight are: 2. Improved quality of life by improving quality of a person's care and support (pg. 27)*	1.2 D Develop and implement strategies to determine if/how changes made regarding policy changes, training, staff, protocols, documentation, etc. impact the quality of life for persons intended to be served.- **Strategy #2 Utilize data gathered from National Core Indicator Process (NCI)** (10/15/2013)	9/1/2014	DHS/CCA Management Staff, SMEs, contractor to conduct interviews (10/15/2013)	**DSD Integration Manager (Lead)**	1. Obtain agreement with HSDI to pilot NCI (HSDI) 2. Identify sample (11/15/2013 3. Sign contract with Vital Research to conduct Interviews (12/1/2013) 4. Develop work plan to utilize data (2/1/2014) 5. Conduct Interviews (6/1/2014) 6. Make report available (9/1/2014)	One-time funding	Consideration of 2015 Legislative Request	**Incomplete**	Copy of report. Copy of work plan
EC 1D	**1.0 D Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Quality of Life** *The advisory committee states that the goals of successful monitoring, reporting and oversight are: 2. Improved quality of life by improving quality of a person's care and support (pg. 27)*	1.3 D Other strategies See Olmstead Plan Quality of Life Survey EC 24.0	6/30/2014	N/A	N/A	N/A	N/A	N/A	**N/A**	N/A
EC 1E	**1.0 E Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Permitted Techniques** *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 (pg. 18)* *The advisory committee recommends that use of permitted techniques be tied to notifications and reporting. (pg. 19)* *The committee members recommend the Commissioner develop a process for review of specific permitted techniques. (pg. 19)* *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. 20)* *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 (pg. 20)* *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. (pg. 20) 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. (pg. 20-–21)*	1.1 E Develop and implement policy and procedures to address use of **PERMITTED techniques** (10/20/2013)	1/1/2014	Content SMEs and stakeholders including providers, Rule 40 Advisory Committee members and OMHDD, Provider organizations 10/20/2013)	**DSD 245D/Services and Standards Policy Consultants (Lead)**, State Program Administrator Licensing Rule 40 Advisory Committee Members and OMHDD, ARRM, MACASSA(Minnesota Association of County Social Service Administrators)	1. Address use and reporting of PERMITTED techniques in 245D.06 subd 7 and 245D.061 (1/1/2014) 2. Address use and reporting of PERMITTED techniques in BIRF **(See EC 1A)** 3. Incorporate use of permitted techniques in Positive Behavior Supports Manual **(See EC 3)**	None	N/A	**Incomplete**	BIRF Reports, Positive Support Transition Plans
EC 1F	**1.0 F Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Prohibited Techniques** *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 foradic 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; 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. (pg. 20)*	1. 1 F Develop and implement policy and procedures to address **prohibited techniques** (10/20/2013)	1/1/2014	Content SMEs and stakeholders including providers, Rule 40 Advisory Committee members and OMHDD, Provider organizations 10/20/2013)	**DSD 245D/Services and Standards Policy Consultants (Lead)**, State Program Administrator Licensing Rule 40 Advisory Committee Members and OMHDD, ARRM, MACASSA(Minnesota Association of County Social Service Administrators)	1. Use of PROHIBITED techniques addressed in MN Statute 245D.06 subd 5, 245D.04, Vulnerable Adults and Maltreatment of Minor Act Minnesota Statute 626.556 and 626.557 (1/1/2014) 2. Incorporate use of prohibited techniques in **BIRF (See EC 1A)** 3. Incorporate use of prohibited techniques in **Positive Behavior Supports Manual (See EC 3)**	None	N/A	**Incomplete**	BIRF, Positive Behavior Support Manual
	POSITIVE BEHAVIOR SUPPORT									

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	RESOURCES REQUIRED (with date established or added)	PERSON(S) RESPONSIBLE	ACTIONS TAKEN (with date actions taken)	OBSTACLES (with date established or added)	ACTIONS TO ADDRESS OBSTACLES (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete, Approved Revised Deadline)	Documentation for Verification
EC 2	**2.0 Positive Support Transition Plan (PSTP)** - • *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. (pg. 33)* • *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 (pg. 14)* • *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.* *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; (pg. 16 & 17)*	2.1 Make available on DHS web site PSTP template and instructions. (6/1/2013)	1/1/2014	Content subject matter experts (SMEs), IT technical staff , web support staff and DSD management, OMHDD and Rule 40 Advisory Committee members to review/approved PSTP (6/2/2013)	**245D/Services and Standards Policy Consultants (Lead)**, DSD Division Director, DSD , DSD Community Capacity Team Unit Supervisor, DHS Executive Clinical Director, MNITS Technical staff	1. Develop draft PSTP form (8/1/2013) 2. Solicit feedback on PSTP from DHS staff (8/27/2013) 3. Solicit feedback on PSTP from providers and OMHDD - Received feedback from Mount Olivet Rolling Acres and Meridian Services providers; met with Roberta Opheim and Roger Schwab OMHDD 9/26 – OMHDD provided feedback and gave their approval. Met with providers 10/14/2013 4. Based on feedback received from DSD and stakeholders finalize PSTP (Tentative date 11/15/2013) 5. Meet with IT technical staff regarding changes to be made to PSTP (Tentative date 10/21/2013) 6. Initiate process in SharePoint for approval from DHS Executive Clinical Director, Behavioral Med Practitioner, MSHS Cambridge, State Program Admin Manager, Commissioner's Office Project Management , DSD Division Director and DSD Operation Manage to post PSTP (Tentative date 10/20/2103)	**N/A**	**N/A**	**Incomplete**	URL to PSTP form and instructions on DHS web site
EC 2	**2.0 Positive Support Transition Plan (PSTP)** - • *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. (pg. 33)* • *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 (pg. 14)* • *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.* *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; (pg. 16 & 17)*	2.2 Initiate Training & Regional Meetings on PSTP and BIRF (**See Positive Support Strategies Training - EC 8.0)** (6/1/2013)	12/1/2013	N/A	N/A	N/A	N/A	N/A	**N/A**	N/A
EC	**2.0 Positive Support Transition Plan (PSTP)** - • *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. (pg. 33)* • *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 (pg. 14)* • *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.* *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; (pg. 16 & 17)*	2.3 Release supplemental instructional materials that are not part of licensing enforcement (See **Positive Behavior Supports Manual - EO 3.0**) (6/1/2013)	1/15/2014	N/A	N/A	N/A	N/A	N/A	**N/A**	N/A
EC 2	**2.0 Positive Support Transition Plan (PSTP)** - • *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. (pg. 33)* • *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 (pg. 14)* • *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.* *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; (pg. 16 & 17)*	2.4 Initiate review of Positive Support Transition Plans (6/1/2013)	2/1/2014	Content subject matter experts (SMEs), IT technical staff , DSD Management, Ombudsman for Mental Health and Developmental Disabilities(OMHDD), Rule 40 Advisory Committee Members (6/1/2013)	**DSD 245D/Services and Standards Policy Consultants(Lead)**, State Program Administrator Licensing, DSD Community Capacity Team lead and team, DHS Executive Clinical Director, DHS Licensing Staff, OMHDD	1. Develop process for the submission and review of PSTPs 2. Communicate with providers requirements regarding submission of all PBSP to DHS 3.Idenify data elements to be reviewed to determine: How many plans are developed (within required timeframe);Are prohibited procedures under 245D being phased out according to the timeline in 245D.06, subdivision 8; Are target behaviors and target intervention decreasing and are quality of life indicators increasing 4. Obtain input from DHS licensing, DHS Executive Clinical Director, OMHDD and Colleen Wieck on specific report needs 5.Create database to capture data elements 6. Generate monthly reports and route to DHS licensing reports involving 245D violations (2/1/2014)	N/A	N/A	**Incomplete**	Reports
EC 3	**3.0 Positive Behavior Supports Manual (positive practices manual) -** • *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. 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 (pg. 14).* • *Proper screening tools or checklists be used to determine when functional assessment/functionol behavioral assessments are necessary (pg. 15)* • *Using the existing mental health crisis services for children and adults and mobile crisis teams (pg. 15)* • *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 assess met (pg. 15)* • *Assessment. 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. (pg. 16)* • *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. Committee members recommend a positive strategies section: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. (pg. 16, 17)* • *The advisory committee recommends a non---exhaustive list of permitted positive support strategy examples be provided in the forthcoming positive support manual. (pg. 17)*	3.1 Develop DRAFT Positive Behavior Supports Manual (6/1/2013)	7/1/2013	Content SMEs , OMHDD, Rule 40 Advisory Committee members (8/1/2013)	**DSD 245D/Services and Standards Policy Consultants (Lead)**, DSD Community Capacity Team Unit Supervisor, DHS Executive Clinical Director	1. Develop DRAFT Positive Behavior Supports Manual outline using existing positive behavior practices and manuals developed by other states (including Arizona) (5/1/13) 2. Draft reviewed by Rick Amado(5/15/213)	N/A	N/A	**Complete**	Copy of Draft Manual

Rule 40 Implementation Plan (Proposed), dated October 30, 2013

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	RESOURCES REQUIRED (with date established or added)	PERSON(S) RESPONSIBLE	ACTIONS TAKEN (with date actions taken)	OBSTACLES (with date established or added)	ACTIONS TO ADDRESS OBSTACLES (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete, Approved Revised Deadline)	Documentation for Verification
EC 3	**3.0 Positive Behavior Supports Manual (positive practices manual) -** *• 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. 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 (pg. 14).* *• Proper screening tools or checklists be used to determine when functional assessment/functional behavioral assessments are necessary (pg. 15)* *• Using the existing mental health crisis services for children and adults and mobile crisis teams (pg. 15)* *• 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 assess met (pg. 15)* *• Assessment. 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. (pg. 16)* *• 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. Committee members recommend a positive strategies section:* *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. (pg. 16, 17)* *• The advisory committee recommends a non---exhaustive list of permitted positive support strategy examples be provided in the forthcoming positive support manual. (pg. 17)*	3.2 Contract with University of Minnesota Institute on Community Integration (U of M /ICI to work with DHS on development of a Positive Behavior Supports Manual (8/1/2013)	10/15/2013	DHS Contract development staff (Lead), U of M/ICI contract staff (8/1/2013)	**Continuing Care MFD (Money Follows the person Demonstration) Agency Policy Specialist (Lead)** , DSD Operations Manager	1. Develop amendment to existing ICI contract to include deliverables related to development of the Positive Behavior Practices Manual (9/25/2013) 2. Route contract for approval (10/15/2013)	N/A	N/A	**Complete**	Copy of contract
EC 3	**3.0 Positive Behavior Supports Manual (positive practices manual) -** *• 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. 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 (pg. 14).* *• Proper screening tools or checklists be used to determine when functional assessment/functional behavioral assessments are necessary (pg. 15)* *• Using the existing mental health crisis services for children and adults and mobile crisis teams (pg. 15)* *• 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 assess met (pg. 15)* *• Assessment. 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. (pg. 16)* *• 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. Committee members recommend a positive strategies section:* *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. (pg. 16, 17)* *• The advisory committee recommends a non---exhaustive list of permitted positive support strategy examples be provided in the forthcoming positive support manual. (pg. 17)*	3.3 Pilot version of Positive Behavior Supports Manual submitted to DHS (8/1/2013)	1/1/2014	Content SMEs and web accessibility staff (8/1/2013); contract manager (to ensure timely completion of deliverables), external	**DSD Operation Manager (Lead),** Assigned ICI staff, DSD 245D/Services and Standards Policy Consultants, DSD Community Capacity Team Unit Supervisor, DHS Executive Clinical Director	1. U of M/ ICI to discuss review protocol (10/24/2013) Provide DHS DSD with work plan of deliverables and timeline (tentative date 10/30/2013) 2. DHS approves work plan and ICI staff assigned to project (tentative date 11/5/2013) 3. Obtain internal and external stakeholder input on table of contents (11/15/2015) 4. Provide DHS DSD with preliminary draft of manual (tentative date - 12/4/2013) 5. Draft reviewed by DSD, DHS Executive Clinical Director, External Clinical SME, Colleen Wieck, OMHDD, and other external stakeholders (Tentative date - 12/19/2013). 6. Final pilot version of manual approved by DSD Director, DHS Executive Clinical Director, Colleen Wieck, OMHDD and DHS Jensen Compliance Office and other external stakeholders (Tentative date - 1/1/2014).	DHS needs to identify external clinical SME to review final draft of manual	DSD Division Director and Operations Manager contacting Clinical SME to determine interest and availability	**Incomplete**	Meeting notes, Copy of U of M/ ICI Review Protocol with timelines, Copy of Manual

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	RESOURCES REQUIRED (with date established or added)	PERSON(S) RESPONSIBLE	ACTIONS TAKEN (with date actions taken)	OBSTACLES (with date established or added)	ACTIONS TO ADDRESS OBSTACLES (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete, Approved Revised Deadline)	Documentation for Verification
EC 3	**3.0 Positive Behavior Supports Manual (positive practices manual) -** *• 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. 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 (pg. 14).* *• Proper screening tools or checklists be used to determine when functional assessment/functional behavioral assessments are necessary (pg. 15)* *• Using the existing mental health crisis services for children and adults and mobile crisis teams (pg. 15)* *• 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 assess met (pg. 15)* *• Assessment. 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. (pg. 16)* *• 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. Committee members recommend a positive strategies section: 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. (pg. 16, 17)* *• The advisory committee recommends a non---exhaustive list of permitted positive support strategy examples be provided in the forthcoming positive support manual. (pg. 17)*	3.4 Positive Behavior Supports Manual posted on DHS public web site (8/1/2013)	4/1/2014	Web technical support staff (8/1/2013)	**DSD TTC Unit supervisor (Lead)** and TTC web support staff	1. TTC staff completes accessibility review of pilot manual (tentative date - 1/10/2014) 2. Pilot Manual posted on DHS web site requesting feedback (1/15/2014) 3. Review feedback received and update manual including best practices based on approval from SME (4/1/2014)	N/A	N/A	**Incomplete**	URL to on-line module
EC 3	**3.0 Positive Behavior Supports Manual (positive practices manual) -** *• 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. 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 (pg. 14).* *• Proper screening tools or checklists be used to determine when functional assessment/functional behavioral assessments are necessary (pg. 15)* *• Using the existing mental health crisis services for children and adults and mobile crisis teams (pg. 15)* *• 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 assess met (pg. 15)* *• Assessment. 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. (pg. 16)* *• 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. Committee members recommend a positive strategies section: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. (pg. 16, 17)* *• The advisory committee recommends a non---exhaustive list of permitted positive support strategy examples be provided in the forthcoming positive support manual. (pg. 17)*	3.5 E-list communication to all stakeholders announcing availability of Positive Behavior Supports Manual (8/1/2013)	1/30/2014	Web technical support staff (8/1/2013)	**DSD 245D/Services and Standards Policy Consultants (Lead),** DSD Community Capacity Team Unit Supervisor, DHS Executive Clinical Director	1. DSD SME drafts communication (tentative date 1/5/2014) 2. DSD Division Director and DHS compliance Office approves communication (tentative date 1/15/2014)	N/A	N/A	**Incomplete**	URL to e-list communication(s)
	TECHNICAL ASSISTANCE									
EC 4	**4.0 Positive Behavior Supports (PBS) and Person Centered Planning (PCP) Technical Assistance and Supports -** *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. (pg. 31).* *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, (pg. 33).*	4.1 Hire staff for Community Capacity Team (CCT) - (8/1/2013) The Community Capacity Team to include staff with: clinical background, DHS systems/policy background service deliver any county background and policy and data analysis background	1/1/2014	Staff to develop position descriptions and complete 1768 process, DHS management for approval, DHS Human Resources staff, Interview Team (8/1/2013)	**DSD Operations Manager (Lead)**, DHS Deputy Director, DSD Division Director, DSD Operations Section Manager, DHS Executive Clinical Director, DHS HR staff	1. Develop position descriptions (8/15/2013) 2. Initiate 1768s - DHS platform used to establish or fill positions other HR actions (8/23/13) 3. Post positions (Community Capacity Team Lead posted 10/11/2013, list received 10/25/2013) 4. Initiate interviews (11/15/2014) 5. Select candidate for each open position 6. Identify start date for each position	HR cannot complete processing of 1768 until position descriptions are reviewed and approved by Deputy Commissioner(9/10/2013)	All positions descriptions reviewed and approved by Rick Amado/Anne Barry (9/16/2013)	**Incomplete**	Copy of position description; copy of posting, list of hire date for each position
EC 4	**4.0 Positive Behavior Supports (PBS) and Person Centered Planning (PCP) Technical Assistance and Supports -** *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. (pg. 31).* *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, (pg. 33).*	4.2 Initiate On-Site Support (8/1/2013)	2/1/2014	Content SMEs on PCP/PBP (8/1/2013)	**DSD Community Capacity Team Lead (Lead),** DHS Executive Clinical Director, Community Support Services (CSS) , Metro Crisis Coordination Program (MCCP)	1. Initiate development of work plan to address provision of technical assistance education and consultation to lead agencies, providers, division staff and management on PBP, PCP, use of permitted and prohibited techniques in behavior intervention and related policies and practices, to assure compliance as well as informing federal, state, agency, division and legal requirements and goals (tentative date - 1/1/2014) 2. Initiate on-site support (2/01/2014)	Work plan cannot be completed until lead for project is hired (9/30/2013)	DSD Operation Manager met with HR to discuss urgency of completing review process of PD for leads first (10/3/2013)	**Incomplete**	Copy of Community Capacity Team Work plan
EC 4	**4.0 Positive Behavior Supports (PBS) and Person Centered Planning (PCP) Technical Assistance and Supports -** *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. (pg. 31).* *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, (pg. 33).*	4.3 Initiate Monthly Technical Assistance Webinars with providers and lead agencies (8/1/2013)	12/1/2013	Content SMEs on PCP/PBP, Go-To-Webinar Support staff (8/1/2013)	**DSD Community Capacity Team Lead (Lead),** CCB Team , 245D/Services and Standards Policy Consultants, DHS Executive Clinical Director, DSD TTC Unit Supervisor and webinar staff,	1. Initiate development of webinar work plan (Tentative date - 11/1/2013) 2. Schedule Webinars 3. Send out announcement of webinars	Work plan cannot be completed until lead for project is hired (9/30/2013)	DSD Operation Manager met with HR to discuss urgency of completing review process of PD for leads first (10/3/2013)	**Incomplete**	Schedule of webinars, attendance records
EC 4	**4.0 Positive Behavior Supports (PBS) and Person Centered Planning (PCP) Technical Assistance and Supports -** *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. (pg. 31).* *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, (pg. 33).*	4.4 Identify data to obtain needed information to measure impact of technical assistance (8/1/2013)	2/1/2014	Data/policy analysis staff (8/1/2013)	**DSD Community Capacity Team Lead (Lead),** Community Capacity Team, DSD Community Supports and Consumer Safeguards Unit Supervisor and data specialist	1. Work with Community Capacity Lead and team and unit supervisor to develop work plan to a. Identify measurable quality outcomes b. Identify data needs; access data sources and data systems to obtain needed information. c. Conduct analysis to identify people and groups of people at risk of admission to ER/hospital/institutional settings and unnecessarily long stays who should be discharged to community services. d. Examine individual and system-wide opportunities and barriers to discharge or diverted admission. (Tentative date - 2/1/2014)	Work cannot be initiated until project staff are hired (9/30/2013)	DSD Operation Manager met with HR to discuss urgency of completing review process of PD for leads first (10/3/2013)	**Incomplete**	Copy of work plan, copy of reports
EC 5	**5.0 Guidelines for the use of Psychotropic Medications -** ***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.(pg. 39)*	5.1 Develop guidelines for the use of psychotropic medications and a checklist that are consistent with best practices and address the need for routine assessments of negative side effects	7/1/2014	SMEs, DHS/DSD contract staff, DHS management for approval of contract, stakeholders for review and feedback	**DSD Operations Manager (Lead)**, DSD Division Directors, DHS Clinical Director, State-Operated Transition Director, DSD Community Supports and Consumer Safeguard Unit	1. Develop contract 12/1/2013) 2. Approve Contract (12/30/2013) 3. Implement contract (1/1/2014) 4. Draft Guidelines (4/1/2014) 5. Review draft guidelines with stakeholders (5/1/2014) 6. Complete guidelines (7/1/2014)	Dr. Ferron is planning on retiring 1/1/2013. Time to be dedicated on manual prior to retirement will impact cost of contract	DHS Division Director awaiting feedback from state-operated services on Dr. Ferron's availability prior to his retirement	**Incomplete**	Copy of Medication Guidelines, Copy of Contract

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	RESOURCES REQUIRED (with date established or added)	PERSON(S) RESPONSIBLE	ACTIONS TAKEN (with date actions taken)	OBSTACLES (with date established or added)	ACTIONS TO ADDRESS OBSTACLES (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete, Approved Revised Deadline)	Documentation for Verification
	TRAINING									
EC 6	**6.0 Training Goals -** *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) (pg. 22)* *Training was discussed as an annual requirement and as orientation material.* *The advisory committee did not come to consensus on a set hour requirement. Some recommend twenty hours of annual training. For comparative purposes, MS 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. and, MS 245B.07, subd. 5. 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. (pg. 22)*	6.1 Develop and implement policy to address training goals and requirements (10/20/2013)	1/1/2014	Content SMEs and stakeholders including providers, Rule 40 Advisory Committee members and OMHDD, Provider organizations 10/20/2013)	**DSD 245D/Services and Standards Policy Consultants(Lead)**, State Program Administrator Licensing Rule 40 Advisory Committee Members and OMHDD, ARRM, MACASSA(Minnesota Association of County Social Service Administrators)	1. Address training goals in 245D.09 (1/1/2014) 2. Address training goals in best practices included in Positive Behavior Supports Manual **(SEE EC 3)**	None	N/A	**Incomplete**	BIRF Reports, Positive Support Transition Plans
EC 7	**7.0 Training Plan -** *Staff training is very important to the advisory committee. (pg. 21)* *Training provided by DHS addresses training needs identified by the Rule 40 Advisory Committee for: 1. Behavior staff (pg. 23); 2. Provider executives, managers and owners(pg. 24); 3. Case managers (pg. 24); 4. Family members, legal guardians and conservators (pg. 24);5. Persons receiving services (pg. 25) and* *6. DHS policy staff (pg. 25)* *The advisory committee recommends evaluation of training. Committee members discussed and recommended using the Donald Kirkpatrick five levels of evaluation. 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 and 5. Measurement of return on investment for training: Do outcomes make training sustainable? (pg. 25)*	7.1 Develop Comprehensive Training plan to include : On-line training, webinars and in-person training. (7/1/2013)	2/1/2014	DSD Policy staff, DSD training support staff U of M//ICI Training staff and DSD Management 7/1/2013)	**245D/Services and Standards Policy Consultants and DSD TTC Unit Supervisor (Leads)** DSD Division Director, DSD DHS Executive Clinical Director	1. Meet with TTC staff to map out training identified in Rule 40 Advisory Committee Report (11/1/2013) 2. Meet with 245D/Services and Standards Policy Consultants to identify any additional training needs and discuss training modalities (12/01/2013) 3. Meet with U of M/ICI contracted training staff to review training plan (1/1/2014) 4. Review plan with DHS management, OMHDD, Coleen Wieck and Jensen Compliance Office(12/30/12) 5. Implement and monitor plan (2/1/2014)	N/A	N/A	**Incomplete**	Copy of training plan, meeting notes, e-mails
EC 8	**8.0 Positive Support Strategies Training**: *The purpose of positive support strategies is to build repertoires of personal effectiveness in licensed settings.(pg. 15). Advisory committee members recommend: 1. Requiring providers to be trained, competent and use positive support strategies (pg. 14). The advisory committee values making training affordable and accessible. This means providing interactive online curriculum when possible and appropriate (pg. 22) .*	8.1 Initiate webinars for providers, families, lead agencies (case managers) (8/1/2013)	2/1/2014	Content SMEs on Positive Behavior Practices, Rule 40 Modernization Requirements, Go-To Meeting technical support staff, stakeholders (8/1/2013)	**DSD 245D/Services and Standards Policy Consultants(Lead)**, DSD Community Capacity Team lead and team, DHS Executive Clinical Director, DHS Licensing Staff, DSD Training Technical Assistance and Communication (TTC) unit supervisor and staff, OMHDD	1. Meet with TTC staff regarding on-line modality options (9/1/2014) 2. Conduct first webinar for providers and lead agencies (10/8/2013) 3. Conduct webinar targeted to families and advocates (2/1/2014)	N/A	N/A	**Incomplete**	Attendance records for webinar; PowerPoint used for webinar
EC 8	**8.0 Positive Support Strategies Training**: *The purpose of positive support strategies is to build repertoires of personal effectiveness in licensed settings.(pg. 15). Advisory committee members recommend: 1. Requiring providers to be trained, competent and use positive support strategies (pg. 14). The advisory committee values making training affordable and accessible. This means providing interactive online curriculum when possible and appropriate (pg. 22) .*	8.2 Initiate regional in-person training for providers (8/1/2013)	1/1/2014	Content SMEs on Positive Behavior Practices, Rule 40 Modernization Requirements, training support staff, statewide locations, stakeholders (8/1/2013)	**DSD 245D/Services and Standards Policy Consultants (Lead),** DSD Community Capacity Team lead and staff , DHS Licensing Staff, DSD TTC unit supervisor staff, OMHDD, DSD Community Capacity Team Staff, DSD Division Director	1. Meet with TTC staff regarding planning for regional training.(9/1/2014) 2. Conduct regional in-person training in Rochester on the BIRF (9/19/2013) 3.Develop schedule for additional regional in-person training (11/15/2013)	N/A	N/A	**Incomplete**	Training attendance records; PowerPoint used for training
EC 8	**8.0 Positive Support Strategies Training**: *The purpose of positive support strategies is to build repertoires of personal effectiveness in licensed settings.(pg. 15). Advisory committee members recommend: 1. Requiring providers to be trained, competent and use positive support strategies (pg. 14). The advisory committee values making training affordable and accessible. This means providing interactive online curriculum when possible and appropriate (pg. 22) .*	8.3 Based on feedback received from face to face and webinar training, developed on-line training for providers (8/1/2013)	4/1/2014	Content SMEs on Positive Behavior Practices, Rule 40 Modernization Requirements, instructional design and web support staff, stakeholders (8/1/2013)	**DSD 245D/Services and Standards Policy Consultants (Lead),** DSD Community Capacity Team Unit Supervisor, DSD TTC unit Supervisor and staff	1. Meet with TTC staff regarding planning for on-line training (11/1/2013)	N/A	N/A	**Incomplete**	URL to on-line module(s)

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EC 9	**9.0 Person-Centered Planning Approaches Training:** *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 (pg. 18)* *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. (pg. 18).*	9.1 Contract with U of M/ICI to provide Person Centered Thinking and Person Centered Planning Training 2-day workshops for providers, case managers and others (7/1/2013)	11/15/2013	DHS contract development staff , U of M /ICI contract staff (7/1/2013)	**Continuing Care MFD Agency Policy Specialist (Lead)**	1. Develop amendment to existing ICI contract to include deliverables related to person-centered thinking and person-centered planning two-day workshops and one-day videoconference training (9/25/2013) 2. Route contract for approval (10/15/2013)	N/A	N/A	**Complete**	Copy of contract
EC 9	**9.0 Person-Centered Planning Approaches Training:** *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 (pg. 18)* *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. (pg. 18).*	9.2 Initiate Person Centered Thinking (PCT) training for providers, case managers and others (7/1/2013)	1/1/2014	U of M/ICI PCT SME, DHS contract management staff (7/1/2013)	**Continuing Care MFD Agency Policy Specialist (Lead**), ICI Staff, DSD Operations Manager, DSD Community Supports and Consumer Safeguards Unit Supervisor, Continuing Care MFD Agency Policy Specialist	1. Provide DHS with work plan for deliverables including proposed dates/locations of PCT Training (Tentative date - 12/15/2013) 2. DHS approves work plan and staff assigned (Tentative date - 12/20/2013) 3. Monitor completion of work plan deliverables - Over a two-year period, approximately 350 individuals will receive the PCT training (7/1/2015)	N/A	N/A	**Incomplete**	Dates/location of PCT Training, attendance records
EC 9	**9.0 Person-Centered Planning Approaches Training:** *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 (pg. 18)* *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. (pg. 18).*	9.3 Initiate Person Centered Planning (PCP) training for providers, case managers and others (7/1/2013)	1/1/2014	U of M/ICI PCP SME, DHS contract management staff (7/1/2013)	**Continuing Care MFD Agency Policy Specialist (Lead),** ICI Staff, DSD Community Supports and Consumer Safeguards Unit Supervisor	1. Provide DHS with work plan for deliverables including proposed dates/locations of PCP Training (Tentative date - 12/15/2013) 2. DHS approves work plan and staff assigned (Tentative date - 12/20/2013) 3. DHS to monitor completion of work plan deliverables - Over a two-year period approximately 100 individuals will receive the PCP training each year. (12/1/2015)	N/A	N/A	**Incomplete**	Dates/location of PCP Training, attendance records
EC 10	**10.0 Person-centered thinking, planning, and organizational and systems change videoconference -** *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 (pg. 18) 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 (pg. 18)*	10.1 Contract with U of M/ICI to provide one-day videoconference training on the principles and concepts of per son-centered thinking, planning, and organizational and systems change for providers, case managers and others (8/1/2013)	11/15/2013	DHS contract development staff , ICI/U of M contract staff (7/1/2013)	**Continuing Care MFD Agency Policy Specialist**	1. Develop amendment to existing ICI contract to include included one day videoconference training on the principles and concepts of person-centered thinking, planning, and organizational and systems change. (9/25/2013) 2. Route contract for approval (10/15/2013)	N/A	N/A	**Complete**	Copy of contract
EC 10	**10.0 Person-centered thinking, planning, and organizational and systems change videoconference -** *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 (pg. 18)* *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 (pg. 18)*	10.2 Initiate statewide videoconferences on the principles and concepts of person-centered thinking, planning, and organizational and systems change. (7/1/2013)	2/1/2014	U of M/ICI PCT/PCP training staff, Videoconferencing staff, DHS contract management staff (7/1/2013)	**Continuing Care MFD Agency Policy Specialist (Lead)** U of M/ICI assigned staff, TTC Unit Supervisor and staff, DHS Virtual Presence Staff	1. Provide DHS with work plan for deliverables including proposed dates/locations of videoconference (Tentative date - 12/15/2013) 2. DHS approves work plan and staff assigned (Tentative date - 12/20/2013) 3. DHS to monitor completion of work plan deliverables - Providers, case managers and others are offered training through (four) videoconference, in a one-day format, on the principles and concepts of person-centered thinking, planning, and organizational and systems change (600 individuals trained in year one, 600 individuals trained in year two) (12/1/2016)	N/A	N/A	**Incomplete**	Schedule of videoconferences, attendance records

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EC 12	**12.0 Person-Centered Positive Behavior Support Training – Evaluation** *The committee recommends the effectiveness of training be measured through demonstrated competency of the skills in the setting in which services are provided (pg. 22) .* *The advisory committee recommends evaluation of training. Committee members discussed and recommended using the Donald Kirkpatrick five levels of evaluation. 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? (pg. 25)*	12.1 Contract with the U of M/ICI to implement an objective and independent evaluation of the Minnesota Positive Behavior Support Initiative (MNPBSI) training programs. (8/1/2013)	9/30/2013	U of M/ ICI staff, DSD contract staff (8/1/2013)	**Continuing Care MFD Agency Policy Specialist (Lead)**	1. Develop amendment to existing ICI contract to include deliverables related to evaluation of Person-Centered Positive Behavior Support Training (9/25/2013) 2. Route contract for approval (10/15/2013)	N/A	N/A	**Complete**	Copy of contract
EC 12	**12.0 Person-Centered Positive Behavior Support Training – Evaluation** *The committee recommends the effectiveness of training be measured through demonstrated competency of the skills in the setting in which services are provided (pg. 22) . The advisory committee recommends evaluation of training. Committee members discussed and recommended using the Donald Kirkpatrick five levels of evaluation. 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? (pg. 25)*	12.2 U of M/ICI to arrange for and implement an objective and independent evaluation of the Minnesota Positive Behavior Support Initiative (MNPBSI) training programs (8/1/2013)	2/1/2014	U of M/ ICI evaluation staff, DHS management staff (8/1/2013)	**Continuing Care MFD Agency Policy Specialist (Lead);** U of M ICI staff, DHS Deputy Director, DSD Division Director, DHS	1. Provide DHS with work plan for deliverables and timelines. (Tentative date 12/15/2013) 2. DHS approves work plan and staff assigned (12/20/2013) 3. DHS to monitor completion of work plan deliverables - Written evaluation reports are due each year of the four-year project (Final report due 6/20/2017)	N/A	N/A	**Incomplete**	Evaluation Reports
EC 13	**13.0 Build in-state training capacity for person centered thinking and person centered planning** - *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 (pg. 34).* *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 (pg. 23)*	13.1 Contract with the U of M/ICI to develop in-state trainer capacity in the areas of PCT and PCP. (8/1/2013)	9/30/2013	U of M/ICI PCT/PCP training staff, DSD contract staff (8/1/2013)	**Continuing Care MFD Agency Policy Specialist**	1. Develop amendment to existing ICI contract to include deliverables related to developing in-state trainer capacity in the areas of PCT and PCP (9/25/2013) 2. Route contract for approval (10/15/2013)	N/A	N/A	**Complete**	Copy of contract
EC 13	**13.0 Build in-state training capacity for person centered thinking and person centered planning** - *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 (pg. 34).* *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 (pg. 23)*	13.2 Recruitment of trainees (8/1/2013)	1/1/2014	U of M/ ICI PCT/PCP training staff, DHS Contract management staff (8/1/2013)	**Continuing Care MFD Agency Policy Specialist (Lead),**Assigned U of M ICI staff ,	1. Provide DHS with work plan of deliverables including timelines (12/15/2013) 2. DHS approves work plan (12/20/2013) 3. ICI provides DHS with list of trainees (1/1/2014)	N/A	N/A	**Incomplete**	List of trainees
EC 13	**13.0 Build in-state training capacity for person centered thinking and person centered planning** - *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 (pg. 34).* *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 (pg. 23)*	13.3 Implement training (8/1/2013)	2/1/2014	U of M/ ICI PCT/PCP training staff, DHS Contract management staff (8/1/2013)	**Continuing Care MFD Agency Policy Specialist (Lead),** U of M ICI staff	1. Provide DHS with schedule of training 2. DHS to monitor completion of work plan deliverables (7/1/2017) • PCT Trainees will receive at least 75 hours of training. • PCP Trainees will receive an additional 50 hours of training. • 10 trainers trained in PCT and 5 in PCP in 2014, 2015, 2016, 2017	N/A	N/A	**Incomplete**	Schedule of training, training attendance
EC 13	**13.0 Build in-state training capacity for person centered thinking and person centered planning** - *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 (pg. 34).* *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 (pg. 23)*	13.4 Implement Community of Practice (8/1/2013)	6/1/2014	U of M/ ICI PCT/PCP training staff, DHS Contract management staff (8/1/2013)	**Continuing Care MFD Agency Policy Specialist (Lead)** , U of M ICI staff	1. Provide DHS with work plan of deliverables including timelines 2. DHS approves work plan 3. DHS to monitor completion of work plan deliverables - community of practice activities including of meeting documentation to discuss training issues and share agency implementation ideas.	N/A	N/A	**Incomplete**	Listing of Community of practice activities, meeting documentation

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EC 14A	**14.0 A College of Direct Supports On-line Training - Core Training** *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) (pg. 22)* ***Core training topics include, in non---priority order** : 1. De---escalation and crisis management, 2. Positive behavior supports, 3. Review of prohibited techniques and why they are not effective or safe, 4. Culture change, 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 and 21. Emergency use of manual restraint techniques and monitoring its use for signs of distress that require cessation. (pg. 22---23)*	14.1 A Contract with U of M /ICI and the College of Direct Supports to work with DHS DSD on module development for the College of Direct Supports (CDS) to be will be available to all providers and families members including core and tiered training that address different mastery levels, one for direct care staff and the other for professional/supervisory staff (8/1/2013)	11/15/2013	DHS contract development staff , TTC staff, U of M/ICI contract staff (8/1/2013)	**Continuing Care MFD Agency Policy Specialist (Lead)**, DSD Operations Manager, DSD TTC Unit Supervisor	1. Meet with U of M (Amy Hewitt to discuss contract needs (8/11/2013) 2. Develop contract amendment to include modifying existing content and development of new content in the CDS (9/25/2013) 3. Route U of M/ ICI contract for approval (10/15/2013) 4. Route contract for expanded access to College of Direct Supports for approval (11/15/2013)	N/A	N/A	**Incomplete**	Meeting notes, e-mails, Copy of contracts
EC 14A	**14.0 A College of Direct Supports On-line Training - Core Training** *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) (pg. 22)* ***Core training topics include, in non---priority order** : 1. De---escalation and crisis management, 2. Positive behavior supports, 3. Review of prohibited techniques and why they are not effective or safe, 4. Culture change, 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 and 21. Emergency use of manual restraint techniques and monitoring its use for signs of distress that require cessation. (pg. 22---23)*	14.2 A The U of M/ICI to evaluate the existing College of Direct Supports (CDS) module content and make recommendations to DHS DSD about course content, suggesting what existing information should be modified and what new content should be developed (8/1/2013)	2/31/2014	U of M/ICI training and content SMEs , DSD Policy Staff, and DSD management (8/1/2013)	**DSD TTC Unit Supervisor (Lead)**, U of M /ICI staff, DSD 245D/Services and Standards Policy Consultant Community Capacity Team Unit Supervisor, DSD Operations Manager	1CI to provide DHS with recommendations for content to be modified and new content to be developed 12/15/2013) 2. Provide DHS with work plan for deliverables and timelines. (Tentative date 1/15/2013) 3. DHS approves work plan (Tentative date 2/10/2014)	Fiscal allocation in contract is insufficient to develop all identified core topics and additional tier training	Pending results of ICI evaluation of existing CDC module content	**Incomplete**	Work plan and timeline for course development
EC 14A	**14.0 A College of Direct Supports On-line Training - Core Training** *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) (pg. 22)* ***Core training topics include, in non---priority order** : 1. De---escalation and crisis management, 2. Positive behavior supports, 3. Review of prohibited techniques and why they are not effective or safe, 4. Culture change, 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 and 21. Emergency use of manual restraint techniques and monitoring its use for signs of distress that require cessation. (pg. 22---23)*	14.3 A The U of M/ICI will work with the assigned DHS staff to produce agreed upon the course changes (8/1/2013)	1/1/2015	Training and content SMEs (8/1/2013)	**DSD TTC Unit Supervisor (Lead)**ICI staff, DSD 245D/Services and Standards Policy Consultant, Community Capacity Team Unit Supervisor	1. DHS to monitor completion of work plan deliverables (1/1/2015)	N/A	N/A	**Incomplete**	URL to course listing on the College of Direct Support web site
EC 14A	**14.0 A College of Direct Supports On-line Training - Core Training** *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) (pg. 22)* ***Core training topics include, in non---priority order** : 1. De---escalation and crisis management, 2. Positive behavior supports, 3. Review of prohibited techniques and why they are not effective or safe, 4. Culture change, 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 and 21. Emergency use of manual restraint techniques and monitoring its use for signs of distress that require cessation. (pg. 22---23)*	14.4 A. Develop and implement marketing plan for CDS (8/1/2013)	12/1/2014	U of M/ ICI College of Direct Supports staff and DSD Communication staff (8/1/2013)	**DSD TTC Unit Supervisor (Lead)**, ICI Staff, TTC Unit Supervisor and staff, DSD Operations manager	1. ICI to provide DHS with recommendations for marketing plan (9/1/2014) 2.Implement Plan (10/1/2014)	N/A	N/A	**Incomplete**	Copy of Marketing Plan

Rule 40 Implementation Plan (Proposed), dated October 30, 2013

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	RESOURCES REQUIRED (with date established or added)	PERSON(S) RESPONSIBLE	ACTIONS TAKEN (with date actions taken)	OBSTACLES (with date established or added)	ACTIONS TO ADDRESS OBSTACLES (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete, Approved Revised Deadline)	Documentation for Verification
EC 14B	***14.0 B College of Direct Supports On-line Training - Tiered Training*** *In addition to core training, the advisory committee recommends additional tiered training requirements for people based on the level of responsibility and qualifications (pg. 22)* ***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 (pg. 23)* ***The second tier of additional training is for behavior staff who 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 (pg. 23 - 24)* ***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 (pg.24)* ***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 (pg. 24)*	14.1 B **(See 1EC 14A - EC 14D)**	12/1/2014	N/A	N/A	N/A	N/A	N/A	N/A	URL to course listing on the College of Direct Support web site
EC 14C	**14.0 C College of Direct Supports On-line Training - Family Members** *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 and 5. De-escalation strategies (Pg. 24)*	14.1 C **(See 14.1 A - 14.1D)**	12/1/2014	N/A	N/A	N/A	N/A	N/A	N/A	URL to course listing on the College of Direct Support web site
EC 15	**15.0 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 (pg. 24)*	15.1 Include in Training Olan specific training and other resources available to case managers to address the advisory committees recommendations for training topics for case managers **(See EC 7 Training Plan)**	2/1/2014	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EC 16	**16.0 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*	16.1 Develop and implement policy to address training requirement for persons receiving services (10/20/2013)	1/1/2015	Content SMEs and stakeholders including providers, Rule 40 Advisory Committee members and OMHDD, Provider organizations 10/20/2013)	**DSD 245D/Services and Standards Policy Consultants(Lead)**, State Program Administrator Licensing Rule 40 Advisory Committee Members and OMHDD, ARRM, MACASSA(Minnesota Association of County Social Service Administrators)	1. Address training needs in 245D (1/1/2014) 2. Provide person's receiving services access selected course in the College of Direct Supports core training topic as well as training on person-centered planning **(See College of Direct Supports Core Training - EC 14A)** 3. Conduct research as to where other resources can be found (3/1/2014) 4. Send out communications to where additional training resources can be found on the DHS web site as well as other locations (5/1/2014)	See 14.2 A	See 14.2 A	**Incomplete**	DHS Licensing Reports, URL to College of Direct Support
EC 17	***17.0 For DHS policy staff advisory committee recommends the following training be made available to them:*** *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 (pg. 25)*	17.1 Develop and implement training plan specific to recommendations from Rule 40 Advisory Committee recommendations for DHS policy staff (10/20/2013)	1/1/2016	DHS Senior Management Staff, DHS policy staff , Human Resources (10/15/2013)	DHS Commissioner, CCA Assistant Commissioner, Assistant Commissioner, Chemical and Mental Health Services, Assistant Commissioner Children and Family Services	1. Initiate effort to provide all DHS with two-day Person-centered Thinking training (12/1/2012) 2. Initiate effort to provide selected DHS staff with additional two-day training on person-centered planning (12/1/2012) 3. Develop capacity within DHS to provide person-centered thinking training to DHS staff (1/1/2015) 4. Provide DHS staff with access to College of Direct Supports **(See EC 14A)**	See 14.2 A	See 14.2 A	**Incomplete**	Training attendance records
	PERSON CENTERED PLANS									
EC 18	**18.0 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. (Pg. 18)*	18.1 Include in Positive Behavior Support manual section on Evidenced-Based Best Practices the inclusion of a separate person-centered section **See also EC 3 Positive Behavior Support Manual (positive practices manual); EC 9 Person-centered Planning Approaches training; EC 10 Person-centered Thinking, planning, and organizational change videoconference**	3/1/2014	N/A	N/A	N/A	N/A	N/A	N/A	Copy of Positive Behavior Support Manual
	VARIANCES									
EC 19	**19.0 - The Commissioner will not grant variances to the requirements** under 245D that do not meet the requirements of section 245A.04 A, subdivision 9; as such The Commissioner will not grant variances to requirements under section 245D.06 [Protected Standards], subdivision 5 [Prohibited procedures] ; or subdivision 6 [Restricted procedures]; or section 245D.061 [Emergency Use of Manual Restraints], subdivision 3[Restrictions when implementing use of manual restraints	19.1 Amend 245D.03, subd. 3 (10/1/2013)	7/1/2014	Licensing staff to draft language, DSD Policy Staff, DSD/DHS Legislative Staff	**State Program Administrator (Lead);** Licensing, DSD 245D/Services and Standards Policy Consultant	1. Develop DHS /CCA White Paper to Amend 245D.03, subd. 3 2. Submit White paper to CCA Legislative Liaison for review 3. Obtain approval to move forward with White Paper from CCA senior management 4. Draft language 5. Language reviewed and approved by DHS Licensing, DSD Division Director and Jensen Compliance Team 6. Submit language for inclusion in CCA's bill **ALL DATES PENDING AT THIS TIME**	N/A	N/A	**Incomplete**	White Paper, Copy of CCA Legislative Bill

Rule 40 Implementation Plan (Proposed), dated October 30, 2013

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	RESOURCES REQUIRED (with date established or added)	PERSON(S) RESPONSIBLE	ACTIONS TAKEN (with date actions taken)	OBSTACLES (with date established or added)	ACTIONS TO ADDRESS OBSTACLES (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete, Approved Revised Deadline)	Documentation for Verification
	IMPLEMENTATION PLAN									
EC 20	**20.0 Develop and Implementation Plan that incorporates the recommendations of the Rule 40 Advisory Committee.** *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 (pg.30).*	20.1 Develop draft implementation plan (8/1/2013)	11/1/2013	DSD Content subject matter experts (SMEs), DHS Licensing staff, project management staff, OMHDD, MN GCDD and DHS Management to review and approve (plan 8/2/2013)	**DSD Operations Manager,** DHS Deputy Director, State Program Admin Manager, Commissioner's Office Project Management, State Program Admin. Manager Sr. Compliance, DSD Division Director, DSD Operations Manager and DSD 245D/Services and Standards Policy Consultants	1. Based on Rule 40 Advisory Committee Report, develop draft plan (10/4/2013) 2. Route internally for review and feedback (10/9/2013) 3. Meet with Roberta Opheim (OMHDD) and Colleen Wieck for feedback (10/10/2013) 4. Update draft plan based on feedback received (10/ 28/2013) 5. Route internally for approval (10/29/13) 6. Submit draft plan to Court Monitor for approval (10/30/2013)	NA	NA	**Incomplete**	Copy of plan meeting notes/e-mail communications
EC 20	**20.0 Develop and Implementation Plan that incorporates the recommendations of the Rule 40 Advisory Committee.** *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 (pg.30).*	20.2 Consultation with Expert concerning Rule 40 Committee Report on areas where committee did not achieve consensus (9/1/2013)	11/1/2013	DHS/DSD Management staff, DHS/DSD and licensing content subject matter experts (9/1/2013), practitioners from the Rule 40 Advisory Committee to provide context of implementation questions they identified that lead to lack of consensus on recommendations 10/3/2013	**DSD Division Director(Lead)** , Dr. Fredda Brown, consultant to the court monitor, , DHS Executive Clinical Director and DSD 245D/Services and Standards Policy Consultants	1. Meet with Dr. Brown to provide perspectives of practitioners as she prepares recommendations based on best practice to address areas of dispute. (10/15/2013 and 10/16/2013) 2.Update/revise plan based on Dr. Brown's recommendations when received **(See also EC 1C)**	N/A	N/A	**Incomplete**	copy of updated plan reflecting Dr. Brown's recommendations
EC 20	**20.0 Develop and Implementation Plan that incorporates the recommendations of the Rule 40 Advisory Committee.** *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 (pg.30).*	20.3 Manage Implementation Plan to ensure all deliverables and timelines are met (9/1/2013)	1/1/2016	Staff to develop position descriptions and complete 1768 process, DHS management for approval, DHS Human Resources staff, interview team (8/1/2013)	**DSD Rule 40 Project Lead staff,** DSD Community Supports and Consumer Safeguards Unit Supervisor**,** Division Director, DSD Operations Manager, HR Staff	1. Develop positions description for Rule 40 Modernization Project Lead and Project Coordinator (9/15/2013) 2. Initiate 1768 process for both positions (9/16/2013) 3. Hire Rule 40 Modernization Project Lead (11/15/13) 4. Hire Project Coordinator (11/15/2013) 5. Update plan as needed (1/1/2016)	HR capacity to complete timely reviews is being impacted by the volume of 1768 requests being received (10/1/2013)	Conduct weekly check-in with HR on status of 1768s and position prioritization by DSD and CCA (10/4/2013)	**Incomplete**	Position description, job postings
EC 20	**20.0 Develop and Implementation Plan that incorporates the recommendations of the Rule 40 Advisory Committee.** *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 (pg.30).*	20.4 Develop work plan for the evaluation DHS Regulatory Standards against the Recommendations of the Rule 40 Advisory Committee Recommendations including consideration of standards to be included in 245A. (10/15/2013)	5/1/2014	SMEs, DHS Senior Management Staff, Legislative Staff (10/15/2013)	**DSD Rule 40 Project Lead staff**, State Program Administrator Licensing, CCA Assist. Commissioner, CCA Legislative Liaison	1. Develop work plan for the evaluation of DHS license or certifications against Advisory Committee Recommendations (3/1/2014) 2. Provide recommendations for next steps (5/1/2013) **Next steps dependent on recommendations**	N/A	N/A	**Incomplete**	Evaluation Reports
	COMMUNICATION PLAN									
EC 21	**21.0 Communication Plan - Plan provides accurate and timely information** Communication on rule repeal, reporting requirements is provided to all stakeholders	21.1 Develop Comprehensive Communication Plan (7/1/2013)	1/30/2014	DSD Policy staff, DSD communication support staff and DSD Management 7/1/2013)	**245D/Services and Standards Policy Consultants (Lead)** DSD Division Director, DHS Executive Clinical Director, DSD TTC Unit Supervisor	1. Meet with TTC unit on approaches to communication plan development 8/19/2013 2. Obtain communication plan template from TTC unit (8/28/2013) 3. Meet with Colleen Wieck and Roberta Opheim for input on communication strategies for families, consumers and advocacy groups (10/10/13) 4. Meet with TTC Unit to map out communication plan (10/10/13) 5. Complete communication plan (tentative date - 12/30/2013) 6. Obtain plan approval from DSD Operations Manager and DSD Director (tentative date 1/30/2014)	N/A	N/A	**Incomplete**	Communication Plan
EC 21	**21.0 Communication Plan - Plan provides accurate and timely information** Communication on rule repeal, reporting requirements is provided to all stakeholders	21.2 Develop communications targeted for providers (7/1/2013)	7/5/2013	DSD Policy staff, DSD e-list support staff(7/1/2013)	**245D/Services and Standards Policy Consultants (Lead),** DSD TTC Unit Supervisor	1. Send out DSD Elist on Discontinued 245B license applications (7/5/2013) 2. Develop and maintain DHS web page on reporting behavioral intervention Incidents (7/26/2013)	NA	NA	**Incomplete**	1. URL to DSD E-List Communication on discontinuance of 245B licenses http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177531# 2. URL to Reporting Behavioral Incidents Web page http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177536
EC 21	**21.0 Communication Plan - Plan provides accurate and timely information** Communication on rule repeal, reporting requirements is provided to all stakeholders	21.3 Develop communication targeted for lead agencies (7/1/2013)	7/5/2013	DSD Policy staff, DSD e-list support staff (7/1/2013)	**245D/Services and Standards Policy Consultants (Lead)**, DSD TTC Unit Supervisor	1. Send out DSD Elist on Discontinued 245B license applications (7/5/2013)	N/A	N/A	**Incomplete**	1. URL to DSD E-List Communication on discontinuance of 245B licenses http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177531# 2. URL to Reporting Behavioral Incidents Web page http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177536

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EC 21	**21.0 Communication Plan - Plan provides accurate and timely information** Communication on rule repeal, reporting requirements is provided to all stakeholders	21.4 Develop communications targeted to other stakeholders including consumers, families, advocacy groups (7/1/2013)	2/1/2014	DSD Policy staff, DSD Public Guardianship Staff, CCA Autism Lead, CCA Communication Officer, DSD communications staff and web-support staff, advocacy group, faith community leaders, funding to develop tools (7/1/2013)	**DSD 245D/Services and Standards Policy Consultants (Lead)** , DSD TTC Unit supervisor and staff, DSD public web site	1. Maintain and update as needed content on the DHS Rule 40 Advisory Committee web page (updated 7/26/2013) 2. Develop strategies to share information on positive behavior practices to targeted groups such as Advocating Change Together, Minnesota Association for Guardianship, and Conservatorship, Autism Society, Board of Education etc. (1/1/2014) 3. Prepare content regarding positive behavior practices for DSD web page (Tentative date - 1/15/14) 4. Develop PowerPoint on Positive Behavior Practices that can be shared with (and used by) general audience (Tentative date 3/01/2014) 5. Seek funding to develop tools that can be used by persons with developmental disabilities to help individuals understand their rights(tentative date (Tentative date - 2/01/2014)	N/A		**Incomplete**	1. URL to DHS Rule 40 Advisory Committee Web page http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_166534 2. Communication plan
EC 21	**21.0 Communication Plan - Plan provides accurate and timely information** Communication on rule repeal, reporting requirements is provided to all stakeholders	21.5 Update Community-based Services Manual (CBSM) with 245D policy changes (7/1/2013)	3/1/2014	DSD Policy staff, DSD management, CBSM support staff(7/1/2013)	**DSD 245D/Services and Standards Policy Consultants(Lead)**, TTC web support staff, DSD waiver manager	1.Update each of the CBSM pages for services under the purview of 245D to include a notice that the service providers will need a 245D and need to use the BIRF (8/16/2013) 2. Update CBSM pages with references to BIRF with hyperlink to form (10/20/2013) 3. Update CBSM to include additional details concerning 245D policy changes (Tentative date 3/1/2014)	NA	NA	**Incomplete**	URL to CBSM Pages
	OTHER DHS ACTIVITES IMPACTING RULE 40									
EC 22	**22.0 Implement Performance-Based Incentive Payment Program** *The advisory committee recommendation addresses the following key processes and elements, which are included in the following this list: .....4. Providing incentives to providers, persons served and family members (pg. 30)*	22.1 Implement Performance-Based Incentive Payment Program (PIPP) to provide providers with opportunities to receive additional funding to cover a quality assurance project including the elimination of aversive techniques, and increase use of positive approaches. (10/15/2013)	6/30/2015	SMEs, CCA management, stakeholders (10/15/2013)	**Aging and Adult Services Planning Director (Lead);** DSD Integration manager	1. Establish workgroup 2. Release RFP (12/1/2014) 3. Grant awards (4/1/2014) 4. Fund projects through 6/30/2015	N/A	N/A	**N/A**	RFP, List of awardees related to quality assurance projects related to the elimination of aversive techniques and the increase of the use of positive approaches
EC 23	**23.0 Critical Access Study** *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. (pg. 34)*	23.1 As part of the **DHS Critical Access Study,** evaluate community capacity for the provision of behavioral support and clinical consultation services. (10/15/2013)	7/1/2014	SMEs, CCA management, stakeholders (10/15/2013)	**Aging and Adult Services Planning Director (Lead);** DSD Integration manager	1. Establish workgroup 2. Release RFP (12/30/213) 3. Initiate process to gather input and recommendations (2/15/2014) 4. Select contractor (2/28/2014) 5. Approve contract 6. Issue Report Other dates pending terms of contract	N/A	N/A	N/A	Copy of RFP, copy of contract, final report
EC 24	**24.0 Olmstead Plan Quality of Life Survey** *The advisory committee states that the goals of successful monitoring, reporting and oversight are: .....2. Improved quality of life by improving quality of a person's care and support (pg. 27)*	24.1 Minnesota will conduct annual surveys of people with disabilities to determine quality of life including: How well they are integrated into and engaged with their community; How much autonomy they have in day to day decisions and whether the are working and living in the most integrated setting that they choose (10/15/2013)	6/30/2014	DHS Management, stakeholders (10/15/2013)	**DSD Division Director (Lead)**	1. Select quality of life outcome indicators and contract with an independent entity to conduct annual assessment (3/30/2014) 2. Independent entity will conduct the quality of life survey to establish a baseline for measuring quality of life outcomes over time as key pieces of the plan are implemented (6/30/2014)	N/A	N/A	N/A	Survey results

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PART II - Rule Making

RM	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	RESOURCES REQUIRED (with date established or added)	PERSON(S) RESPONSIBLE	ACTIONS TAKEN (with date actions taken)	OBSTACLES (with date established or added)	ACTIONS TO ADDRESS OBSTACLES (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete, Approved Revised Deadline)	Documentation for Verification.
RM 1	**1.0 Meet legislative deadlines for proposed rule publication in State Register and for rule adoption.** Publish proposed rules within 18 months of effective date of law authorizing rules. Adopt rules within 24 months of this date.	1.1 Prepare rule development and adoption project timeline to perform all statutorily-required procedures and meet the two statutory deadlines. (7/01/2013)	7/23/2013	N/A	Administrative Law Manager.	Timeline prepared in its initial form on 7/23/2013. Communicated to DHS senior leadership 8/8/2013. Broadly disseminated to DHS policy staff on 9/13/2013. Updated on 9/28/2013.	N/A	N/A	**Complete**	This Jensen Implementation Plan has now become the primary rulemaking timeline for general deadlines.
RM 2	2.0 **Develop rules according to State law using methods to seek input from all classes of persons affected by rules**. Follow procedures under Minnesota Administrative Procedures Act to broadly engage the public in the rulemaking. Seek diverse input.	2.1 Develop Request for Comments using standard template. 5/17/2013	8/15/2013	Legal Analyst. (5/17/2013)	Legal Analyst	Utilizing standard State of Minnesota Rulemaking template, developed the Request for Comments. 8/12/2013	N/A	N/A	**Compete**	Request for Comments.
RM 2	2.0 **Develop rules according to State law using methods to seek input from all classes of persons affected by rules**. Follow procedures under Minnesota Administrative Procedures Act to broadly engage the public in the rulemaking. Seek diverse input.	2.2 Pull together the mailing list of all interested persons, advocates of all classes of persons affected by the rule proposal, professional associations representing classes of persons affected and DHS statutory standard list from historical list. (7/1/2013)	8/26/2013	Legal Analyst. (7/1/2013)	Administrative Law Unit.	Initial List developed and Finalized. 8/22/2013	N/A	N/A	**Complete**	Notice List related to Request for Comments.
RM 2	2.0 **Develop rules according to State law using methods to seek input from all classes of persons affected by rules**. Follow procedures under Minnesota Administrative Procedures Act to broadly engage the public in the rulemaking. Seek diverse input.	2.3 Mail notice to all classes of persons affected by the rule proposal, or to professional associations or advocates that represent them. (7/1/2013)	8/23/2013	N/A	Administrative Law Unit.	All persons on the mailing list was mailed a copy of Request for Comments. 8/23/2013	N/A	N/A	**Complete**	Request for Comments mailing verification.
RM 2	2.0 **Develop rules according to State law using methods to seek input from all classes of persons affected by rules**. Follow procedures under Minnesota Administrative Procedures Act to broadly engage the public in the rulemaking. Seek diverse input.	2.4 Electronically submit the Request for Comments to the State Register. (8/19/2013)	8/19/2013	N/A	Administrative Law Unit.	Emailed Request for Comments to State Register. 8/19/2013	N/A	N/A	**Complete**	Copy of email to State Register.
RM 2	2.0 **Develop rules according to State law using methods to seek input from all classes of persons affected by rules**. Follow procedures under Minnesota Administrative Procedures Act to broadly engage the public in the rulemaking. Seek diverse input.	2.5 Request for Comments published. (8/26/2013)	8/26/2013	N/A	Administrative Law Unit.	Notice published. 8/26/2013	N/A	N/A	**Complete**	Notice that was published in the State Register on August 26, 2013.
RM 3	3.0 **Develop initial rule draft for public input.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	3.1 Identify State policy staff providing primary, first-line policy input on initial rule draft. (9/13/2013).	9/27/2013	Policy staff from the pertinent divisions, including Licensing, Disability Services, Aging, and mental health; Ombudsman for Mental Health and DD Persons; Exec Dir. Of Governor's Council. Minnesota Rulemaking Manual; Revisor's Office Rules Drafting Manual. (9/28/2013)	Directors of the policy divisions. Administrative Law Manager.	DHS and other State staff identified (9/23/2013). Planning meeting scheduled to occur on 10/11/2013.	N/A	N/A	**Complete**	Copy of email from Administrative Law Manager to team members to invite to meeting on 10/11/13. (Additional recipients also copied.)
RM 3	3.0 **Develop initial rule draft for public input.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	3.2 Provide summary training to policy staff about how to draft a rule and the statement of need and reasonableness. (9/13/2013).	10/11/2013	Policy staff from the pertinent divisions, including Licensing, Disability Services, Aging, and mental health; Ombudsman for Mental Health and DD Persons; Exec Dir. Of Governor's Council. Minnesota Rulemaking Manual; Revisor's Office Rules Drafting Manual. (9/28/2013)	Administrative law unit.	DHS and other State staff identified (9/23/2013). Planning meeting scheduled to occur on 10/11/2013.	N/A	N/A	**Complete**	List of Drafting Tips prepared by Legal Analyst.
RM 3	3.0 **Develop initial rule draft for public input.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	3.3 Collaborate about initial rule drafting plans. (9/13/2013).	10/11/2013	Policy staff from the pertinent divisions, including Licensing, Disability Services, Aging, and mental health; Ombudsman for Mental Health and DD Persons; Exec Dir. Of Governor's Council. Minnesota Rulemaking Manual; Revisor's Office Rules Drafting Manual. (9/28/2013)	Directors of the policy divisions. Administrative Law Manager.	DHS and other State staff identified (9/23/2013). Planning meeting scheduled to occur on 10/11/2013.	N/A	N/A	**Complete**	10/11/13 email from Administrative Law Manager to the team to invite to the next draft review meeting on 10/31/13 and confirm plans for draft to be circulated roughly a week before that as time permits.
RM 3	3.0 **Develop initial rule draft for public input.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	3.4 Complete first rough, preliminary front- to-back draft rule for further State discussion and development by all DHS divisions and State reviewers (preparatory to broad public review of a later draft). (7/23/2013)	12/15/2013	Policy staff from the pertinent divisions, including Licensing, Disability Services, Aging, and mental health; Ombudsman for Mental Health and DD Persons; Exec Dir. Of Governor's Council. Advisory Committee Recommendations; Chapter 245D; Minnesota Rulemaking Manual; Revisor's Office Rules Drafting Manual. (9/28/2013)	Directors of the policy divisions. Administrative Law Unit.	Develop	N/A	N/A	**Incomplete**	Draft rule.
RM 4	4.0. **Solicit broad public input from all classes of persons affected by the proposed rule, including providers.** Follow procedures required in Minnesota Administrative Procedures Act and in the guidelines in Minnesota Rulemaking Manual.	4.1. Identify broad classes of persons to invite to upcoming public forum that includes diversity in geography, ethnicity, race, provider type, and recipient type (7/23/13)	4/15/2014	Policy staff and administrative law unit. (9/28/2013)	Directors of the policy divisions.	Actions forthcoming.	N/A	N/A	**Incomplete**	List of places that notice will be placed and recipients it will be sent to.
RM 4	4.0. **Solicit broad public input from all classes of persons affected by the proposed rule, including providers.** Follow procedures required in Minnesota Administrative Procedures Act and guidelines in Minnesota Rulemaking Manual.	4.2 Identify and reserve forum location. (7/23/2013)	4/15/2014	Policy staff and administrative law unit. (9/28/2013)	Directors of the policy divisions.	Actions forthcoming.	N/A	N/A	**Incomplete**	Documentation of reservation of room.
RM 4	4.0. **Solicit broad public input from all classes of persons affected by the proposed rule, including providers.** Follow procedures required in Minnesota Administrative Procedures Act and guidelines in Minnesota Rulemaking Manual.	4.3 Disseminate information about public forum to public. (7/23/13)	4/30/2014	Policy staff and administrative law unit. (9/28/2013)	Directors of the policy divisions.	Actions forthcoming.	N/A	N/A	**Incomplete**	Text used to notify affected classes of persons about forum.
RM 4	4.0. **Solicit broad public input from all classes of persons affected by the proposed rule, including providers.** Follow procedures required in Minnesota Administrative Procedures Act and guidelines in Minnesota Rulemaking Manual.	4.2 Prepare forum agenda and hold public forum.	5/31/2014	Policy staff and administrative law unit. (9/28/2013)	Directors of the policy divisions.	Actions forthcoming.	N/A	N/A	**Incomplete**	Agenda for public forum.
RM 5	5.0 **Prepare statement of need and reasonableness and proposed rule to meet publication deadline.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	5.1 Synthesize public comment from public forum and incorporate into rule draft that is a closer-to-final version. (7/23/2013)	8/30/2014	Policy staff and administrative law unit. (9/28/2013)	Directors of the policy divisions.	Actions forthcoming.	N/A	N/A	**Incomplete**	Updated rule draft of 8/30/13.
RM 5	5.0 **Prepare statement of need and reasonableness and proposed rule to meet publication deadline.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	5.2 Submit draft rule to Legislative Office of the Revisor to convert to format required for future approval to publish to identify format and content issues. (7/23/2013)	9/3/2014	Policy staff and administrative law unit. (9/28/2013)	Directors of the policy divisions.	Actions forthcoming.	N/A	N/A	**Incomplete**	Email from Administrative law unit to Revisor's Office transmitting draft rule for conversion.
RM 5	5.0 **Prepare statement of need and reasonableness and proposed rule to meet publication deadline.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	5.3 Modify DHS template to begin to prepare statement of need and reasonableness(7/23/2013)	9/10/2014	Revisor's Office Rule Drafting Manual. Revisor's Office assigned Assistant Revisor. (9/28/2013)	Administrative Law Manager and directors of the policy divisions.	Actions forthcoming.	The Revisor's Office has statutory authority to approve rule format and certain aspects of content. DHS cannot control the timing of its actions or the content of its input.	Plan plenty of time for work with the Revisor's Office to work through any changes and concerns.	**Incomplete**	Preliminary draft of structural outline of statement of need and reasonableness.
RM 5	5.0 **Prepare statement of need and reasonableness and proposed rule to meet publication deadline.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	5.4 Work with Revisor's office toward achieving agreement on rule part numbering, format, form, grammar, and compliance with statutory content guidelines. (7/23/2013)	9/20/2014	Revisor's Office Rule Drafting Manual. Revisor's Office assigned Assistant Revisor. (9/28/2013)	Administrative Law Manager and directors of the policy divisions.	Actions forthcoming.	The Revisor's Office has statutory authority to approve rule format and certain aspects of content. DHS cannot control the timing of its actions or the content of its input.	Plan plenty of time for work with the Revisor's Office to work through any changes and concerns.	**Incomplete**	Revisor Office-issued draft version of rule.
RM 5	5.0 **Prepare statement of need and reasonableness and proposed rule to meet publication deadline.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	5.5 Seek to have all format and content issues with Revisor's Office resolved and version issued that will be basis to prepare rule- part- by- rule-part analysis in the statement of need and reasonableness and commence rule part by rule part explanations. (9/28/2013)	9/30/2014	Policy staff and administrative law unit. (9/28/2013)	Administrative Law Manager and directors of the policy divisions.	Actions forthcoming.	N/A	N/A	**Incomplete**	Updated Revisor Office-issued draft version of rule (which has consensus between Revisor Office and DHS).
RM 6	6.0 **Notice of public hearing and proposed rule published in State Register and broadly disseminated to affected classes of persons.**	6.1 Contact Office of Administrative Hearings to obtain judge assignment and other information required in Notice of Hearing (7/23/2013)	12/4/2014	Chief Administrative Law Judge and Administrative Law Judge. State Register. (7/23/2013)	Administrative law unit. Chief Administrative Law Judge and Administrative Law Judge.	Actions forthcoming.	N/A	N/A	**Incomplete**	Notice of Hearing.

Rule 40 Implementation Plan (Proposed), dated October 30, 2013

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	RESOURCES REQUIRED (with date established or added)	PERSON(S) RESPONSIBLE	ACTIONS TAKEN (with date actions taken)	OBSTACLES (with date established or added)	ACTIONS TO ADDRESS OBSTACLES (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete, Approved Revised Deadline)	Documentation for Verification
RM 6	6.0 **Notice of public hearing and proposed rule published in State Register and broadly disseminated to affected classes of persons.**	6.2 Submit Notice of Hearing and Proposed Rule to State Register two weeks before publication date. (7/23/2013)	12/9/2014	Chief Administrative Law Judge and Administrative Law Judge. State Register.(7/23/2013)	Administrative law unit. Chief Administrative Law Judge and Administrative Law Judge.	Actions forthcoming.	N/A	N/A	**Incomplete**	Notice of Hearing (which provides notice of **hearing** scheduled in **February 2015**).
RM 7	7.0 **State Administrative Law Judge holds public hearing; post-hearing statutory requirements are met.** *Note: For Evaluation Criteria Nos. 6 & 7, the deadlines all occur after federal court jurisdiction is scheduled to end on December 4, 2014. The information is included to provide context for the earlier activities.*	7.1 Administrative Law Judge (ALJ) from State Office of Administrative Hearings presides over public hearing on proposed rule. Department presents evidence to show that all procedures in the Administrative Procedures Act were followed, and that the rules are needed and reasonable. ALJ receives public testimony from any member of the public who desires speak. (7/23/2013)	2/15/2015	Administrative Law Judge. DHS Policy staff who will present evidence to support rule. Members of the public. (7/23/2013)	Administrative Law Judge.	Actions forthcoming.	The assigned State Administrative Law Judge controls the timing of the hearing based on his or her schedule.	Recommend to ALJ that hearing date occur on or before 2/15/2015. If necessary, convey importance of prompt rule hearing due to pending federal court settlement terms.	**Incomplete**	List of DHS hearing exhibits and/or transcript of hearing.
RM 7	7.0 **State Administrative Law Judge holds public hearing; post-hearing statutory requirements are met.** *Note: For Evaluation Criteria Nos. 6 & 7, the deadlines all occur after federal court jurisdiction is scheduled to end on December 4, 2014. The information is included to provide context for the earlier activities.*	7.2 ALJ issues Report determining whether all procedures in the Administrative Procedures Act were followed and whether the department has authority to adopt the rule. Report identifies any rule defects which must be corrected. (7/23/2013)	4/15/2015	Administrative Law Judge. (7/23/2013)	Administrative Law Judge.	Actions forthcoming.	N/A	N/A	**Incomplete**	ALJ Report.
RM 7	7.0 **State Administrative Law Judge holds public hearing; post-hearing statutory requirements are met.** *Note: For Evaluation Criteria Nos. 6 & 7, the deadlines all occur after federal court jurisdiction is scheduled to end on December 4, 2014. The information is included to provide context for the earlier activities.*	7.3 Department revises rule as necessary to obtain ALJ and/or Chief ALJ approval for rule adoption. (7/23/2013)	6/30/2015	DHS policy staff and administrative law unit staff. (7/21/2013)	DHS policy directors and Administrative Law Unit.	Actions forthcoming.	N/A	N/A	**Incomplete**	Updated Revisor Office-issued draft version of rule that now incorporates any modifications required by Report.
RM 7	7.0 **State Administrative Law Judge holds public hearing; post-hearing statutory requirements are met.** *Note: For Evaluation Criteria Nos. 6 & 7, the deadlines all occur after federal court jurisdiction is scheduled to end on December 4, 2014. The information is included to provide context for the earlier activities.*	7.3 Upon judge's approval of the final rule, Department adopts rule . (7/23/2013)	6/30/2015	DHS policy staff and administrative law unit staff. (7/23/2013)	DHS policy directors and Administrative Law Unit.	Actions forthcoming.	N/A	N/A	**Incomplete**	Order Adopting Rules.
RM - NOTE	**Note:** This note is for informational/context purposes only. To meet the second statutory deadline, DHS will publish a new rule and the repeal of the old Rule 40 in the State Register no later than June 30, 2015, and both will become effective five business days later.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Rule 40 Implementation Plan Project Staff (Proposed), dated October 30, 2013

Role/Title	Responsibility
Administrative Law Manager	Project management of the rule development & adoption process; resolve legal issues relating to rulemaking; ensure that all required procedures in the Minnesota Administrative Procedures Act are followed and assist
Adult Protection Policy	Oversight for Reporting Center for Suspected Vulnerable Adult Maltreatment Common Entry Point
Aging and Adult Services Planning Director	Performance-based Incentive Payment Program (PIPP) Lead
Behavioral Medical Practitioner, MSHS Cambridge	Psychologist -Clinical Expert
CCA Fiscal Director	CCA budgets and forecasts
Continuing Care MFP (Money Follows the Person Demonstration) Agency Policy Specialist	ICI/Moving Home Minnesota Contract Management
DHS Deputy Director	Overall oversight of Jensen Settlement Implementation plan
DHS Executive Clinical Director	Subject Matter Expert for Positive Behavior Practices and Person-Centered Training
Director of DirectCourse at the University of Minnesota Research and Training Center on Community Living Institute on Community Integration (UCEDD)	ICI staff assigned as SME to develop modules for College of Direct Supports
Director, Disability Services Division	Oversight of DSD work plan activities, governance
DSD 245D/Services and Standards Policy Consultant (1)	245D Subject Matter Expert/Lead
DSD 245D/Services and Standards Policy Consultant (2)	245D Subject Matter Expert
DSD Community Capacity Team Lead	Oversight of identified deliverables and staff supervision
DSD Community Supports and Consumer Safeguards Unit Supervisor	Supervisor overseeing Community Capacity Team
DSD Integration Manager	National Core Indicator Project, PIPP
DSD Operations Manager	Oversight of Rule 40 Modernization work plan
DSD Special Projects Manager	MnCHOICES
DSD Training Technical Assistance and Communication (TTC) Unit Supervisor	Training and Communication Support including DHS public web site and County Link
Jensen Compliance Officer, Commissioner's Office Project Management	Jensen Implementation Plan oversight Commissioner's Office Project Management
Legal Analyst, Administrative Law Unit	Rule drafting; ensure that all required procedures in the Minnesota Administrative Procedures Act are followed.
Minnesota Disability Law Center	Provide feedback and approval on identified deliverables
Minnesota Governor's Council on Developmental Disabilities	Provide feedback and approval on identified deliverables
MN Institute on Community Integration	ICI staff assigned to support Positive Behavior Supports Manual Development

Rule 40 Implementation Plan Project Staff (Proposed), dated October 30, 2013

MNITS	IT systems technical staff
Office of Ombudsman for Mental Health and Developmental Disabilities	Provide feedback and approval on identified deliverables
Provider organizational	Provide feedback from provider perspective on identified deliverables
Rule 40 Advisory Committee Members	Provide feedback and approval as needed on work plan deliverables based on committee recommendations
Rule 40 Project Coordinator	Provide leadership and direction in supporting the transition to future-state; manage Jensen Implementation (Rule 40) work plan
Rule 40 Project Lead	Advise and participate in the rule-making processes, to modernize Rule 40 and assure statewide compliance with statutory and legal requirements and goals
State Program Admin Manager, Commissioner's Office Project Management	Jensen Compliance Officer, liaison to court
State Program Administrator Licensing	DHS Licensing Subject Matter Expert

Rule 40 Implementation Plan Acronymns (proposed), dated October 30, 2013

AARM = In the past, the ARRM acronym stood for "Association of Residential Resources in Minnesota." However, because members provide more than residential supports to Minnesotans with disabilities, the organization is now referred to as ARRM

ALJ = Administrative Law Judge
BIRF = Behavior Intervention Reporting Form
CBSM = DHS Community-based Services (policy) Manual
CCA = Continuing Care Administration
CCT = DSD Community Capacity (Building) Team
CDS = College of Direct Supports
CSS = Community Support Services
DSD = Disability Services Division
GCDD = Governors Council on Developmental Disabilities
HR = DHS Human Resources
ICI = Institute on Community Integration at the University of Minnesota
MACSSA - Minnesota Association of County Social Service Administrators
MCCP = Metro Crisis Coordination Program
MDH = Minnesota Department of Health
MDLC = Minnesota Disability Law Center
MNPBSI = Minnesota Positive Behavior Support Initiative
NCI = National Core Indicator
OMHDD = Office of Ombudsman for Mental Health and Developmental Disabilities
PBS = Positive Behavior Supports
PCA = Personal Care Assistance
PCP = Person-Centered Planning
PCT = Person-Centered Thinking
PIPP = Performance Incentive Payment Program
PSTP = Positive Support Transition Plan
RFP= Request for Proposals
SQC = State Quality Council
SME = Subject Matter Expert
TTC = DSD Training Technical Assistance and Communication Team

DHS SPECIFIC AND OTHER TERMS

1768 = DHS platform used to establish or fill positions other HR actions

E-list = Communication tool used by DSD to communicate with counties and other stakeholders

Go - To Meeting - Web conferencing tool used by DSD

Rule 40 Implementation Plan Acronymns (proposed), dated October 30, 2013

MnCHOICES - MnCHOICES is a web-based application that is comprehensive and integrates assessment and support planning for people who need long-term services and supports in Minnesota. MnCHOICES embraces a person-centered approach to ensure services meet each individual's strengths, goals, preferences and assessed needs

Pathlore = DHS Learning Management System

DHS Workplace (SharePoint) = DHS platform for electronic collaboration activities

Rule 40 Implementation Plan Chronological Timetable (Proposed), dated October 30, 2013

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	ACTIONS TAKEN (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete,
EC 1A	**1.0 A Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - *Behavior Intervention Reporting Form (BIRF):*** • *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 the reporting of all permitted and unpermitted use of restraints. A person's voluntary use of restraints must also be reported.(pg.25)* • *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 (pg. 37)* • *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 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. (pg. 26)* • *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* *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 (pg. 26)* • *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 manager; 5. External reviewer; 6. DHS – licensing and policy areas (pg. 26)*	1.1 A Solicit initial stakeholders feedback on BIRF prior to posting on DHS web site (6/1/2013)	7/1/2013	1. Schedule meetings with stakeholders (6/1/2013) 2. Conduct meetings with stakeholders prior to launch of BIRF - Three separate review meetings occurred before launch of the BIRF with varying Rule 40 Advisory Committee Members in attendance on: 04/26/2013 with Kay Hendrickson (OMHDD); 06/07/2013 with Kay Hendrickson & Roberta Opheim (OMHDD); and 06/20/2013 with Kay Hendrickson and other members of the Rule 40 Advisory Group (Anne Henry, Steve Anderson, Kelly Ruiz and Pat Kuehn). 3. Review feedback received from Colleen Wieck GCDD (6/21/2013)	**Complete**
EC 1A	***1.0 A Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Behavior Intervention Reporting Form (BIRF):*** • *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 the reporting of all permitted and unpermitted use of restraints. A person's voluntary use of restraints must also be reported.(pg.25)* • *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 (pg. 37)* • *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 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. (pg. 26)* • *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* *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 (pg. 26)* • *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 manager; 5. External reviewer; 6. DHS – licensing and policy areas (pg. 26)*	1.4 A Review and analyze BIRF reports to identify trends and develop policy recommendations (6/1/2013)	7/1/2013	1. Develop database to capture BIRF data elements - • # reports received; # unduplicated providers submitting a report; # unduplicated persons receiving services reported on; # unduplicated persons receiving services with Rule 40 plan • Individuals with more than one report & Positive Support Transition Plan • Individuals with more than one report & No Positive Support Transition Plan • # Reports Manual Restraint; # Reports Mechanical restraint; # reports with Self-harm/SIB equipment; # reports seat belt; # reports w/time out ; # reports w/ time out/Seclusion; # reports with penalty consequence; # reports include prone restraint; # reports with PRN; # reports call 911; # reports with emergency hospitalization; # reports include injury to someone; # reports using any procedure > 60 minute; # reports received 21 days after intervention date (7/1/2013) 2. Create report format (10/1/2013);3 Initiate running of reports (9/15/2013) ; 4.Obtain input of OMHDD on the frequency of reports (10/15/2013) 5. Complete analysis of data received from 7/13 - 12/2013 (1/15/2014); 6.Develop policy recommendation for rule writing (1/31/2013) ; 7. Provide on-going reports as part of Oversight and Monitoring Process (**See EC 1C Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Monitoring and oversight)**	**Incomplete**

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	ACTIONS TAKEN (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete,
EC 3	**3.0 Positive Behavior Supports Manual (positive practices manual) -** *• 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. 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 (pg. 14).* *• Proper screening tools or checklists be used to determine when functional assessment/functional behavioral assessments are necessary (pg. 15)* *• Using the existing mental health crisis services for children and adults and mobile crisis teams (pg. 15)* *• 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 assess met (pg. 15)* *• Assessment. 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. (pg. 16)* *• 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. Committee members recommend a positive strategies section: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. (pg. 16, 17)* *• The advisory committee recommends a non---exhaustive list of permitted positive support strategy examples be provided in the forthcoming positive support manual. (pg. 17)*	3.1 Develop DRAFT Positive Behavior Supports Manual (6/1/2013)	7/1/2013	1. Develop DRAFT Positive Behavior Supports Manual outline using existing positive behavior practices and manuals developed by other states (including Arizona) (5/1/13) 2. Draft reviewed by Rick Amado(5/15/213)	**Complete**
EC 21	**21.0 Communication Plan - Plan provides accurate and timely information** Communication on rule repeal, reporting requirements is provided to all stakeholders	21.2 Develop communications targeted for providers (7/1/2013)	7/5/2013	1. Send out DSD Elist on Discontinued 245B license applications (7/5/2013) 2. Develop and maintain DHS web page on reporting behavioral intervention Incidents (7/26/2013)	**Incomplete**

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	ACTIONS TAKEN (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete,
EC 21	**21.0 Communication Plan - Plan provides accurate and timely information** Communication on rule repeal, reporting requirements is provided to all stakeholders	21.3 Develop communication targeted for lead agencies (7/1/2013)	7/5/2013	1. Send out DSD Elist on Discontinued 245B license applications (7/5/2013)	**Incomplete**
EC 1A	**1.0 A Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Behavior Intervention Reporting Form (BIRF):** • *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 the reporting of all permitted and unpermitted use of restraints. A person's voluntary use of restraints must also be reported.(pg.25)* • *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 (pg. 37)* • *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 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. (pg. 26)* • *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* *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 (pg. 26)* • *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 manager; 5. External reviewer; 6. DHS – licensing and policy areas (pg. 26)*	1.2 A Make available on DHS web site Behavior Intervention Reporting Form (BIRF) and instructions (6/1/2013)	7/8/2013	1. Meet with IT technical staff regarding BIRF purpose and format (4/15/2013) 2. Develop BIRF draft (6/10/2013) 3. Obtain approval of BIRF from DSD Management and Rule 40 Advisory Committee members and Jensen Compliance Committee (7/1/2013) 4. Launch BIRF on the DHS web site (7/5/2013) 5. Meet with IT technical staff regarding minor changes to be made to BIRF to increase functionality based on feedback received from OMHDD, ARRM and providers using the form (8/1/2013) 6. Meet with OMHDD (Kay Henrickson and Roger Schwab) to review changes and obtain approval (8/6/2013) 7. Obtain approval from the Jensen Compliance Team to post BIRF revisions (8/10/2013) 8. Update BIRF on DHS web site (8/13/2013)	**Complete**
RM 1	**1.0 Meet legislative deadlines for proposed rule publication in State Register and for rule adoption.** Publish proposed rules within 18 months of effective date of law authorizing rules. Adopt rules within 24 months of this date.	1.1 Prepare rule development and adoption project timeline to perform all statutorily-required procedures and meet the two statutory deadlines. (7/01/2013)	7/23/2013	Timeline prepared in its initial form on 7/23/2013. Communicated to DHS senior leadership 8/8/2013. Broadly disseminated to DHS policy staff on 9/13/2013. Updated on 9/28/2013.	**Complete**
RM 2	2.0 **Develop rules according to State law using methods to seek input from all classes of persons affected by rules**. Follow procedures under Minnesota Administrative Procedures Act to broadly engage the public in the rulemaking. Seek diverse input.	2.1 Develop Request for Comments using standard template. 5/17/2013	8/15/2013	Utilizing standard State of Minnesota Rulemaking template, developed the Request for Comments. 8/12/2013	**Compete**
RM 2	2.0 **Develop rules according to State law using methods to seek input from all classes of persons affected by rules**. Follow procedures under Minnesota Administrative Procedures Act to broadly engage the public in the rulemaking. Seek diverse input.	2.4 Electronically submit the Request for Comments to the State Register. (8/19/2013)	8/19/2013	Emailed Request for Comments to State Register. 8/19/2013	**Complete**

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	ACTIONS TAKEN (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete,
RM 2	2.0 **Develop rules according to State law using methods to seek input from all classes of persons affected by rules**. Follow procedures under Minnesota Administrative Procedures Act to broadly engage the public in the rulemaking. Seek diverse input.	2.3 Mail notice to all classes of persons affected by the rule proposal, or to professional associations or advocates that represent them. (7/1/2013)	8/23/2013	All persons on the mailing list was mailed a copy of Request for Comments. 8/23/2013	**Complete**
RM 2	2.0 **Develop rules according to State law using methods to seek input from all classes of persons affected by rules**. Follow procedures under Minnesota Administrative Procedures Act to broadly engage the public in the rulemaking. Seek diverse input.	2.2 Pull together the mailing list of all interested persons, advocates of all classes of persons affected by the rule proposal, professional associations representing classes of persons affected and DHS statutory standard list from historical list. (7/1/2013)	8/26/2013	Initial List developed and Finalized. 8/22/2013	**Complete**
RM 2	2.0 **Develop rules according to State law using methods to seek input from all classes of persons affected by rules**. Follow procedures under Minnesota Administrative Procedures Act to broadly engage the public in the rulemaking. Seek diverse input.	2.5 Request for Comments published. (8/26/2013)	8/26/2013	Notice published. 8/26/2013	**Complete**
RM 3	3.0 **Develop initial rule draft for public input.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	3.1 Identify State policy staff providing primary, first-line policy input on initial rule draft. (9/13/2013).	9/27/2013	DHS and other State staff identified (9/23/2013). Planning meeting scheduled to occur on 10/11/2013.	**Complete**
EC 12	**12.0 Person-Centered Positive Behavior Support Training – Evaluation** *The committee recommends the effectiveness of training be measured through demonstrated competency of the skills in the setting in which services are provided (pg. 22) . The advisory committee recommends evaluation of training. Committee members discussed and recommended using the Donald Kirkpatrick five levels of evaluation. 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? (pg. 25)*	12.1 Contract with the U of M/ICI to implement an objective and independent evaluation of the Minnesota Positive Behavior Support Initiative (MNPBSI) training programs. (8/1/2013)	9/30/2013	1. Develop amendment to existing ICI contract to include deliverables related to evaluation of Person-Centered Positive Behavior Support Training (9/25/2013) 2. Route contract for approval (10/15/2013)	**Complete**
EC 13	**13.0 Build in-state training capacity for person centered thinking and person centered planning** - *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 (pg. 34). 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 (pg. 23)*	13.1 Contract with the U of M/ICI to develop in-state trainer capacity in the areas of PCT and PCP. (8/1/2013)	9/30/2013	1. Develop amendment to existing ICI contract to include deliverables related to developing in-state trainer capacity in the areas of PCT and PCP (9/25/2013) 2. Route contract for approval (10/15/2013)	**Complete**
RM 3	3.0 **Develop initial rule draft for public input.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	3.2 Provide summary training to policy staff about how to draft a rule and the statement of need and reasonableness. (9/13/2013).	10/11/2013	DHS and other State staff identified (9/23/2013). Planning meeting scheduled to occur on 10/11/2013.	**Complete**

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	ACTIONS TAKEN (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete,
RM 3	3.0 **Develop initial rule draft for public input.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	3.3 Collaborate about initial rule drafting plans. (9/13/2013).	10/11/2013	DHS and other State staff identified (9/23/2013). Planning meeting scheduled to occur on 10/11/2013.	**Complete**
EC 3	***3.0 Positive Behavior Supports Manual (positive practices manual) -*** *• 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. 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 (pg. 14).* *• Proper screening tools or checklists be used to determine when functional assessment/functional behavioral assessments are necessary (pg. 15)* *• Using the existing mental health crisis services for children and adults and mobile crisis teams (pg. 15)* *• 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 assess met (pg. 15)* *• Assessment. 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. (pg. 16)* *• 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. Committee members recommend a positive strategies section: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. (pg. 16, 17)* *• The advisory committee recommends a non---exhaustive list of permitted positive support strategy examples be provided in the forthcoming positive support manual. (pg. 17)*	3.2 Contract with University of Minnesota Institute on Community Integration (U of M /ICI to work with DHS on development of a Positive Behavior Supports Manual (8/1/2013)	10/15/2013	1. Develop amendment to existing ICI contract to include deliverables related to development of the Positive Behavior Practices Manual (9/25/2013) 2. Route contract for approval (10/15/2013)	**Complete**
EC 20	**20.0 Develop and Implementation Plan that incorporates the recommendations of the Rule 40 Advisory Committee.** *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 (pg.30).*	20.1 Develop draft implementation plan (8/1/2013)	11/1/2013	1. Based on Rule 40 Advisory Committee Report, develop draft plan (10/4/2013) 2. Route internally for review and feedback (10/9/2013) 3. Meet with Roberta Opheim (OMHDD) and Colleen Wieck for feedback (10/10/2013) 4. Update draft plan based on feedback received (10/28/2013) 5. Route internally for approval (10/29/13) 6. Submit draft plan to Court Monitor for approval (10/30/2013)	**Incomplete**
EC 20	**20.0 Develop and Implementation Plan that incorporates the recommendations of the Rule 40 Advisory Committee.** *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 (pg.30).*	20.2 Consultation with Expert concerning Rule 40 Committee Report on areas where committee did not achieve consensus (9/1/2013)	11/1/2013	1. Meet with Dr. Brown to provide perspectives of practitioners as she prepares recommendations based on best practice to address areas of dispute. (10/15/2013 and 10/16/2013) 2.Update/revise plan based on Dr. Brown's recommendations when received **(See also EC 1C)**	**Incomplete**

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EC 1C	***1.0 C Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Monitoring and oversight*** - *• 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 (pg. 27)* *• **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. (pg. 27)* *• **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. (pg. 28)* *• **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. (pg. 28)* *• **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 (pg. 28); 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* *actively. (pg. 28)*	1.1 C Meet with Subject Matter Expert (Dr. Fredda Brown to discuss best practices for monitoring and oversight (10/1/2013)	11/15/2013	1. Meet with Dr. Brown to provide perspectives of practitioners as she prepares recommendations based on best practice to address areas of dispute. (10/15/2013 - 10/16/2013) 2. Receive recommendations Dr. Brown (11/4/2013) 3. Review recommendations and identify action steps to develop review process (11/15/2013)	**Incomplete**
EC 9	**9.0 Person-Centered Planning Approaches Training:** *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 (pg. 18) 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. (pg. 18).*	9.1 Contract with U of M/ICI to provide Person Centered Thinking and Person Centered Planning Training 2-day workshops for providers, case managers and others (7/1/2013)	11/15/2013	1. Develop amendment to existing ICI contract to include deliverables related to person-centered thinking and person-centered planning two-day workshops and one-day videoconference training (9/25/2013) 2. Route contract for approval (10/15/2013)	**Complete**
EC 10	**10.0 Person-centered thinking, planning, and organizational and systems change videoconference -** *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 (pg. 18) 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 (pg. 18)*	10.1 Contract with U of M/ICI to provide one-day videoconference training on the principles and concepts of person-centered thinking, planning, and organizational and systems change for providers, case managers and others (8/1/2013)	11/15/2013	1. Develop amendment to existing ICI contract to include included one-day videoconference training on the principles and concepts of person-centered thinking, planning, and organizational and systems change. (9/25/2013) 2. Route contract for approval (10/15/2013)	**Complete**
EC 11	**11.0 Person-Centered Positive Behavior Support Training** *Advisory committee members recommend:* *1. Requiring providers to be trained, competent and use positive support strategies; (pg. 15)*	11.1 Contract with the U of M/ICI to provide the Minnesota Positive Behavior Support Initiative (MNPBSI) intensive training.	11/15/2013	1. Develop amendment to existing ICI contract to include included delivery of Minnesota Positive Behavior Support Initiative (MNPBSI) intensive training to 50-75 trainees with each cohort having 12-15 participants. (9/25/2013) 2. Route contract for approval (10/15/2013)	**Complete**

Rule 40 Implementation Plan Chronological Timetable (Proposed), dated October 30, 2013

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	ACTIONS TAKEN (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete,
EC 14A	**14.0 A College of Direct Supports On-line Training - Core Training** *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) (pg. 22)* ***Core training topics include, in non---priority order** : 1. De---escalation and crisis management, 2. Positive behavior supports, 3. Review of prohibited techniques and why they are not effective or safe, 4. Culture change, 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 and 21. Emergency use of manual restraint techniques and monitoring its use for signs of distress that require cessation. (pg. 22---23)*	14.1 A Contract with U of M /ICI and the College of Direct Supports to work with DHS DSD on module development for the College of Direct Supports (CDS) to be will be available to all providers and families members including core and tiered training that address different mastery levels, one for direct care staff and the other for professional/supervisory staff (8/1/2013)	11/15/2013	1. Meet with U of M (Amy Hewitt to discuss contract needs (8/11/2013) 2. Develop contract amendment to include modifying existing content and development of new content in the CDS (9/25/2013) 3. Route U of M/ ICI contract for approval (10/15/2013) 4. Route contract for expanded access to College of Direct Supports for approval (11/15/2013)	**Incomplete**
EC 2	**2.0 Positive Support Transition Plan (PSTP)** - *• 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. (pg. 33)* *• 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 (pg. 14)* *• 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.* *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; (pg. 16 & 17)*	2.2 Initiate Training & Regional Meetings on PSTP and BIRF (**See Positive Support Strategies Training - EC 8.0)** (6/1/2013)	12/1/2013	N/A	**N/A**
EC 4	**4.0 Positive Behavior Supports (PBS) and Person Centered Planning (PCP) Technical Assistance and Supports -** *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. (pg. 31).* *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, (pg. 33).*	4.3 Initiate Monthly Technical Assistance Webinars with providers and lead agencies (8/1/2013)	12/1/2013	1. Initiate development of webinar work plan (Tentative date - 11/1/2013) 2. Schedule Webinars 3. Send out announcement of webinars	**Incomplete**
RM 3	3.0 **Develop initial rule draft for public input.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	3.4 Complete first rough, preliminary front- to-back draft rule for further State discussion and development by all DHS divisions and State reviewers (preparatory to broad public review of a later draft). (7/23/2013)	12/15/2013	Develop	**Incomplete**
EC 1A	***1.0 A Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Behavior Intervention Reporting Form (BIRF):*** *• 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 the reporting of all permitted and unpermitted use of restraints. A person's voluntary use of restraints must also be reported.(pg.25)* *• 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 (pg. 37)* *• 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 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. (pg. 26)* *• 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* *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 (pg. 26)* *• 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 manager; 5. External reviewer; 6. DHS – licensing and policy areas (pg. 26)*	1.5 A Develop and implement policy to ensure appropriate and timely notification are made	1/1/2014	1. Notifications requirements for providers included in 245D.O6 and 245D.061 and in BIRF	**Incomplete**

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EC 1E	**1.0 E Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Permitted Techniques** *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 (pg. 18)* *The advisory committee recommends that use of permitted techniques be tied to notifications and reporting. (pg. 19)* *The committee members recommend the Commissioner develop a process for review of specific permitted techniques. (pg. 19)* *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. 20)* *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 (pg. 20)* *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. (pg. 20) 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. (pg. 20---21)*	1.1 E Develop and implement policy and procedures to address use of **PERMITTED techniques** (10/20/2013)	1/1/2014	1. Address use and reporting of PERMITTED techniques in 245D.06 subd 7 and 245D.061 (1/1/2014) 2. Address use and reporting of PERMITTED techniques in BIRF **(See EC 1A)** 3. Incorporate use of permitted techniques in Positive Behavior Supports Manual **(See EC 3)**	**Incomplete**
EC 1F	**1.0 F Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Prohibited Techniques** *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; 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. (pg. 20)*	1. 1 F Develop and implement policy and procedures to address **prohibited techniques** (10/20/2013)	1/1/2014	1. Use of PROHIBITED techniques addressed in MN Statute 245D.06 subd 5, 245D.04, Vulnerable Adults and Maltreatment of Minor Act Minnesota Statute 626.556 and 626.557 (1/1/2014) 2. Incorporate use of prohibited techniques in **BIRF (See EC 1A)** 3. Incorporate use of prohibited techniques in **Positive Behavior Supports Manual (See EC 3)**	**Incomplete**
EC 2	**2.0 Positive Support Transition Plan (PSTP)** - *• 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. (pg. 33)* *• 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 (pg. 14)* *• 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.* *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; (pg. 16 & 17)*	2.1 Make available on DHS web site PSTP template and instructions. (6/1/2013)	1/1/2014	1. Develop draft PSTP form (8/1/2013) 2. Solicit feedback on PSTP from DHS staff (8/27/2013) 3. Solicit feedback on PSTP from providers and OMHDD - Received feedback from Mount Olivet Rolling Acres and Meridian Services providers; met with Roberta Opheim and Roger Schwab OMHDD 9/26 – OMHDD provided feedback and gave their approval. Met with providers 10/14/2013 4. Based on feedback received from DSD and stakeholders finalize PSTP (Tentative date 11/15/2013) 5. Meet with IT technical staff regarding changes to be made to PSTP (Tentative date 10/21/2013) 6. Initiate process in SharePoint for approval from DHS	**Incomplete**

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EC 3	***3.0 Positive Behavior Supports Manual (positive practices manual) -*** *• 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. 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 (pg. 14).* *• Proper screening tools or checklists be used to determine when functional assessment/functional behavioral assessments are necessary (pg. 15)* *• Using the existing mental health crisis services for children and adults and mobile crisis teams (pg. 15)* *• 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 assess met (pg. 15)* *• Assessment. 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. (pg. 16)* *• 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. Committee members recommend a positive strategies section: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. (pg. 16, 17)* *• The advisory committee recommends a non---exhaustive list of permitted positive support strategy examples be provided in the forthcoming positive support manual. (pg. 17)*	3.3 Pilot version of Positive Behavior Supports Manual submitted to DHS (8/1/2013)	1/1/2014	1. U of M/ ICI to discuss review protocol (10/24/2013) Provide DHS DSD with work plan of deliverables and timeline (tentative date 10/30/2013) 2. DHS approves work plan and ICI staff assigned to project (tentative date 11/5/2013) 3. Obtain internal and external stakeholder input on table of contents (11/15/2015) 4. Provide DHS DSD with preliminary draft of manual (tentative date - 12/4/2013) 5. Draft reviewed by DSD, DHS Executive Clinical Director, External Clinical SME, Colleen Wieck, OMHDD, and other external stakeholders (Tentative date - 12/19/2013). 6. Final pilot version of manual approved by DSD Director, DHS Executive Clinical Director, Colleen Wieck, OMHDD and DHS Jensen Compliance Office and other external stakeholders (Tentative date - 1/1/2014).	**Incomplete**
EC 4	**4.0 Positive Behavior Supports (PBS) and Person Centered Planning (PCP) Technical Assistance and Supports -** *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. (pg. 31).* *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, (pg. 33).*	4.1 Hire staff for Community Capacity Team (CCT) - (8/1/2013) The Community Capacity Team to include staff with: clinical background, DHS systems/policy background service deliver any county background and policy and data analysis background	1/1/2014	1. Develop position descriptions (8/15/2013) 2. Initiate 1768s - DHS platform used to establish or fill positions other HR actions (8/23/13) 3. Post positions (Community Capacity Team Lead posted 10/11/2013, list received 10/25/2013) 4. Initiate interviews (11/15/2014) 5. Select candidate for each open position 6. Identify start date for each position	**Incomplete**
EC 6	**6.0 Training Goals -** *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) (pg. 22)* *Training was discussed as an annual requirement and as orientation material.* *The advisory committee did not come to consensus on a set hour requirement. Some recommend twenty hours of annual training. For comparative purposes, MS 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. and, MS 245B.07, subd. 5. 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. (pg. 22)*	6.1 Develop and implement policy to address training goals and requirements (10/20/2013)	1/1/2014	1. Address training goals in 245D.09 (1/1/2014) 2. Address training goals in best practices included in Positive Behavior Supports Manual **(SEE EC 3)**	**Incomplete**
EC 8	**8.0 Positive Support Strategies Training**: *The purpose of positive support strategies is to build repertoires of personal effectiveness in licensed settings.(pg. 15). Advisory committee members recommend: 1. Requiring providers to be trained, competent and use positive support strategies (pg. 14). The advisory committee values making training affordable and accessible. This means providing interactive online curriculum when possible and appropriate (pg. 22) .*	8.2 Initiate regional in-person training for providers (8/1/2013)	1/1/2014	1. Meet with TTC staff regarding planning for regional training.(9/1/2014) 2. Conduct regional in-person training in Rochester on the BIRF (9/19/2013) 3.Develop schedule for additional regional in-person training (11/15/2013)	**Incomplete**
EC 9	**9.0 Person-Centered Planning Approaches Training:** *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 (pg. 18) 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. (pg. 18).*	9.2 Initiate Person Centered Thinking (PCT) training for providers, case managers and others (7/1/2013)	1/1/2014	1. Provide DHS with work plan for deliverables including proposed dates/locations of PCT Training (Tentative date - 12/15/2013) 2. DHS approves work plan and staff assigned (Tentative date - 12/20/2013) 3. Monitor completion of work plan deliverables - Over a two-year period, approximately 350 individuals will receive the PCT training (7/1/2015)	**Incomplete**

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EC 9	**9.0 Person-Centered Planning Approaches Training:** *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 (pg. 18) 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. (pg. 18).*	9.3 Initiate Person Centered Planning (PCP) training for providers, case managers and others (7/1/2013)	1/1/2014	1. Provide DHS with work plan for deliverables including proposed dates/locations of PCP Training (Tentative date - 12/15/2013) 2. DHS approves work plan and staff assigned (Tentative date - 12/20/2013) 3. DHS to monitor completion of work plan deliverables - Over a two-year period approximately 100 individuals will receive the PCP training each year. (12/1/2015)	**Incomplete**
EC 13	**13.0 Build in-state training capacity for person centered thinking and person centered planning** - *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 (pg. 34).* *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 (pg. 23)*	13.2 Recruitment of trainees (8/1/2013)	1/1/2014	1. Provide DHS with work plan of deliverables including timelines (12/15/2013) 2. DHS approves work plan (12/20/2013) 3. ICI provides DHS with list of trainees (1/1/2014)	**Incomplete**
EC 1A	***1.0 A Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Behavior Intervention Reporting Form (BIRF):*** • *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 the reporting of all permitted and unpermitted use of restraints. A person's voluntary use of restraints must also be reported.(pg.25)* • *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 (pg. 37)* • *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 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. (pg. 26)* • *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* *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 (pg. 26)* • *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 manager; 5. External reviewer; 6. DHS – licensing and policy areas (pg. 26)*	1.3 A Solicit additional stakeholders feedback on BIRF (6/1/2013)	1/15/2014	1. Meet with stakeholder to get input on BIRF (Met with ARRM and MACSSA 8/12/13) 2. Meet with Rule 40 Advisory Committee Members OMHDD and Colleen Wieck regarding recommendation for possible changes to BIRF (Tentative date - 12/1/2013) 3. Obtain approval from DSD Division Director and Jensen Compliance Office to make any recommended changes to BIRF (Tentative date - 12/15/2013) 4. Send out communication tot stakeholders regarding changes (Tentative date12/20/2013) 5. Make approved changes to BIRF (Tentative date 1/15/2013)	**Incomplete**
EC	**2.0 Positive Support Transition Plan (PSTP)** - • *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. (pg. 33)* • *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 (pg. 14)* • *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.* *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; (pg. 16 & 17)*	2.3 Release supplemental instructional materials that are not part of licensing enforcement (See **Positive Behavior Supports Manual - EO 3.0**) (6/1/2013)	1/15/2014	N/A	**N/A**

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EC 3	**3.0 Positive Behavior Supports Manual (positive practices manual) -** *• 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. 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 (pg. 14).* *• Proper screening tools or checklists be used to determine when functional assessment/functional behavioral assessments are necessary (pg. 15)* *• Using the existing mental health crisis services for children and adults and mobile crisis teams (pg. 15)* *• 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 assess met (pg. 15)* *• Assessment. 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. (pg. 16)* *• 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. Committee members recommend a positive strategies section: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. (pg. 16, 17)* *• The advisory committee recommends a non---exhaustive list of permitted positive support strategy examples be provided in the forthcoming positive support manual. (pg. 17)*	3.5 E-list communication to all stakeholders announcing availability of Positive Behavior Supports Manual (8/1/2013)	1/30/2014	1. DSD SME drafts communication (tentative date 1/5/2014) 2. DSD Division Director and DHS compliance Office approves communication (tentative date 1/15/2014)	**Incomplete**
EC 21	**21.0 Communication Plan - Plan provides accurate and timely information** Communication on rule repeal, reporting requirements is provided to all stakeholders	21.1 Develop Comprehensive Communication Plan (7/1/2013)	1/30/2014	1. Meet with TTC unit on approaches to communication plan development 8/19/2013 2. Obtain communication plan template from TTC unit (8/28/2013) 3. Meet with Colleen Wieck and Roberta Opheim for input on communication strategies for families, consumers and advocacy groups (10/10/13) 4. Meet with TTC Unit to map out communication plan (10/10/13) 5. Complete communication plan (tentative date - 12/30/2013) 6. Obtain plan approval from DSD Operations Manager and DSD Director (tentative date 1/30/2014)	**Incomplete**
EC 1C	***1.0 C Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Monitoring and oversight -*** *• 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 (pg. 27)* *• **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. (pg. 27)* *• **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. (pg. 28)* *• **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. (pg. 28)* *• **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 (pg. 28); 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* *actively. (pg. 28)*	1.2 C Based on Dr. Brown recommendations, develop monitoring and oversight process that meets best practice for oversight of use of restraints (10/1/2013)	2/1/2014	1. Meet with DHS Licensing, DHS Executive Clinical Director, and identified stakeholders to design structure/process (12/15/2013) 2. Review and seek input from OMHDD and Colleen Wieck on process (12/24/2013) 3. Obtain final approval on review process and implementation plan from DSD Division Director and DHS Jensen Compliance Office (2/1/2014)	**Incomplete**

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EC 2	**2.0 Positive Support Transition Plan (PSTP)** - • *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. (pg. 33)* • *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 (pg. 14)* • *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.* *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; (pg. 16 & 17)*	2.4 Initiate review of Positive Support Transition Plans (6/1/2013)	2/1/2014	1. Develop process for the submission and review of PSTPs 2. Communicate with providers requirements regarding submission of all PBSP to DHS 3.Idenify data elements to be reviewed to determine: How many plans are developed (within required timeframe);Are prohibited procedures under 245D being phased out according to the timeline in 245D.06, subdivision 8; Are target behaviors and target intervention decreasing and are quality of life indicators increasing 4. Obtain input from DHS licensing, DHS Executive Clinical Director, OMHDD and Colleen Wieck on specific report needs 5.Create database to capture data elements	**Incomplete**
EC 4	**4.0 Positive Behavior Supports (PBS) and Person Centered Planning (PCP) Technical Assistance and Supports -** *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. (pg. 31).* *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, (pg. 33).*	4.2 Initiate On-Site Support (8/1/2013)	2/1/2014	1. Initiate development of work plan to address provision of technical assistance education and consultation to lead agencies, providers, division staff and management on PBP, PCP, use of permitted and prohibited techniques in behavior intervention and related policies and practices, to assure compliance as well as informing federal, state, agency, division and legal requirements and goals (tentative date - 1/1/2014) 2. Initiate on-site support (2/01/2014)	**Incomplete**
EC 4	**4.0 Positive Behavior Supports (PBS) and Person Centered Planning (PCP) Technical Assistance and Supports -** *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. (pg. 31).* *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, (pg. 33).*	4.4 Identify data to obtain needed information to measure impact of technical assistance (8/1/2013)	2/1/2014	1. Work with Community Capacity Lead and team and unit supervisor to develop work plan to a. Identify measurable quality outcomes b. Identify data needs; access data sources and data systems to obtain needed information. c. Conduct analysis to identify people and groups of people at risk of admission to ER/hospital/institutional settings and unnecessarily long stays who should be discharged to community services. d. Examine individual and system-wide opportunities and barriers to discharge or diverted admission. (Tentative date - 2/1/2014)	**Incomplete**
EC 7	**7.0 Training Plan -** *Staff training is very important to the advisory committee. (pg. 21)* *Training provided by DHS addresses training needs identified by the Rule 40 Advisory Committee for: 1. Behavior staff (pg. 23); 2. Provider executives, managers and owners(pg. 24); 3. Case managers (pg. 24); 4. Family members, legal guardians and conservators (pg. 24);5. Persons receiving services (pg. 25) and* *6. DHS policy staff (pg. 25)* *The advisory committee recommends evaluation of training. Committee members discussed and recommended using the Donald Kirkpatrick five levels of evaluation. 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 and 5. Measurement of return on investment for training: Do outcomes make training sustainable? (pg. 25)*	7.1 Develop Comprehensive Training plan to include : On-line training, webinars and in-person training. (7/1/2013)	2/1/2014	1. Meet with TTC staff to map out training identified in Rule 40 Advisory Committee Report (11/1/2013) 2. Meet with 245D/Services and Standards Policy Consultants to identify any additional training needs and discuss training modalities (12/01/2013) 3. Meet with U of M/ICI contracted training staff to review training plan (1/1/2014) 4. Review plan with DHS management, OMHDD, Coleen Wieck and Jensen Compliance Office(12/30/12) 5. Implement and monitor plan (2/1/2014)	**Incomplete**
EC 8	**8.0 Positive Support Strategies Training**: *The purpose of positive support strategies is to build repertoires of personal effectiveness in licensed settings.(pg. 15). Advisory committee members recommend: 1. Requiring providers to be trained, competent and use positive support strategies (pg. 14). The advisory committee values making training affordable and accessible. This means providing interactive online curriculum when possible and appropriate (pg. 22) .*	8.1 Initiate webinars for providers, families, lead agencies (case managers) (8/1/2013)	2/1/2014	1. Meet with TTC staff regarding on-line modality options (9/1/2014) 2. Conduct first webinar for providers and lead agencies (10/8/2013) 3. Conduct webinar targeted to families and advocates (2/1/2014)	**Incomplete**

EC	EVALUATION CRITERION	REQUIRED TASKS (with date established or added)	SPECIFIC TASK DEADLINE	ACTIONS TAKEN (with date actions taken)	STATUS OF TASK COMPLETION (Complete, Incomplete,
EC 10	**10.0 Person-centered thinking, planning, and organizational and systems change videoconference -** *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 (pg. 18)* *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 (pg. 18)*	10.2 Initiate statewide videoconferences on the principles and concepts of person-centered thinking, planning, and organizational and systems change. (7/1/2013)	2/1/2014	1. Provide DHS with work plan for deliverables including proposed dates/locations of videoconference (Tentative date - 12/15/2013) 2. DHS approves work plan and staff assigned (Tentative date - 12/20/2013) 3. DHS to monitor completion of work plan deliverables - Providers, case managers and others are offered training through (four) videoconference, in a one-day format, on the principles and concepts of person-centered thinking, planning, and organizational and systems change (600 individuals trained in year one, 600 individuals trained in year two) (12/1/2016)	**Incomplete**
EC 12	**12.0 Person-Centered Positive Behavior Support Training – Evaluation** *The committee recommends the effectiveness of training be measured through demonstrated competency of the skills in the setting in which services are provided (pg. 22) .* *The advisory committee recommends evaluation of training. Committee members discussed and recommended using the Donald Kirkpatrick five levels of evaluation. 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? (pg. 25)*	12.2 U of M/ICI to arrange for and implement an objective and independent evaluation of the Minnesota Positive Behavior Support Initiative (MNPBSI) training programs (8/1/2013)	2/1/2014	1. Provide DHS with work plan for deliverables and timelines. (Tentative date 12/15/2013) 2. DHS approves work plan and staff assigned (12/20/2013) 3. DHS to monitor completion of work plan deliverables - Written evaluation reports are due each year of the four-year project (Final report due 6/20/2017)	**Incomplete**
EC 13	**13.0 Build in-state training capacity for person centered thinking and person centered planning** - *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 (pg. 34).* *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 (pg. 23)*	13.3 Implement training (8/1/2013)	2/1/2014	1. Provide DHS with schedule of training 2. DHS to monitor completion of work plan deliverables (7/1/2017) • PCT Trainees will receive at least 75 hours of training. • PCP Trainees will receive an additional 50 hours of training. • 10 trainers trained in PCT and 5 in PCP in 2014, 2015, 2016, 2017	**Incomplete**
EC 15	**15.0 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 (pg. 24)*	15.1 Include in Training Olan specific training and other resources available to case managers to address the advisory committees recommendations for training topics for case managers **(See EC 7 Training Plan)**	2/1/2014	N/A	N/A
EC 21	**21.0 Communication Plan - Plan provides accurate and timely information** Communication on rule repeal, reporting requirements is provided to all stakeholders	21.4 Develop communications targeted to other stakeholders including consumers, families, advocacy groups (7/1/2013)	2/1/2014	1. Maintain and update as needed content on the DHS Rule 40 Advisory Committee web page (updated 7/26/2013) 2. Develop strategies to share information on positive behavior practices to targeted groups such as Advocating Change Together, Minnesota Association for Guardianship, and Conservatorship, Autism Society, Board of Education etc. (1/1/2014) 3. Prepare content regarding positive behavior practices for DSD web page (Tentative date - 1/15/14)	**Incomplete**

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EC 14A	**14.0 A College of Direct Supports On-line Training - Core Training** *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) (pg. 22)* ***Core training topics include, in non---priority order** : 1. De---escalation and crisis management, 2. Positive behavior supports, 3. Review of prohibited techniques and why they are not effective or safe, 4. Culture change, 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 and 21. Emergency use of manual restraint techniques and monitoring its use for signs of distress that require cessation. (pg. 22---23)*	14.2 A The U of M/ICI to evaluate the existing College of Direct Supports (CDS) module content and make recommendations to DHS DSD about course content, suggesting what existing information should be modified and what new content should be developed (8/1/2013)	2/28/2014	1CI to provide DHS with recommendations for content to be modified and new content to be developed 12/15/2013) 2. Provide DHS with work plan for deliverables and timelines. (Tentative date 1/15/2013) 3. DHS approves work plan (Tentative date 2/10/2014)	**Incomplete**
EC 18	**18.0 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. (Pg. 18)*	18.1 Include in Positive Behavior Support manual section on Evidenced-Based Best Practices the inclusion of a separate person-centered section **See also EC 3 Positive Behavior Support Manual (positive practices manual); EC 9 Person- centered Planning Approaches training; EC 10 Person-centered Thinking, planning, and orgaizational change videoconference**	3/1/2014	N/A	N/A
EC 21	**21.0 Communication Plan - Plan provides accurate and timely information** Communication on rule repeal, reporting requirements is provided to all stakeholders	21.5 Update Community-based Services Manual (CBSM) with 245D policy changes (7/1/2013)	3/1/2014	1.Update each of the CBSM pages for services under the purview of 245D to include a notice that the service providers will need a 245D and need to use the BIRF (8/16/2013) 2. Update CBSM pages with references to BIRF with hyperlink to form (10/20/2013) 3. Update CBSM to include additional details concerning 245D policy changes (Tentative date 3/1/2014)	**Incomplete**
EC 3	**3.0 Positive Behavior Supports Manual (positive practices manual) -** *• 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. 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 (pg. 14).* *• Proper screening tools or checklists be used to determine when functional assessment/functional behavioral assessments are necessary (pg. 15)* *• Using the existing mental health crisis services for children and adults and mobile crisis teams (pg. 15)* *• 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 assess met (pg. 15)* *• Assessment. 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. (pg. 16)*	3.4 Positive Behavior Supports Manual posted on DHS public web site (8/1/2013)	4/1/2014	1. TTC staff completes accessibility review of pilot manual (tentative date - 1/10/2014) 2. Pilot Manual posted on DHS web site requesting feedback (1/15/2014) 3. Review feedback received and update manual including best practices based on approval from SME (4/1/2014)	**Incomplete**
EC 8	**8.0 Positive Support Strategies Training**: *The purpose of positive support strategies is to build repertoires of personal effectiveness in licensed settings.(pg. 15). Advisory committee members recommend: 1. Requiring providers to be trained, competent and use positive support strategies (pg. 14). The advisory committee values making training affordable and accessible. This means providing interactive online curriculum when possible and appropriate (pg. 22) .*	8.3 Based on feedback received from face to face and webinar training, developed on-line training for providers (8/1/2013)	4/1/2014	1. Meet with TTC staff regarding planning for on-line training (11/1/2013)	**Incomplete**
RM 4	4.0. **Solicit broad public input from all classes of persons affected by the proposed rule, including providers.** Follow procedures required in Minnesota Administrative Procedures Act and in the guidelines in Minnesota Rulemaking Manual.	4.1. Identify broad classes of persons to invite to upcoming public forum that includes diversity in geography, ethnicity, race, provider type, and recipient type (7/23/13)	4/15/2014	Actions forthcoming.	**Incomplete**

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RM 4	4.0. **Solicit broad public input from all classes of persons affected by the proposed rule, including providers.** Follow procedures required in Minnesota Administrative Procedures Act and guidelines in Minnesota Rulemaking Manual.	4.2 Identify and reserve forum location. (7/23/2013)	4/15/2014	Actions forthcoming.	**Incomplete**
RM 4	4.0. **Solicit broad public input from all classes of persons affected by the proposed rule, including providers.** Follow procedures required in Minnesota Administrative Procedures Act and guidelines in Minnesota Rulemaking Manual.	4.3 Disseminate information about public forum to public. (7/23/13)	4/30/2014	Actions forthcoming.	**Incomplete**
EC 20	**20.0 Develop and Implementation Plan that incorporates the recommendations of the Rule 40 Advisory Committee.** *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 (pg.30).*	20.4 Develop work plan for the evaluation DHS Regulatory Standards against the Recommendations of the Rule 40 Advisory Committee Recommendations including consideration of standards to be included in 245A. (10/15/2013)	5/1/2014	1. Develop work plan for the evaluation of DHS license or certifications against Advisory Committee Recommendations (3/1/2014) 2. Provide recommendations for next steps (5/1/2013) **Next steps dependent on recommendations**	**Incomplete**
RM 4	4.0. **Solicit broad public input from all classes of persons affected by the proposed rule, including providers.** Follow procedures required in Minnesota Administrative Procedures Act and guidelines in Minnesota Rulemaking Manual.	4.2 Prepare forum agenda and hold public forum.	5/31/2014	Actions forthcoming.	**Incomplete**
EC 1C	***1.0 C Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Monitoring and oversight -*** *• 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 (pg. 27)* *• **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. (pg. 27)* *• **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. (pg. 28)* *• **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. (pg. 28)* *• **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 (pg. 28); 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 actively. (pg. 28)*	1.3 C Implement Monitoring Oversight and Process(10/1/2013)	6/1/2014	1. Identify DHS staff and stakeholders to be part of the oversight process (2/1/2014) 2. Review list of identified DHS staff and stakeholders with DSD Division Director, DHS Licensing, OMHDD, Colleen Wieck and Jensen Compliance Office (2/15/2014) 3. Finalize DHS staff and stakeholders to be part of the oversight process (3/1/2014) 4. Implement approved review process (6/1/2014)	**Incomplete**

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EC 13	**13.0 Build in-state training capacity for person centered thinking and person centered planning** - *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 (pg. 34).* *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 (pg. 23)*	13.4 Implement Community of Practice (8/1/2013)	6/1/2014	1. Provide DHS with work plan of deliverables including timelines 2. DHS approves work plan 3. DHS to monitor completion of work plan deliverables - community of practice activities including of meeting documentation to discuss training issues and share agency implementation ideas.	**Incomplete**
EC 1D	**1.0 D Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Quality of Life** *The advisory committee states that the goals of successful monitoring, reporting and oversight are: 2. Improved quality of life by improving quality of a person's care and support (pg. 27)*	1.3 D Other strategies See Olmstead Plan Quality of Life Survey EC 24.0	6/30/2014	N/A	**N/A**
EC 24	**24.0 Olmstead Plan Quality of Life Survey** *The advisory committee states that the goals of successful monitoring, reporting and oversight are: .....2. Improved quality of life by improving quality of a person's care and support (pg. 27)*	24.1 Minnesota will conduct annual surveys of people with disabilities to determine quality of life including: How well they are integrated into and engaged with their community; How much autonomy they have in day to day decisions and whether the are working and living in the most integrated setting that they choose (10/15/2013)	6/30/2014	1. Select quality of life outcome indicators and contract with an independent entity to conduct annual assessment (3/30/2014) 2. Independent entity will conduct the quality of life survey to establish a baseline for measuring quality of life outcomes over time as key pieces of the plan are implemented (6/30/2014)	N/A
EC 5	**5.0 Guidelines for the use of Psychotropic Medications -** ***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.(pg. 39)*	5.1 Develop guidelines for the use of psychotropic medications and a checklist that are consistent with best practices and address the need for routine assessments of negative side effects	7/1/2014	1. Develop contract 12/1/2013) 2. Approve Contract (12/30/2013) 3. Implement contract (1/1/2014) 4. Draft Guidelines (4/1/2014) 5. Review draft guidelines with stakeholders (5/1/2014) 6. Complete guidelines (7/1/2014)	**Incomplete**
EC 19	**19.0 - The Commissioner will not grant variances to the requirements** under 245D that do not meet the requirements of section 245A.04 A, subdivision 9; as such The Commissioner will not grant variances to requirements under section 245D.06 [Protected Standards], subdivision 5 [Prohibited procedures] ; or subdivision 6 [Restricted procedures]; or section 245D.061 [Emergency Use of Manual Restraints], subdivision 3[Restrictions when implementing use of manual restraints	19.1 Amend 245D.03, subd. 3 (10/1/2013)	7/1/2014	1. Develop DHS /CCA White Paper to Amend 245D.03, subd. 3 2. Submit White paper to CCA Legislative Liaison for review 3. Obtain approval to move forward with White Paper from CCA senior management 4. Draft language 5. Language reviewed and approved by DHS Licensing, DSD Division Director and Jensen Compliance Team 6. Submit language for inclusion in CCA's bill **ALL DATES PENDING AT THIS TIME**	**Incomplete**
EC 23	**23.0 Critical Access Study** *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. (pg. 34)*	23.1 As part of the **DHS Critical Access Study,** evaluate community capacity for the provision of behavioral support and clinical consultation services. (10/15/2013)	7/1/2014	1. Establish workgroup 2. Release RFP (12/30/213) 3. Initiate process to gather input and recommendations (2/15/2014) 4. Select contractor (2/28/2014)	N/A
RM 5	5.0 **Prepare statement of need and reasonableness and proposed rule to meet publication deadline.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	5.1 Synthesize public comment from public forum and incorporate into rule draft that is a closer-to-final version. (7/23/2013)	8/30/2014	Actions forthcoming.	**Incomplete**

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EC 1D	**1.0 D Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Quality of Life** *The advisory committee states that the goals of successful monitoring, reporting and oversight are: 2. Improved quality of life by improving quality of a person's care and support (pg. 27)*	1.1 D Develop and implement strategies to determine if/how changes made regarding policy changes, training, staff, protocols, documentation, etc. impact the quality of life for persons intended to be served.- **Strategy #1 MnCHOICES -** Persons receiving waiver services and PCA services will be assessed annually for quality of life indicators via the MnCHOICES assessment. (7/1/2013)	9/1/2014	1. Launch MnCHOICES in first implementer counties (11/5/2013) 2 Develop report to look specifically at quality of life indicators included in MnCHOICES (6/1/2014) 4. Statewide implementation of MnCHOICES (8/1/2014) 5. Develop process to automate reports to provide to oversight and monitoring team (9/1/2014)	**Incomplete**
EC 1D	**1.0 D Reporting, Reviews and Oversight: to reduce and eliminate the use of restraints - Quality of Life** *The advisory committee states that the goals of successful monitoring, reporting and oversight are: 2. Improved quality of life by improving quality of a person's care and support (pg. 27)*	1.2 D Develop and implement strategies to determine if/how changes made regarding policy changes, training, staff, protocols, documentation, etc. impact the quality of life for persons intended to be served.- **Strategy #2 Utilize data gathered from National Core Indicator Process (NCI)** (10/15/2013)	9/1/2014	1. Obtain agreement with HSDI to pilot NCI (HSDI) 2. Identify sample (11/15/2013 3. Sign contract with Vital Research to conduct Interviews (12/1/2013) 4. Develop work plan to utilize data (2/1/2014) 5. Conduct Interviews (6/1/2014) 6. Make report available (9/1/2014)	**Incomplete**
RM 5	5.0 **Prepare statement of need and reasonableness and proposed rule to meet publication deadline.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	5.2 Submit draft rule to Legislative Office of the Revisor to convert to format required for future approval to publish to identify format and content issues. (7/23/2013)	9/3/2014	Actions forthcoming.	**Incomplete**
RM 5	5.0 **Prepare statement of need and reasonableness and proposed rule to meet publication deadline.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	5.3 Modify DHS template to begin to prepare statement of need and reasonableness(7/23/2013)	9/10/2014	Actions forthcoming.	**Incomplete**
RM 5	5.0 **Prepare statement of need and reasonableness and proposed rule to meet publication deadline.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	5.4 Work with Revisor's office toward achieving agreement on rule part numbering, format, form, grammar, and compliance with statutory content guidelines. (7/23/2013)	9/20/2014	Actions forthcoming.	**Incomplete**
RM 5	5.0 **Prepare statement of need and reasonableness and proposed rule to meet publication deadline.** Follow procedures required in Minnesota Administrative Procedures Act; and in the guidelines in the Minnesota Rulemaking Manual and Revisor's Office Minnesota Rules Drafting Manual.	5.5 Seek to have all format and content issues with Revisor's Office resolved and version issued that will be basis to prepare rule- part- by- rule- part analysis in the statement of need and reasonableness and commence rule part by rule part explanations. (9/28/2013)	9/30/2014	Actions forthcoming.	**Incomplete**
EC 14A	**14.0 A College of Direct Supports On-line Training - Core Training** *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) (pg. 22)* ***Core training topics include, in non---priority order** : 1. De---escalation and crisis management, 2. Positive behavior supports, 3. Review of prohibited techniques and why they are not effective or safe, 4. Culture change, 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 and 21. Emergency use of manual restraint techniques and monitoring its use for signs of distress that require cessation. (pg. 22---23)*	14.4 A. Develop and implement marketing plan for CDS (8/1/2013)	12/1/2014	1. ICI to provide DHS with recommendations for marketing plan (9/1/2014) 2.Implement Plan (10/1/2014)	**Incomplete**

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EC 14B	***14.0 B College of Direct Supports On-line Training - Tiered Training*** *In addition to core training, the advisory committee recommends additional tiered training requirements for people based on the level of responsibility and qualifications (pg. 22)* ***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 (pg. 23)* ***The second tier of additional training is for behavior staff who 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 (pg. 23 - 24)* ***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 (pg.24)* ***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 (pg. 24)*	14.1 B **(See 1EC 14A - EC 14D)**	12/1/2014	N/A	N/A
EC 14C	**14.0 C College of Direct Supports On-line Training - Family Members** *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 and 5. De-escalation strategies (Pg. 24)*	14.1 C **(See 14.1 A - 14.1D)**	12/1/2014	N/A	N/A
RM 6	6.0 **Notice of public hearing and proposed rule published in State Register and broadly disseminated to affected classes of persons.**	6.1 Contact Office of Administrative Hearings to obtain judge assignment and other information required in Notice of Hearing (7/23/2013)	12/4/2014	Actions forthcoming.	**Incomplete**