UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, Guardians and next friends of Bradley J. Jensen, *et al.,*

Plaintiffs

v.

Minnesota Department of Human Services, an agency of the State of Minnesota, *et al.,*

Defendants

Civil No. 09-1775 (DWF/FLN)

Independent Consultant and Monitor

# REPORT TO THE COURT: COMPREHENSIVE PLAN OF ACTION

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November 26, 2013

On August 28, 2013, in lieu of contempt and other sanctions for established and conceded non-compliance, the Court required the Department of Human Services (DHS) to submit plans for implementation. DHS had not adopted such planning despite almost a year of urging by the Court, and the Court's repeated concerns about DHS' delays and non-compliance.[1]

The Court characterized the "plan" to consist of three elements: 1) a plan for the Settlement Agreement's Evaluation Criteria and the MSHS-Cambridge closure, 2) a plan for the Rule 40 modernization, and 3) the *Olmstead* Plan. Each of these is an element of a tripartite "Comprehensive Plan of Action," parts one and two of which are attached here.

The implementation plans, which are subject to the Court's review and approval, are an element of the "heightened supervision" the Court found to be appropriate for two reasons: "compliance continues to be insufficient and Defendants have not established a comprehensive implementation plan." Essentially a remedy, further relief or sanction for non-compliance,[2] the plans

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[1] *See, e.g.,* The Court had urged for almost a year that an implementation plan be developed. *E.g.,* Court's Letter to Parties, January 9, 2013 (Dkt. 192) ("The primary purpose of my letter is to urge all of the parties to do their best to develop an implementation plan that would include tasks, deadlines, persons responsible, possible amendments to extend the jurisdiction of the Court for an additional period of time, etc., consistent with our discussions on December 11th."); Order of March 19, 2013 at 2 (Doc. No. 205) (urging development of implementation plan); Order of April 23, 2013 (Dkt. 211) ("the Court urged the parties to utilize their best efforts to develop and implementation plan that would include tasks, deadlines, persons responsible, and possible amendments to extend the jurisdiction of the Court for an additional period of time, consistent with the discussion that occurred at the December 11, 2012 status conference."); Order of August 28, 2013 at 7-11 (detailing "sluggish pace," examples of non-compliance, and Court's effort to elicit plans for implementation).

The Court Monitor expressed concern over the absence of such planning. *Monitor's Response to Court's January 23, 2013 Letter* at 5 (Feb. 4, 2013) (Doc. No. 198) (no implementation plan exists; "Defendants have not yet put sufficient shoulders to the *Jensen* wheel."); *Status Report on Compliance* at 40 ("There is no roadmap for implementation of the settlement agreement.").

[2] Reports filed by Court Monitor describe non-compliance, unchallenged by Defendants. Months before his June 11, 2013 *Status Report on Compliance*, the Court Monitor expressed concern. *See, e.g.*, *Monitor's Response to Court's January 23, 2013 Letter* at 4-6 (Feb. 4, 2013) (Doc. No. 198) (stating areas of

will provide an enforceable roadmap[3] toward an end to active judicial oversight over DHS.

After Defendants' concededly unsuccessful efforts to produce adequate implementation plans under the August 28, 2013 Order, the Court ordered the Court Monitor to finalize the plans.[4] Rather than relying on Defendants to establish plans voluntarily, the Court thus determined that it must intervene and mandate what is to be done to bring about compliance.

In ordering the implementation plans, the Court expressed the hope that this would avoid "an order to show cause or contempt proceedings so that the resources of all parties concerned can be focused on individuals with developmental disabilities in the communities within which they are living or hope to be living."[5]

The Court Monitor attaches here a two-part Comprehensive Plan of Action:

> Part I covers the Evaluation Criteria and Cambridge Closure.[6]
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> Part II is a Behavioral Supports Plan of Action which covers the Rule 40 modernization, supported by the Department of Human Services' acceptance of the Rule 40 Advisory Committee recommendations.

Part III of the Comprehensive Plan of Action will be the *Olmstead* Plan which will be addressed in a subsequent report.

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non–compliance, including those conceded by Defendants). Multiple areas of serious non-compliance documented in the June 11, 2013 *Status Report on Compliance* were conceded by DHS. *See* DHS June 4, 2013 letter attached to the *Status Report. See also* findings by the Court of non-compliance, indifference and concealment at hearing on sanctions on June 25, 2013.

[3] "DHS has no roadmap for implementation of the settlement agreement." June 11, 2013 *Status Report on Compliance* at 16.

[4] Because the Department's draft and docketed plan versions were not acceptable, the Court Monitor was granted the "responsibility and authority to finalize the Department of Human Services Plan" for the original settlement and the Cambridge Closure. Order of October 17, 2013 (Dkt. 237); Order of November 1, 2013 (same re Rule 40 modernization plan).

[5] Order of August 28, 2013 at 15.

[6] The Order of August 28, 2013 required that the Cambridge Closure plan include a presentation of closure-specific detail. Because the Comprehensive Plan of Action significantly affects DHS' proposal in that regard, DHS will rewrite that Cambridge Closure section for its first monthly update.

**Elements of the Plan.** Several features of the Plan deserve emphasis:

- There is discussion of the Plan's purposes, scope and management.
- The plans require the creation of a fully-staffed Jensen Implementation Team which will be responsible to manage – and will be held responsible for – compliance with the Court's mandates.[7]
- Dozens of the tasks which DHS proposed have been deleted to reduce the tasks for which DHS will be accountable to the Court.
- DHS is expected to set its own deadlines for completion of tasks. They will do this in their first monthly update. If these dates are reasonable, they will be approved by the Court Monitor, subject to review by the Court.
- The Court Monitor emphasizes specific fundamental mandates, set forth in the Evaluation Criteria.[8] Compliance with the listed "Required Tasks" will evidence satisfaction of the Evaluation Criteria.
- The Required Tasks may be modified for good cause shown.[9]

**Restraints and Seclusion.** DHS has successfully ended the use of mechanical restraints and seclusion at MSHS-Cambridge. Cambridge clients typically have a dual diagnosis: both mental health and developmental disabilities. The Cambridge process is a good model for implementing DHS' commitment to reduction and elimination restraints and seclusion elsewhere in the system.

While the principles are the same as those accepted by the Department of Human Services, the Court Monitor recognizes that there are complexities in application of the provisions in this Plan to large facilities such as Anoka Metro Regional Treatment Center and Minnesota Security Hospital, and in

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[7] *See,* for example, Court Monitor, June 11, 2013 *Status Report on Compliance* at 16 ("Compliance with the Settlement Agreement is not likely to be achieved without intensified and sufficiently staffed professional teams with *authority* to ensure compliance.")

[8] Based on circumstances over the past twenty-three months, some of the prior Evaluation Criteria have been focused. To further compliance and facilitate compliance review, some new Evaluation Criteria have been established.

[9] *See* Order of August 28, 2013 at 3 (Dkt. 224):

> Any requests for modification of due dates under the above provisions of this Order and Memorandum, or for modification of the Plans' deadlines or other elements, shall be in writing, for good cause shown, and shall, in the first instance, be addressed and resolved by the Court Monitor, subject to review by the Court on written application by any party.

the mental health context. Consequently, the applicability of this Plan to those Providers is limited at this time as provided in this Plan; for those Providers, the Plan provides a period of time for study and to consider the particulars of implementation. However, basic reporting and other requirements are included in the plan for these entities.

**Ending Active Jurisdiction**. Although injunctions may be permanent, the federal court should not be expected to supervise DHS' compliance in perpetuity. Therefore, the Plan requires DHS to submit in twenty (20) months a plan for quality assurance mechanism(s) which will permit the Court to end its active jurisdiction.

**Additional Recommendations to the Court**. Based on the record of this case, and the Court's findings and observations at the November 25, 2013 hearing on Plaintiffs' motion for sanctions, it is recommended that the Court:

- Require that DHS publicize the two attached plans both publicly and among all DHS staff, and provide training in the Settlement Agreement and the plans to DHS staff, with such training approved and participated in by the Court Monitor and his consultants.

- Recognize that the intensive efforts in addressing the Order of August 28, 2013 were not anticipated in the nine month Court Monitor budget previously approved by the Court.[10]

Respectfully submitted,

/s David Ferleger
Court Monitor

June 26, 2013 (served by email on the parties)

[10] The Order of August 28, 2013 (Dkt. 224) requires the Court Monitor to submit a monitoring plan after completion of the implementation plans. He will do so. That will be an appropriate time to address the skewing of the earlier-anticipated review processes and their budget.

# COMPREHENSIVE PLAN OF ACTION
# PART I

## I. INTRODUCTION

On December 5, 2011, the United States District Court for the District of Minnesota adopted the Settlement Agreement in this class action. The settlement was intended to bring significant improvements to the care and treatment of individuals with developmental and other disabiltiies in the State of Minnesota. Significant progress has been made; however, as the Court has found, the pace of progress has been slow, there have delays in implementation and there has been significant conceded non-compliance. The Court initially responded by appointing a court monitor. Subsequently, the Court and Court Monitor coax DHS several times to adopt an implementation plan and then, by Order of August 28, 2013, the Court required submission of an implementation plan for the Court's review and approval. This plan covers the elements of the Settlement Agreement, with the exception of the Olmstead Plan and the Rule 40 modernization plan; these are addressed in separate plans. In response to the Court Monitor's June 11, 2013 Status Report on Compliance, the Department of Human Services announced it would repurpose MSHS-Cambridge and, to comply with the Settlement Agreement, would close the facility in favor of community services. Therefore, this plan also covers the closure of the MSHS-Cambridge facility and its replacement by small community homes with accompanying protections, services and supports.

## II. PURPOSES

This *Comprehensive Plan of Action: Part 1* has several purposes:
a) to secure for residents of MSHS-Cambridge, and the community homes and programs which will succeed it, the benefits of the Settlement Agreement applicable to "facility" residents,
b) to provide protections, services and supports in accordance with professional best practices,
c) to provide for the expansion of community services to allow for the provision of assessment, triage, and care coordination to assure persons with developmental disabilities receive the appropriate level of care at the right time, in the right place, and in the most integrated setting in accordance with the U.S. Supreme Court decision in *Olmstead v. L.C.* , 527 U.S. 582 (1999),
d) to establish long term monitoring of, individuals with clinical and situational complexities in order to help avert crisis reactions, provide strategies for service entry changing needs, and to prevent multiple transfers within the system, and
e) to provide both internal and external monitoring of compliance.

This *Comprensive Plan of Action* has three parts. This is Part I. Part II, a separate document, is a Positive Behavioral Support Plan to modernize what was called "Rule 40." Part III is the state-wide all-disability *Olmstead* Plan. See Order of August 28, 2013. All three plans should be considered, interpreted and implemented together.

## III. SCOPE AND MANAGEMENT

This Implementation Plan encompasses the provisions of the Settlement Agreement, adopted by the Court on December 5, 2011, which address a) the replacement of the Minnesota Extended Treatment Option (METO) by the smaller MSHS-Cambridge program on the same grounds as METO, and b) the closure of MSHS-Cambridge as a facility for long-term care and the move of its residents to permanent homes in the community, and c) the development of sufficient small community homes for temporary short-term care to address crisis needs of individuals with developmental disabilties who, in the past, would have been institutionalized. In addition, and as importantly, this Implementation Plan encompasses changes which affect the entire Department of Human Services system of protections, services and supports with regard to provision of community services. These changes will promote development, support and monitoring of appropriate community services for people with disabilities.

The Department of Human Services will establish a Jensen Implementation Team ("Team") comprised of a minimum of four full-time professional staff, with clerical assistance, which will be responsible for management and coordination of this Part I and also Part II of this Plan. The Team will have a designated leader skilled in leadership in the field of developmental disabilities, and will have sufficient resources to fulfill its responsibilities. The Team will also be responsible for the Department of Human Services elements of the *Olmstead* Plan.

The Jensen Implementation Team will be responsible -- and will be held responsible -- for candid, independent and complete reporting, including on compliance and non-compliance. The Team shall be responsible for monthly updates to the Court and Court Monitor, and for promptly gathering and providing all information requested by the Court Monitor. The monthly updates will be provided a week in advance in draft to the Court Monitor, Plaintiffs Class Counsel, the Ombudsman for Mental Health and Developmental Disabilities, and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities. The work of the Jensen Implementation Team shall not abridge the ability of Department employees and others to communicate freely and privately with the Court Monitor.

The fundamental imperatives of this Plan are embodied in the Evaluation Criteria which are highlighted and indicated by whole arabic numbers. The Evaluation Criteria are intended to be permanent. The Evaluation Criteria are in most cases accompanied by Required Tasks (arabic decimal numbers) which describe actions to be taken to fulfill the Evaluation Criteria. Status of compliance with the Required Tasks will be reported by DHS monthly. The Required Tasks may be modified for good cause shown in accordance with the procedure established by the Court.

## IV. REPORTING, REVIEWS, OVERSIGHT AND QUAILTY ASSURANCE

DHS will create and implement a plan that will effectively monitor compliance with the Court's orders, including but not limited to the Evaluation Criteria, and provide for quality assurance, after the conclusion of the Court's active judicial oversight. Also, that plan will provide for maintenance of a system of therapeutic follow-up with persons served to provide a safety network, as needed, to assure appropriate transition planning, protections, services and supports, and help prevent re-institutionalization and other transfers to more restrictive settings. A proposed Plan shall be submitted to the Court in 20 months for review and approval. At least 60 days before submission of the proposed Plan, DHS shall provide a draft to the Court Monitor, Plaintiffs Class Counsel, the Ombudsman for Mental Health and Developmental Disabilities and the Executive Director of the Governor's Council on Developmental Disabilities.

| CONDITIONS, CARE AND PROGRAMS | | | | | | | | | |
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| **Settlement Agreement Section IV. METO CLOSURE** | | | | | | | | | |
| **REQUIRED TASKS** | | **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) | **Verifying Documentation** |
| **1. METO closed as required by the Jensen Settlement Agreement.** | | | | | | | | | |
| **2. METO successors comply with Olmstead v. L.C. METO successors are and will remain licensed to serve people with developmental disabilities. Cambridge and successor facilities will eliminate unnecessary segregation of individuals with developmental disabilities. Each individual's program will include multiple opportunities on an ongoing basis to engage with: (1) typical community citizens with a valued status in (2) regular community settings, (3) participating in valued activities (4) in recognizable roles. These community activities will be highly individualized, drawn from the person centered planning processes, and developed alongside the individual.** | | | | | | | | | |
| 2.1 | Each individual's planning processes will specfically address increasing integration within the following life areas: (1) home; (2) work; (3) transportation; (4) lifelong learning and education; (5) healthcare and healthy living; and (6) community and civic engagement. | | | | | | | | Person Centered Plan Transition Plan Document |
| 2.2 | Cambridge and successor facilities apply strong efforts to individualize and personalize the interior setting of the home. This includes exerting maximal feasible efforts to assist individuals to personalize and individualize their bedrooms and common areas, to make each common area aesthetically pleasing, and to actively support individuals to bring, care for, acquire, and display personal possessions, photographs and important personal items. Consistent with person-centered plans, this may include the program purchasing such items which will build towards transition to a new place to live. | | | | | | | | Purchasing records Person Centered Plans Transition Plans Personal Possessions Inventory |

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| **3. METO successors utilize person centered planning principles and positive behavioral supports consistent with applicable best practices including, but not limited to the Assoc. of Positive Behavior Supports, Standards of Practice for Positive Behavior Supports .** | | | | | | | | | |
| 3.1 | Each individual will be involved to the greatest extent possible in the development of a person-centered profile centering on learning from the person and those who know the person best about their history, preferences, life experiences, interests, talents, and capacities among other areas within 20 days of admission. This profile will be updated and revised as more is learned over time on a monthly basis, or more frequently.<br><br>A revised person centered profile format will be developed from the current Person Centered Description to include the above areas and to include a method to note when revisions and additons are made, by whom, and in what venue *(e.g.*, a person centered meeting of the support team, interview, an individual update by a staff member, a phone call). | | | | | | | | Person Centered Profile /Description<br>Person centered team meeting notes<br>Planning meeting attendance records |
| 3.2 | From the understanding in the person-centered profile, a person centered plan will be completed which includes the development of a shared vision of the future to work towards within 30 days of admission, as well as agreements and shared objectives and commitments to work towards. | | | | | | | | Person Centered Profile/Description<br>Person Centered team meeting notes<br>Planning meeting attendance records |
| 3.3 | The person centered plan will directly inform the development of the individualized program plans. Individual program plans will build on the strengths and interests of the individual, and moving towards increasing relationships, roles, and community integration in these areas of life. | | | | | | | | Person Centered Profile/Description & team meeting notes. Meeting attendance records. Positive Behavior Support Plan |

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| 3.4 | The person centered plan will directly inform the development of a Positive Behavior Support Plan. Life direction, talents, and interests will be capitalized on in any planned intervention. Each behavior support plan will include teaching strategies to increase competencies and build on the strengths of the person. | | | | | | | | Person Centered Profile/Description & team meeting notes. Meeting attendance records. Positive Behavior Support Plan |
| 3.5 | Each behavior support plan will be unique to each individual. The use of token economies, and contingent reinforcement will be used sparingly and only when weighed again the potential risks to the person's image and competencies in terms of exercising personal autonomy. | | | | | | | | Person Centered Profile/Description & team meeting notes. Meeting attendance records. Positive Behavior Support Plan |
| 3.6 | Each behavior support plan will include a summary of the person's history and life experiences, the difficulties and problems the person is experiencing, past strategies and results, and a comprehensive functional behavioral analysis, from which strategies are derived. | | | | | | | | Positive Behavior Support Plan. Functional Behavioral Analysis |

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| 3.7 | Each Functional Behavioral Analysis will include a:<br>a. Review of records for psychological, health and medical factors which may influence behaviors<br>b. Assessment of the person's likes and dislikes (events/activities/objects/people)<br>c. Interviews with individual, caregivers and team members for their hypotheses regarding the causes of the behavior;<br>d. Systematic observation of the occurrence of the identified behavior for an accurate definition/description of the frequency, duration and intensity;<br>e. Review of the history of the behavior and previous interventions, if available;<br>f. Systematic observation and analysis of the events that immediately precede each instance of the identified behavior; | | | | | | | | Functional Behavioral Analysis |
| | g. Systematic observation and analysis of the consequences following the identified behavior;<br>h. Analysis of functions that these behaviors serve for the person;<br>i. Analysis of the settings in which the behavior occurs most/least frequently. Factors to consider include the physical setting, the social setting, the activities occurring and available, degree of participation and interest, the nature of teaching, schedule, routines, the interactions between the individual and others, degree of choice and control, the<br>amount and quality of social interaction, etc.<br>j. Synthesis and formulation of all the above information to formulate a hypothesis regarding the underlying causes and/or function of the targeted behavior. | | | | | | | | |

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| 3.8 | Each positive behavior support plan will include:<br>1. Understanding how and what the individual is communicating;<br>2. Understanding the impact of others' presence, voice, tone, words, actions and gestures;<br>3. Supporting the individual in communicating choices and wishes;<br>4. Supporting workers to change their behavior when it has a detrimental impact;<br>5. Temporarily avoiding situations which are too difficult or too uncomfortable for the person;<br>6. Enabling the individual to exercise as much control and decision making as possible over day-to-day routines;<br>7. Assisting the individual to increase control over life activities and environment;<br>8. Teaching the person coping, communication and emotional self-regulation skills;<br>9. Anticipating situations that will be challenging, and assisting the individual to cope or calm;<br>10. Offering an abundance of positive activities, physical exercise, and relaxation, and<br>11. Modifying the environment to remove stressors (such as noise, light, etc.). | | | | | | | | Positive Behavior Support Plan |
| 3.9 | The format used for Positive Behavioral Support Plans will be revised to include each of the above areas, and will be used consistently. | | | | | | | | Positive Behavioral Support Plan |

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| **4. METO successors serve only "Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety."** | | | | | | | | | |
| 4.1 | All referrals for admission will be reviewed by the admissions coordinator to assure that they are persons with a Developmental Disability and meet the criteria of exhibiting severe behaviors and present a risk to public safety taking into account court ordered admissions. | | | | | | | | Census Records. Intake information for each individual. Court commitment records. Bulletin 12-76-01 issued on 2-12-13 |
| **5. METO successors notify parents and guardians of residents, at least annually, of their opportunity to comment in writing, by e-mail, and in person, on the operation of th** | | | | | | | | | |
| 5.1 | Initiate annual written survey process to all families, guardians and stakeholders whose individual of interest was served within the past year which solicits input on the operation of successor facilities.Each survey will include notification that comments on facility operations may be offered in person or by mail or telephone by contacting facility director or designee. | | | | | | | | Survey document. Completed survey documents. Mailing list. Admissions data |
| 5.2 | Aggregate data will be collected from survey responses received from each survey process. Program staff will develop an action plan to outline changes which will be made as a result of survey data, and implement those changes. | | | | | | | | Aggregate data from each survey round |

| SETTLEMENT AGREEMENT SECTION V.A. PROHIBITED TECHNIQUES – RESTRAINT | | | | | | | | | |
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| | **REQUIRED TASKS** | **DUE DATE** | **AMENDED DUE** | **RESPONSIBLE PARTY(s)** | **RESOURCES REQUIRED (w/date added)** | **ACTIONS TAKEN (w/date added)** | **ANTICIPATED OBSTACLES (w/date added)** | **STATUS w/date (Complete/Incomplete)** | **VERIFYING DOCUMENTATION** |
| **6. The State/DHS immediately and permanently discontinues all the prohibited restraints and techniques.** | | | | | | | | | |
| 6.1 | DHS will issue a memorandum to all staff confirming the Department's commitment to provide services and supports which are consistent with best practices including: 1) Providing individuals with a safe and therapeutic environment which includes positive behavioral supports and training on behavioral alternatives; 2) Recognizing that restraints are not a therapeutic intervention; 3) An immediate prohibition on prone restraint, mechanical restraints, seclusion and time out; 4) DHS's goal towards immediate reduction and eventual elimination of restraint use whenever possible; and 5) Restraint use is permitted only in an emergency when imminent risk of physical harm is present and only after less intrusive measures have failed to abate such risk. | | | | | | | | Memorandum and confirmation of its dissemination to all staff |
| 6.2 | The State/DHS shall remove "mechanical restraint," "prone restraint," "prone hold" and all other prohibited techniques from all current forms and protocols, e.g., METO #31032/DHS# 3654. | | | | | | | | |

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| 6.3 | DHS policy(s) on Emergency Interventions shall minimally include: 1) The type of emergency interventions permitted and prohibited; 2) The protocol for administering emergency interventions; 3) The authorization and supervision needed for each emergency intervention; 4) The medical monitoring required during and after each restraint; 5) The review requirements of each emergency intervention (administrative, internal and external); 6) The data collection and aggregate data review of restrictive intervention usage. DHS policy shall separate and clearly delineate "therapeutic interventions" from "emergency restraint/interventions."<br><br>Current policy/procedures shall be revised to comply with these requirements. | | | | | | | | |
| 6.4 | All staff members have received competency-based training on the policy/procedures identified immediately above. | | | | | | | | |
| 6.5 | Competency-based training on the policy/procedures identified above has been incorporated into both orientation and annual training curricula. | | | | | | | | |

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| **7. The State/DHS has not used any of the prohibited restraints and techniques.** | | | | | | | | | |
| 7.1 | Staff will specify on Restraint Form which emergency technique was employed, verifying that a prohibited technique was not used. | | | | | | | | |
| 7.2 | The supervisor will review each restraint with staff by the end of his/her shift, verifying that: 1) The threat of imminent harm warranted the emergency intervention, 2) The intervention was an approved technique and no suspicion exists that a prohibited technique was used; and 3) When applicable, what immediate corrective measures/administrative actions need to be taken. | | | | | | | | |
| 7.3 | Any/all use of prohibited techniques, e.g., prone restraints, mechanical restraints, seclusion, timeout, etc., will be investigated as potential allegations of abuse. Staff are required to immediately report any suspected use of prohibited restraints/techniques to their supervisor.) | | | | | | | | |
| 7.4 | Reporting and review forms/procedures are revised, and utilized, to incorporate the above 7.1, 7.2 and 7.3. | | | | | | | | |
| **8. Medical restraint, and psychotropic/ neuroleptic medication have not been administered to residents for punishment, in lieu of habilitation, training, behavior support plans, for staff c** | | | | | | | | | |
| 8.1 | DHS policy shall specifically forbid the use of restrictive interventions, including medical restraints and/or psychotropic/neuroleptic medication for: the purposes of punishment; in lieu of habilitation, training, or behavior support plans; for staff convenience; or as a behavior modification. | | | | | | | | |
| 8.2 | DHS policy will specify medication management protocols consistent with best practices in the support and treatment of individuals with cognitive and/or mental health disabilities. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION V. B. PROHIBITED TECHNIQUES - POLICY | | | | | | | | | |
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| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **9. Restraints are used only in an emergency.** | | | | | | | | | |
| 9.1 | Staff will clearly document, on the restraint form, the circumstances leading up to the restraint and what imminent risk of harm precipitated the application of the restraint. This shall include what antecedent behaviors were present, what de-escalation and intervention strategies were employed and their outcomes. | | | | | | | | |
| 9.2 | In the event a restraint was used in the absence of imminent risk of harm, staff will be immediately retrained on DHS's policies addressing the "Therapeutic Interventions and Emergency Use of Personal Safety Techniques" policy with such retraining being entered into their personnel file. | | | | | | | | |
| **10. The Policy (Settlement Agreement Att. A, as it may be revised) was followed in each instance of manual or mechanical restraint** | | | | | | | | | |
| 10.1 | As part of its data management processes, the facility will collect, review and analyze information related to staff's adherence to restraint policy. | | | | | | | | |
| **11. There were no instances of prone restraint, chemical restraint, seclusion or time out. [Seclusion: evaluated under Sec. V.C. Chemical restraint: evaluated under Sec. V.D.]** | | | | | | | | | |
| 11.1 | Facility policy shall clearly identify prone restraint, chemical restraint, seclusion and timeout as "prohibited." | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION V.C. PROHIBITED TECHNIQUES – SECLUSION AND TIME OUT | | | | | | | | | |
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| | **REQUIRED TASKS** | **DUE DATE** | **AMENDED DUE** | **RESPONSIBLE PARTY(s)** | **RESOURCES REQUIRED (w/date added)** | **ACTIONS TAKEN (w/date added)** | **ANTICIPATED OBSTACLES (w/date added)** | **STATUS w/date (Complete/Incomplete)** | **VERIFYING DOCUMENTATION** |
| **12. There were zero instances of the use of Seclusion.** | | | | | | | | | |
| 12.1 | Facility policy shall specify that the use of seclusion is prohibited. | | | | | | | | |
| **13. There were zero instances of the use of Room Time Out from Positive Reinforcement.** | | | | | | | | | |
| 13.1 | Facility policy shall specify that the use of time out from positive reinforcement is prohibited. | | | | | | | | |
| SETTLEMENT AGREEMENT SECTION V.D. PROHIBITED TECHNIQUES – CHEMICAL RESTRAINT | | | | | | | | | |
| | **REQUIRED TASKS** | **DUE DATE** | **AMENDED DUE** | **RESPONSIBLE PARTY(s)** | **RESOURCES REQUIRED (w/date added)** | **ACTIONS TAKEN (w/date added)** | **ANTICIPATED OBSTACLES (w/date added)** | **STATUS w/date (Complete/Incomplete)** | **VERIFYING DOCUMENTATION** |
| **14. There were zero instances of drug / medication use to manage resident behavior OR to restrain freedom of movement.** | | | | | | | | | |
| 14.1 | Facility policy specifies that the use of drugs/medications to manage resident behavior OR to restrain one's freedom of movement are prohibited. | | | | | | | | |
| **15. There were zero instances of PRN orders (standing orders) of drug/ medication used to manage behavior or restrict freedom of movement.** | | | | | | | | | |
| 15.1 | Facility policy specifies that PRN/standing order medications are prohibited from being used to manage resident behavior or restrict one's freedom of movement. | | | | | | | | |
| 15.2 | DHS policy shall include a clearly outlined protocol for the approved use and follow-up review of PRN medications for the treatment of psychiatric and medical conditions. | 12/31/13 | | | | | | | |

| SETTLEMENT AGREEMENT SECTION V.E. PROHIBITED TECHNIQUES – 3rd PARTY EXPERT | | | | | | | | | |
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| | **REQUIRED TASKS** | **DUE DATE** | **AMENDED DUE** | **RESPONSIBLE PARTY(s)** | **RESOURCES REQUIRED (w/date added)** | **ACTIONS TAKEN (w/date added)** | **ANTICIPATED OBSTACLES (w/date added)** | **STATUS w/date (Complete/Incomplete)** | **VERIFYING DOCUMENTATION** |
| **16. There is a protocol to contact a qualified Third Party Expert.** | | | | | | | | | |
| 16.1 | Facility policy stipulates that a Third Party Expert will be consulted within 30 minutes of the emergency's onset. | | | | | | | | |
| **17. There is a list of at least 5 Experts pre-approved by Plaintiffs & Defendants. In the absence of this list, the DHS Medical or designee shall be contacted.** | | | | | | | | | |
| **18. DHS has paid the Experts for the consultations.** | | | | | | | | | |
| **19. A listed Expert been contacted in each instance of emergency use of restraint.** | | | | | | | | | |
| **20. Each consultation occurred no later than 30 minutes after presentation of the emergency.** | | | | | | | | | |
| **21. Each use of restraint was an "emergency."** | | | | | | | | | |
| **22. The consultation with the Expert was to obtain professional assistance to abate the emergency condition, including the use of positive behavioral supports techniques, safety techniques, and other best practices. If the Expert was not available, see V.F. below.** | | | | | | | | | |
| 17 to 22.1 | On the restraint form, staff will identify the Third Party or other expect and will document all recommendations given by the consultant,techniques, and the efficacy and outcomes of such interventions. When reviewing the restraint form 24 hrs post-restraint, Designated Coordinator will verify that staff contacted the medical officer within 30 minutes of the emergency's onset. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION V.F. PROHIBITED TECHNIQUES – MEDICAL OFFICER REVIEW | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **23. The responsible supervisor contacted the DHS medical officer on call not later than 30 minutes after the emergency restraint use began.** | | | | | | | | | |
| 23.1 | On the Restraint Form, the supervisor will document both the date/time that the emergency restraint began and the date/time s/he contacted the designated medical officer. | | | | | | | | |
| **24. The medical officer assessed the situation, suggested strategies for de- escalating the situation, and approved of or discontinued the use of restraint.** | | | | | | | | | |
| 24.1 | The supervisor will document on the restraint form and in the resident's record, the medical officer's de-escalation strategies, the outcome of those strategies used and whether approval was needed and/or given for continued restraint use. | | | | | | | | |
| **25. The consultation with the medical officer was documented in the resident's medical record.** | | | | | | | | | |
| 25.1 | When conducting his/her post-restraint review, the Designated Coordinator will verify that the supervisor contacted the medical officer within 30 minutes of the emergency restraint and documented the details in the resident's medical record. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION V.G. PROHIBITED TECHNIQUES – ZERO TOLERANCE FOR ABUSE AND NEGLECT | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **26. All allegations were fully investigated and conclusions were reached. Individuals conducting investigations will not have a direct or indirect line of supervision over the alleged perpetrators. Individuals conducting investigations, interviews and/or writing investigative reports will receive competency-based training in best practices for conducting abuse/neglect investigations involving individuals with cognitive and/or mental health disabilities and interviewing.** | | | | | | | | | |
| 26.1 | Individuals having responsibility for investigative duties will receive 8 hours of continuing education or in-service training each year specific to investigative practices. (cross reference MN Stat 626.557 Subd. 9c) | | | | | | | | |
| 26.2 | Each investigation will undergo a quality review by a peer or supervisor who has, at minimum been trained in the requirements set forth in this Implementation Plan. | | | | | | | | |
| 26.3 | The Department will maintain an electronic data management system, to track all information relevant to abuse/neglect investigations. This data management system will minimally incude: 1) Incident date; 2) Report date; 3) Incident location; 4) Provider; 5) Allegation type; 6) Alleged victim; 7) Alleged perpetrator(s); 8) Injuries sustained; 9) Assigned investigator; 10) Date investigative report is completed; 11) Substantiation status; 10) Disciplinary action taken; 12) Systemic issues identified and the corrective measures taken to resolve such issue; 13) Whether or not the case was referred to the county attorney; and 14) Whether or not charges were filed; and 15) Outcome of charges. | | | | | | | | |

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| **27. All staff members found to have committed abuse or neglect were disciplined pursuant to DHS policies and collective bargaining agreement, if applicable.** | | | | | | | | | |
| 27.1 | Discipline occurs when abuse or neglect is substantiated. | | | | | | | | |
| 27.2 | The Department's electronic data management system will maintain data relative to substantiated cases of abuse/neglect and the disciplinary actions taken in each instance. | | | | | | | | |
| **28. Where appropriate, the State referred matters of suspected abuse or neglect to the county attorney for criminal prosecution.** | | | | | | | | | |
| 28.1 | Effective no later than July 1, 2014, all allegations will be submitted to the common entry point to determine whether or not the case will be referred to the county attorney for criminal prosecution. (NOTE: MN Statute 626.557 Subd. 9/Vulnerable Adults Act indicates that this process is to begin July 1, 2014). | | | | | | | | |
| **SETTLEMENT AGREEMENT SECTION VI.A. RESTRAINT REPORTING & MGMT – FORM 31032** | | | | | | | | | |
| **REQUIRED TASKS** | | **DUE DATE** | **AMENDED DUE** | **RESPONSIBLE PARTY(s)** | **RESOURCES REQUIRED (w/date added)** | **ACTIONS TAKEN (w/date added)** | **ANTICIPATED OBSTACLES (w/date added)** | **STATUS w/date (Complete/Incomplete)** | **VERIFYING DOCUMENTATION** |
| **29. Form 31032 (or its successor) was fully completed whenever use was made of manual or mechanical restraint.** | | | | | | | | | |
| 29.1 | When reviewing the restraint form 24 hrs post-restraint, the Designated Coordinator will verify that Form 31032 was completed timely, accurately and in its entirety. | | | | | | | | |
| **30. For each use, Form 31032 (or its successor) was timely completed by the end of the shift.** | | | | | | | | | |
| 30.1 | When reviewing the restraint form 24 hrs post-restraint, the Designated Coordinator will verify that Form 31032 was completed timely, accurately and in its entirety. | | | | | | | | |

| **31. Each Form 31032 (or its successor) indicates that no prohibited restraint was used.** | | | | | | | | | |
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| 31.1 | Staff will indicate what type of restraint was used on Form 31032. | | | | | | | | |
| 31.2 | When reviewing the restraint form 24 hrs post-restraint, the Designated Coordinator will verify that no prohibited techniques were used. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION VI.B RESTRAINT REPORTING & MGMT- NOTIFICATIONS | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **32. Within 24 hours, and no later than one business day, Form 31032 (or its successor) in each instance was submitted to the Office of Health Facility Compliance** | | | | | | | | | |
| 32.1 | Form 31032 (or its successor) is sent to the Office of Health Facility Compliance within 24 hours. | | | | | | | | |
| **33. Within 24 hours, and no later than one business day, Form 31032 in each instance was submitted to the Ombudsman for MH & DD** | | | | | | | | | |
| 33.1 | Form 31032 (or its successor) is sent to the Ombudsman for MH & DD within 24 hours. | | | | | | | | |
| **34. Within 24 hours, and no later than one business day, Form 31032 in each instance was submitted to the DHS Licensing** | | | | | | | | | |
| 34.1 | Form 31032 (or its successor) is sent to DHS Licensing within 24 hours. | | | | | | | | |
| **35. Within 24 hours, and no later than one business day, Form 31032 in each instance was submitted to the Court Monitor and to the DHS Internal Reviewer** | | | | | | | | | |
| 35.1 | Form 31032 (or its successor) is sent to the Court Monitor and to the DHS Internal Reviewer within 24 hours. | | | | | | | | |
| **36. Within 24 hours, and no later than one business day, Form 31032 in each instance was submitted to the client's family and/or guardian.** | | | | | | | | | |
| 36.1 | Form 31032 (or its successor) is sent to the client's family/guardian within 24 hours. | | | | | | | | |
| **37. Within 24 hours, and no later than one business day, Form 31032 in each instance was submitted to the Case manager.** | | | | | | | | | |
| 37.1 | Form 31032 (or its successor) is sent to sent to the case manager within 24 hours. | | | | | | | | |
| **38. Within 24 hours, and no later than one business day, Form 31032 in each instance was submitted to the Plaintiff's counsel.** | | | | | | | | | |
| 38.1 | Form 31032 (or its successor) is sent to the Plaintiff's counsel within 24 hours. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION VI.C. RESTRAINT RESPONSES ARE NOT TO REPLACE OTHER INCIDENT REPORTING, INVESTIGATION, ANALYSIS & FOLLOW-UP | | | | | | | | | |
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| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **39. Other reports, investigations, analyses and follow up were made in each case of restraint use.** | | | | | | | | | |
| 39.1 | The Designated Coordinator will review each incident, injury and/or restraint use within 1 business day of its occurrence to: 1) Evaluate the immediate health and safety of the individual(s) involved; 2) Ensure no prohibited techniques were used; 3) Ensure all documentation and notifications were properly made; and 4) Determine what, if any, immediate measures must be taken. | | | | | | | | |
| 39.2 | The Designated Coordinator will convene an IDT meeting within 3 business days of a restraint to: 1) Review the circumstances surrounding the behavioral emergency; 2) Determine what factors likely contributed to the behavioral emergency, i.e. life event, environmental, relational discord, etc.; 3) Identify what therapeutic interventions, including individualized strategies were employed and why they were unsuccessful in de-escalating the situation; 4) Review and assess the efficacy of the individual's PBS plan, making changes as needed; 5) Determine if trends/patterns can be identified with this individual or this living area; and 6) Take all corrective measures deemed necessary, indicating what actions are being taken, the party responsible for taking such action; the date by which these action will be taken and how the efficacy of such actions will be monitored. Documentation of the IDT meeting, including attendees, review and actions taken will be thoroughly documented in the individual's record. | | | | | | | | |

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| 39.3 | When changes to an individual's program plan and/or PBS plan are recommended during the IDT's restraint review, the Designated Coordinator will ensure that such changes are made within 10 business days of the restraint. | | | | | | | | |
| 39.4 | A facility-based Positive Behavioral Supports Review (PBSR), comprised of both behavioral analysts and non-clinical staff, will be established and maintained for the purposes of: 1) Reviewing all positive behavioral support plans to ensure they adhere to current best practicse; 2) Approving and monitoring the efficacy of all positive behavioral support plans; 3) Reviewing the use of any restrictive and/or emergency interventions, i.e. restraints, 911 calls, etc. The PBSR Committee will meet on a monthly basis. | | | | | | | | |
| 39.5 | The PBSR committee will maintain meetings minutes detailing attendance (person/title); chairperson; individual and aggregate data review; issues and trends identified (individual and systemic); corrective measures to be taken; dates by which such corrective measures are to be completed; responsible parties, and follow-up of the previous month's action plans. | | | | | | | | |
| 39.6 | The Department will identify and address any trends or patterns from investigations . | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION VII.B. RETRAINT REVIEW - INTERNAL REVIEWER | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **40. DHS designated one employee with responsibility for monitoring the Facility's use of restraints as the Internal Reviewer.** | | | | | | | | | |
| 40.1 | Richard S. Amado, PhD has been designated as the internal reviewer. | | | | | | | | |
| **41. The Facility provided Form 31032 to the Internal Reviewer within 24 hours of the use of manual or mechanical restraint.** | | | | | | | | | |
| 41.1 | The shift supervisor/adminstrator on duty will notify the Internal Reviewer of the restraint by the end of his/her shift. Notification will be made electronically along with the completed Restraint Form (DHS #3654, METO #31032 or their successor). | | | | | | | | |
| **42. TThe Internal Reviewer will consult with staff present and directly involved with each restraint to address: 1) Why/how deescalation strategiesand less restrictive inteventions failed t** | | | | | | | | | |
| 42.1 | The Internal Reviewer will consult with staff present and directly involved with each restraint to address: 1) Why/how deescalation strategiesand less restrictive inteventions failed to abate the threat of harm, 2) What additional behavioral support strategies may assist the individual. 3) Systemic and individual issues raised by the use of restraint, and and the Internal Reviewer will also review *Olmstead* or other issues arising from or related to, admissions, discharges and other separations from the facility. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION VII.B. RETRAINT REVIEW - EXTERNAL REVIEWER | | | | | | | | | |
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| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **43. There is an External Reviewer.On April 23, 2013, the Court appointed the Court Monitor as the External Reviewer.** | | | | | | | | | |
| **44. The External Reviewer was approved by the Plaintiffs and Defendants.** | | | | | | | | | |
| **There is no Evaluation Criterion 45 (former EC 45 is superceded by EC 43).** | | | | | | | | | |
| **There is no Evaluation Criterion 46 (former EC 46 is superceded by EC 43).** | | | | | | | | | |
| **47. DHS funds the costs of the external reviewer .** | | | | | | | | | |
| 43 to 47.1 | By Order of April 23, 2013, the Court appointed the Court Monitor as the External Reviewer. Under procedures established by the Court, the Court Monitor submits invoices to the Court. DHS deposits sufficient funds into the Court's Registry. The Court ensures payment is made by DHS. | | | | | | | | |
| **There is no Evaluation Criterion 48 (former EC 48 is superceded by EC 43).** | | | | | | | | | |
| **49. After providing Plaintiffs and the Department the opportunity to review and comment on a draft, the External Reviewer issued written quarterly reports (beginning 3/5/12) informing** | | | | | | | | | |
| **50. There are recommendations and offers of technical assistance.** | | | | | | | | | |
| **51. Court Monitor, in conjunction with duties and responsibilities under the Order of July 17, 2012, the Court Monitor reviews and makes judgments on compliance, makes recommendati** | | | | | | | | | |
| 49 to 51.1 | In conjunction with duties and responsibilities under the Order of July 17, 2012, the Court Monitor reviews and makes judgments on compliance, makes recommendations and offers technical assistance in his discretion, and files quarterly and other reports with the Court. Timing of reports is subject to the Court's needs, results of Monitor's reviews, and to the monitoring plan pursuant to the Order of August 28, 2013. | | | | | | | | |
| **52. The following have access to the Facility and its records: The Office of Ombudsman for Mental Health and Developmental Disabilities, The Disability Law Center, and Plaintiffs' counsel** | | | | | | | | | |
| 52.1 | Open access to the Facility, its successors, and their records is given to the Office of Ombudsman-MH/DD, The Disability Law Center and Plaintiffs' counsel. | | | | | | | | |
| **53. The following exercised their access authority: The Office of Ombudsman for Mental Health and Developmental Disabilities, The Disability Law Center, and Plaintiffs' counsel.** | | | | | | | | | |

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| 53.1 | The Ombudsman-MH/DD, Disability Law Center and Plaintiffs' counsel have all exercised their authority to access the Facility, its successors, and their records. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION VIII. TRANSITION PLANNING | | | | | | | | | |
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| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **54. The State undertakes best efforts to ensure that each resident is served in the most integrated setting appropriate to meet such person's individualized needs, including home or community settings. Each individual currently living at Cambridge and successor facilities and all individuals admitted will be assisted to move towards more integrated community settings which are highly individualized and maximize the opportunity for social and physical integration, given each person's legal standing. In every situation, opportunities to move to a living situation with more freedom and which is more typical will be pursued.** | | | | | | | | | |
| 54.1 | Each individual currently living at Cambridge and successor facilities and all individuals admitted in the future will be assisted to move towards more integrated community settings which are highly individualized and maximize the opportunity for social and physical integration, given each person's legal standing. In every situation, opportunities to move to a living situation with more freedom and which is more typical will be pursued. | | | | | | | | Person Centered Plans and Transition Plans in Individual service records |
| 54.2 | Regarding transition planning for individuals entering more restrictive settings, the tasks under Evaluation Criterias 57, 58, 59 and 60 shall be fulfilled. | | | | | | | | Person Centered Plans and Transition |
| **55. The State actively pursues the appropriate discharge of residents and provided them with adequate and appropriate transition plans, protections, supports, and services consistent with such person's individualized needs, in the most integrated setting and where the individual does not object.** | | | | | | | | | |
| 55.1 | Each individual currently living at Cambridge, and successor facilities and any individuals admitted prior to its closure will have an appropriate transition plan developed within 30 days of admission in accordance with the individual needs and preference for the most integrated setting possible. (For this purpose "admission" and "commitment" are treated the same.). | | | | | | | | Individual Transition plans in service records |

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| 55.2 | For individuals who may by law or court order be required to enter more restrictive and less integrated circumstances, such as incarceration in a prison, person centered planning and transition planning is given the same importance as voluntary admissions. All efforts will be towards preparation and transition, safeguarding, negotiating with facilities, supports while in facility, and immediate post-facility transition into well-matched supports. | | | | | | | | |
| **56. Each resident and the resident's family and/or legal representative has been permitted to be involved in the team evaluation, decision making, and planning process to the greatest extent practicable, using whatever communication method he or she (or they) prefer.** | | | | | | | | | |
| 56.1 | Each individual and/or the individual's family and/or legal representative as desired by the individual or required by guardianship is permitted, actively encouraged, and welcomed to be involved in the individual's person centered planning and decision making to the greatest extent practicable utilizing whatever communication method the individual prefers and respecting the individual's right to choose the participants. Written invitations to all planning and evaluation meetings will be extended. Alternate means of participation will be extended to those who cannot travel or attend, including phone and video conferencing. | | | | | | | | Written invitations to the individual resident and their family/legal representatives to all planning and team meetings. Contact Lists |

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| 56.2 | Each individual will be invited and encouraged to participate in and take leadership in the person-centered planning processes when this is possible and desired by the person. In all circumstances, the person centered planning process will be engaged in for and with all individuals at Cambridge, with the understanding that transition and change will happen, that the people at Cambridge are vulnerable people at the height of hard times, and may need the alliance and support of other allies to support the process of moving forward. High quality person centered planning, including the development of person centered profiles, plans, and transition plans, will not be delayed or minimized by a person's perceived level of readiness to take leadership of the process, or willingness to engage in the process. | | | | | | | | Person Centered Profile and Plan. Written invitations to all planning process meetings. Attendance/signature pages for all team meetings and gatherings |

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| **57. To foster each resident's self- determination and independence, the State uses person centered planning principles at each stage of the process to facilitate the identification of the resident's specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs.** | | | | | | | | | |
| 57.1 | Person Centered Planning a) will be started immediately upon meeting the person, before admission if possible; b) will be on-going; c) will be supported by a team of people who represent the interests of the person, if need be. d) without exception, and only if the person objects to the inclusion of specific people, the support team will include willing family members, case managers, current, past and future service workers, and at least one individual who is in a freely-given relationship with the person which is conflict-free. This can include a community advocate, citizen advocate, family member, or other individual who only has the welfare of the individual to consider. If the individual is unable or unwilling to participate, people who know about and care for the individual will still be invited to engage in sharing their perspectives about what that positive future can be and what is needed to bring it about.This process will begin at first contact, with a first person centered plan drawn up by day 30 after admission or 45 days from approval of this Plan for existing individuals living at Cambridge or successor facilities. | | | | | | | | Individual Profile/Person Centered Description. Signature page of participants in profile development. IPP/Person Centered Plan Signature pages in plan development that indicate presence at planning meetings |
| 57.2 | All person-centered team members will contribute ideas, suggestions, and possibilities for envisioning a positive and possible future, and to deepen the understanding and vision of the team and the person. They will offer clarity, depth, probing for the big themes and issues which need to be present in the person's life, and go well beyond simply "listening" to the focus person's ideas and recording them. Being a member of a person centered team involves engagement, responsibility, maturity, and an acknowledgement of one's role in a person's life. | | | | | | | | Updated and annotated person centered profile/description. Updated and annotated Person Centered Plan |

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| 57.3 | Each Person Centered Plan will be enriched, altered and moved forward at least every 30 days as the person becomes better known and moves towards a new living situation. As plans for this new living situation emerge, each plan will include all activities relevent for transition to a new living situation, relevent and necessary supports to assure the person will have good success, and protections that need to be in place. | | | | | | | | Updated and annotated person centered profile/description. Updated and annotated |
| 57.4 | The information from each Person Centered Plan will be fully incorporated into each person's transition plan, Positive Behavior Support Plan, goal plans, and service objectives within any Individual Service Plan. | | | | | | | | Person Centered Profile/Description. Person Centered Plan Positive Behavior Support Plan. Individualized Service Plan |
| 57.5 | All plan facilitators will have significant experience and background in facilitation, social devaluation and its consequences, and the principles of Normalization/ Social Role Valorization, person centered thinking, and the various and vast array of useful tools and techniques which may be of use for a particular person. In this manner, a thoughful, authentic, individualized and successful planning process will result in meaningful outcomes. Evidence of use of various, individualized techniques for different individual people will be clear in the development of person centered plans. (PATH, MAPS, Personal Futures Planning, One Page Profiles, and Helen Sanderson's Person Centred Thinking, are examples) | | | | | | | | Facilitator CV, Staff Training Records, Training Curriculi |

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| 57.6 | An annual learning and professional development plan which includes the above areas will be developed with and for each facilitator of person centered processes. It may include reading, research, formal, and informal training, mentoring, and development events. These learning and professional development plans will include a minimum of 25 hours per year of educational activities (formal and informal) focused on person centered planning, and will be completed as planned. Attendance at professional conferences, in and out of state, will be supported and facilitated. | | | | | | | | Staff Training Record, Annual Professional Development Plan for Facilitators |
| 57.7 | Person Centered Planning will include the intentional development of each support team's understanding and analysis of the individual's particular life experiences and how they have impacted the person. Themes, patterns, potential responses, and lessons should be drawn from this knowledge. Biographical timelines, or other person-centered means to capture histories and understand the person will be conducted for each person, with the collaboration of the person and family, if appropriate. | | | | | | | | Person Centered Profile/Description. Person Centered Plan |
| 57.8 | The development of a person centered description or personal profile will be used to develop the initial person-centered plan. | | | | | | | | Person Centered Profile/Description. Person Centered Plan |

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| 57.9 | The formats for the Person Centered Plan, person centered description or personal profile will be revised to comply with the content requirements of this Implementation Plan. The Individualized Program Plan will be clearly labeled as the Person Centered Plan.<br><br>The Individualized Program Plan/Person Centered Plan will be re-designed to reflect a person-centered approach and style. This will include adding: 1. the focus person's goals, interests and vision for the future; 2. The identification of any actions and plans towards achieving those goals; 3. Support to be provided and by whom; 4. Use of everyday, informal language and avoidance of unnecessary service jargon. Objectives for any Individualized Program Plan, no matter what it is called or who requires it, conducted separately or together, will be drawn directly from the person-centered description/profile. | | | | | | | | Individualized Program Plan/Person Centered Plan Person Centered profile/description |
| **58. Each resident has been given the opportunity to express a choice regarding preferred activities that contribute to a quality life.** | | | | | | | | | |
| 58.1 | For each person served at Cambridge and successor facilities, the Person Centered Plan will include preferred activities, areas the person wants to learn and grow in, relationships to strengthen, and competencies to learn. | | | | | | | | Activity Records. Person Centered Plans |
| 58.2 | Frequent, daily opportunities will be built into daily life for each person to engage in meaningful activities that are personalized, individualized, and selected by the person. These will be activities planned with the person, and carried out in an individualized fashion. "House activities" will generally not be consistent with providing individualized, person-centered activities which the person freely chooses to engage in. | | | | | | | | Person Centered Plan. Transition Planning Document |

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| **59. The State undertakes best efforts to provide each resident with reasonable placement alternatives. This may include living situations which are not offered in existing structured services. It may also be impossible to "show" a person a service that matches their needs, even though they may select that option from several. If an existing residential service is not identified or available, the appropriate service must be created, using an individualized service design process.** | | | | | | | | | |
| 59.1 | Each individual's Person Centered Plan will embody continuously increasing clarity at each revision/development meeting on what an ideal living situation may look like for the person. These will support and describe "must have" components which must be in place in any considered situation. This may include living situations which are not offered in existing structured services. It may also be impossible to "show" a person a service that matches their needs, even though they may select that option from several. | | | | | | | | Person Centered Plan.Transitio n Planning Document |
| 59.2 | If an existing service/living situation is identified and selected by the individual with assistance from the support team, alterations, enhancements, and additional supports will be added whenever appropriate to ensure robust community supports which meet the essential needs for assistance, structure, and support as outlined in the Person Centered Plan. "Must haves" identified as in 59.1 are required to be in place. | | | | | | | | Person Centered Plan. Transition Planning Document |
| 59.3 | If an existing residential service is not identified or available, the appropriate service must be created, using an individualized service design process. | | | | | | | | Transition Planning Document |
| 59.4 | When a living situation is identified as a possibility, the individual and the support team as appropriate will have multiple opportunities to visit, meet potential house-mates, interview the staff, and provider, spend time in the situation, and be given the opportunity to make a choice about the living situation, request program enhancements or adjustments, or decline the option. | | | | | | | | Transition Planning Document |

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| 59.5 | When a discharge into an alternative living situation is agreed upon, the transition plan will be further developed and finalized. This pre-discharge iteration of the transition plan will include not only the sharing of information and documents transfers between providers, but additionally:<br>1. An individualized plan to facilitate a smooth move<br>2. Assistance to the person to navigate the move with ease, and arrange for safeguarding and transfer of the person's belongings.<br>3. Planning for and making purchases for new home<br>4. Assistance to become familiar with new neighborhood, area, town<br>5. Planning for packing and move day<br>6. Personalization of new home<br>7. Notification of family and friends<br>8. Post office and utility changes<br>9. Introductions to neighbors<br>10. Setting up opportunities to deepen relationships with future housemates<br>11. Celebrations, welcoming, and farewells<br>12. Designing layout of space, window treatments, etc.<br>These types of considerations are a part of the typical processes that valued adults in our culture when preparing to move, and these and others shall be considered. | | | | | | | | Completed Transition Planning Document. Daily Individual Record |
| 59.6 | The format for the transition plan will incorporate and provide for address of the elements in 59.6 above. | | | | | | | | Completed Transition Planning Document. Daily Individual Record |

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| **60. The provisions under this Transition Planning Section have been implemented in accord with the *Olmstead* decision and including the Required Tasks below.** | | | | | | | | | |
| 60.1 | Any living arrangement, day service, or other service which is administered or organized in a segregated manner must be justified in writing as a part of the transition plan as being necessary. In a segregated manner means that the people served are all people with disabilities who are have not specifically chosen to live or be served together. This justification will be accompanied by objectives to increase social and physical integration which will be included in service planning objectives and program planning. | | | | | | | | Individual Program Plans Transition Plans,Person Centered Plans |
| 60.2 | All services provided and planned for, and transitioned into must be adequate, appropriate, and carefully monitored. This need for monitoring will be carefully weighed by each person centered team and addressed. This includes services at Cambridge and new living and working situations a person is transitioning into. | | | | | | | | Person Centered Plan, Transition Plan |
| 60.3 | All services provided at Cambridge and in future living arrangements will include assisting people to have meaningful roles in community life, civic life, relationships, work and career, home, and areas of personal interest. When appropriate, these areas of engagement will be envisioned by the team alongside the individual served, and opportunities will be created for this engagement in everyday life. These roles and engagements will be consistently identified and addressed within the Person-Centered Planning, Transition, and the Positive Behavior Support Plans development processes. | | | | | | | | Person Centered Descriptions/Profiles. Person Centered Plans, Positive Behavior Support Plans. Transition Plans |
| 60.4 | The above areas of engagement (community life, civic life, relationships, career, home, personal interests) will be included in each Person-Centered Plan as focus areas for planning and related onjectives. | | | | | | | | Person Centered Plan |

| SETTLEMENT AGREEMENT SECTION IX.A. OTHER PRACTICES AT THE FACILITY – STAFF TRAINING | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| REQUIRED TASKS | | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **61. Facility treatment staff received training in positive behavioral supports, person centered approaches, therapeutic interventions, personal safety techniques, crisis intervention and** | | | | | | | | | |
| 61.1. | All current Cambridge Staff and successor facilities in all positions receive annual standardized training in<br>1. Positive Behavior Supports<br>2. Person Centered Approaches<br>3. Therapeutic Interventions<br>4. Personal safety techniques<br>5. Crisis Intervention<br>6. Post-Crisis Evaluation | | | | | | | | Training curricula. Training attendance records |
| 61.2 | All new or temporary staff at Cambridge and successor facilities in all positions receive standardized pre-service training in<br>1. Positive Behavior Supports<br>2. Person Centered Approaches<br>3. Therapeutic Interventions<br>4. Personal safety techniques<br>5. Crisis Intervention<br>6. Post-Crisis Evaluation | | | | | | | | Training Curricula. Training Attendance Records |
| 61.3 | The Department will record, monitor and follow-up with the facility administration to ensure that all facility treatment staff receive all necessary training including, but not limited to, EC 62-64, below. | | | | | | | | |

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| **62. This training was consistent with applicable best practices, including but not limited to the Association of Positive Behavior Supports, Standards of Practice for Positive Behavior Supports (http://apbs.org) (February, 2007). ll staff training programs at Cambridge and successor facilities will be competency-based with staff demonstrating current competency in both knowledge and skills.** | | | | | | | | | |
| 62.1 | All staff training programs at Cambridge and successor facilities will be competency-based with staff demonstrating current competency in both knowledge and skills. | | | | | | | | Training Curricula & Training Records |
| 62.2 | Training curricula are developed, based on, and consistent with best practices in: 1) Positive Behavioral Supports; 2) Person-Centered approaches/practices; 3) therapeutic Intervention Strategies; 4) personal safety techniques; and 5) crisis intervention and post crisis evaluation. | | | | | | | | Training Curricula & Training Records |
| 62.3 | Each training program (that is, 1) Positive Behavioral Supports; 2) Person-Centered approaches/practices; 3) therapeutic Intervention Strategies; 4) personalsSafety techniques and 5) crisis intervention & post crisis evaluation), will be evaluated at least annually and revised, if appropriate, to ensure adherence to evidence-based and best practices. | | | | | | | | Training Curricula & Training Records |
| 62.4 | DHS will ensure training programs promote sensitivity awareness surrounding individuals with cognitive and mental health disabilities and how their developmental level, cultural/familial background, history of physical or sexual abuse and prior restraints may affect their reactions during behavioral emergencies. | | | | | | | | Training Curricula & Training Records |
| 62.5 | DHS will ensure that training programs are designed to also develop staff's self-awareness of how their own experiences, perceptions and attitudes affect their response to behavioral issues and emergencies. | | | | | | | | Training Curricula & Training Records |

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| **63. Facility staff receive the specified number of hours of training subsequent to September l, 2010 and prior to December 31, 2011: Therapeutic interventions (8 hours); Personal safety** | | | | | | | | | |
| 63.1 | Competency-based training curriculum is developed which minimally provides 8 hours training in Therapeutic Interventions, Personal Safety Techniques and Medically Monitoring Restraints. | | | | | | | | Training Curricula & Training Records |
| 63.2 | All current employees receive 8 hours of competency-based training on Therapeutic Interventions. | | | | | | | | Training Curricula & Training Records |
| 63.3 | All current employees receive 8 hours of competency-based training on Personal Safety Techniques | | | | | | | | Training Curricula & Training Records |
| 63.4 | All current employees receive 8 hours of competency-based training on Medically Monitoring restraints. | | | | | | | | Training Curricula & Training Records |
| **64. For each instance of restraint, all staff involved in imposing restraint received all the above training.** | | | | | | | | | |
| 64.1 | No staff member is permitted to be assigned to direct support services until having received all required orientation and/or annual inservice training on all elements of EC 63, above. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION IX.B. OTHER PRACTICES AT THE FACILITY – HOURS OF TRAINING | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **65. Facility staff receive the specified number of hours of training: Person centered planning and positive behavior supports (with at least sixteen (16) hours on person centered thinking/planning): a total 40 hours; Post Crisis Evaluation and Assessment (4 hours).** | | | | | | | | | |
| 65.1 | All facility staff have received the specified number of hours of training subsequent to September 1, 2010 and prior to March 31,2012: Person centered planning and positive behavior supports (with at least sixteen (16) hours on person centered thinking/planning): a total 40 hours; Post Crisis Evaluation and Assessment, (4 hours). | | | | | | | | Staff Training Records. Training Curricula |

| SETTLEMENT AGREEMENT SECTION IX.C. OTHER PRACTICES AT THE FACILITY – VISITOR POLICY | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **66. Residents are permitted unscheduled and scheduled visits with immediate family and/or guardians, at reasonable hours, unless the Interdisciplinary Team (IDT) reasonably determine** | | | | | | | | | |
| 66.1 | Facilitate and allow all individuals to have scheduled and unscheduled visits with immediate family and/or guardians and other visitors if not contraindicated by court order or person centered plans. | | | | | | | | Visitor Policies. Training Records. Staff meetings. Individual service records |
| **67. Visitors are allowed full and unrestricted access to the resident's living areas, including kitchen, living room, social and common areas, bedroom and bathrooms, consistent with all res** | | | | | | | | | |
| 67.1 | Facilitate all visitors access to the individual's living areas, including kitchen, living room, social and common areas, bedroom and bathrooms, with attention paid to the right of individual privacy and person centered plans or court requirements. | | | | | | | | Visitor Policies. Training Records. Staff meetings. Individual service records |
| **68. Residents are allowed to visit with immediate family members and/or guardians in private without staff supervision, unless the IDT reasonably determines this is contraindicated.** | | | | | | | | | |
| 68.1 | Provide privacy, if desired by the individual, for all individuals when visiting with immediate family members and/or guardians, unless the person centered plans reasonably determines this is contraindicated or visitation rules are court ordered. | | | | | | | | Visitor Policies. Training Records. Staff meetings. Individual service records |

| SETTLEMENT AGREEMENT SECTION IX.D. OTHER PRACTICES AT THE FACILITY – NO INCONSISTENT PUBLICITY | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| REQUIRED TASKS | | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **69. There is marketing, recruitment and publicity regarding the Facility.** | | | | | | | | | |
| 69.1 | Clearly state the facility's purpose in a bulletin to state court judges, county directors, social service supervisors and staff, county attorneys and Consumers and Families and Legal Representatives of consumers of Developmental Disabilities services. | | | | | | | | |
| **70. The facility has a mission consistent with the Settlement Agreement and this Implementation Plan.** | | | | | | | | | |
| **71. The recruitment, publicity and marketing are consistent with the mission.** | | | | | | | | | |
| 70 to 70.1 | Review the facility's purpose to make sure that it is consistent with the Jensen Settlement Agreement and with this Implementation Plan, including the closure of MSHS-Cambridge.<br><br>All recruitment, publicity and marketing of the facility will be consistent with this Primary Action Plan. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION IX.E. OTHER PRACTICES AT THE FACILITY – POSTING REQUIREMENTS | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| REQUIRED TASKS | | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **72. The Facility continues to post the Health Care Bill of Rights, the name and phone number of the person within the Facility to whom inquiries about care and treatment may be directed, and a brief statement describing how to file a complaint with the Office of Health Facility Complaints, including the address and phone number of that office.** | | | | | | | | | |
| **73. The Health Care Bill of Rights posting is in a form and with content which is understandable by residents and family/guardians.** | | | | | | | | | |
| 72 to 73.1 | A copy of the required Minnesota Health Care Bill of Rights and information on how to file a complaint with Office of Health Facility Complaints will be posted and explained to individuals as required by law. Information on how to contact the OHFC will be included.<br><br>Apart from any Bill of Rights format which may be required by state law, an alternative version at an appropriate reading level for residents, and with clearly understandable content, will be provided to individuals, parents and guardians on admission and annually thereafter. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION X.A. SYSTEM WIDE IMPROVEMENTS – EXPANSION OF COMMUNITY SUPPORT SVCS | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| REQUIRED TASKS | | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **74. The expansion of community services under this provision allows for the provision of assessment, triage, and care coordination to assure persons with developmental disabilities** | | | | | | | | | |
| 74.1 | Community Support Services (CSS) provides assessment, triage, and care coordination so that persons with developmental disabilities can receive the appropriate level of care in the most integrated setting | | | | | | | | |
| 74.2 | Collect and manage data to track CSS interventions noted in 74.1 and their outcomes. | | | | | | | | |
| 74.3 | Provide necessary administrative/ management support within CSS to accomplish central data management and analysis. | | | | | | | | |
| 74.4 | Focus weekly "diversion" meetings to include person-centered development strategies rather than considering only existing vacancies and challenges. From this perspective: a) Review any proposed admissions to more restrictive settings and consider all possible diversion strategies; b) Review status of transition planning for all living at Cambridge; c) Add active, individualized planning/development focus to these transition discussions which is consistent with the Olmstead Plan and includes such activities as developing a person centered RFS for anyone at Cambridge without an identified and appropriate targeted home in the community. | | | | | | | | |
| 74.5 | Weekly diversion meetings consider all individuals in danger of losing their living situation with an emphasis upon development of integrated alternatives where none are available. | | | | | | | | Weekly team meeting minutes |

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| 74.6 | CSS has additional administrative/ managerial support to insure documentation and analysis of all diversion efforts and their impact on individuals' stability regarding living situations and behavioral/ mental health. | | | | | | | | |
| 74.7 | CSS provides continuous and on-going diversion from institutionalization and placement in less integrated settings whenever possible by establishing procedures for assessment, care planning, and providing additional services, supports and expertise for individuals in jeopardy of losing their placements or living situations due to behavioral or mental health problems. | | | | | | | | Long Term Care Consultation Assessment for each individual receivng such services. Individual documentation from county, tribe, lead agency case manager. |
| 74.8 | The Department will collect and review data relative to admissions and transitions. This shall include, but not be limited to: a) individual's name, date of birth and county of origin; b) current residence, provider and type of residential setting, e.g independent living; family of origin, group home, ICF/ID, etc.; c) date the individual moved to or was admitted to current residence; d) previous residences, providers and residential settings; e) dates of previous admissions and transitions including reason(s) for moves. | | | | | | | | |

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| **75. The State identifies, and provides long term monitoring of, individuals with clinical and situational complexities in order to help avert crisis reactions, provide strategies for service entry changing needs, and to prevent multiple transfers within the system.** | | | | | | | | | |
| 75.1 | Monitor individuals who have moved into the community since December 5, 2011 by developing a community review protocol which: a) reflects the requirements of the Settlement Agreement and the Olmstead Plan; b) is predicated upon person centered planning and positive behavior supports; c) identifies quality indicators related to such areas as: overall quality of life, health, clinical treatment, crisis prevention, autonomy/ rights/ self-determination, social integration, employment/ day opportunities, staffing (numbers and required training, qualifications, competencies) d) establishes "key" indicators, the absence of any of which results in immediate follow-up; e) provides review of previous situations which resulted in moves to more restrictive living, working or educational settings; f) identifies non-negotiable services and supports necessary to maintain current appropriate living, working, educational environments; and g) is consistent with best professional practices. | | | | | | | | Newly created community review protocol |
| 75.2 | Obtain Court Monitor approval of new protocol under Task 75.1. Pilot new protocol. Obtain Court Monitor approval of any revised protocol. | | | | | | | | |
| 75.3 | The Department will develop and implement an electronic data collection system which tracks the status of all corrective action plans generated by the Community Review, following up with the appropriate provider or county to ensure task completion. | | | | | | | | |

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| 75.4 | The Department wil develop and maintain a centralized electronic incident management (IM) system to be used by all residential and habilitative providers serving individuals with ID/DD statewide. The IM system will be used to centralize the collection, tracking and analysis of all significant events, i.e. incidents/injuries, abuse/neglect investigations; restraints, emergencies (medical and behaviorally-related). Data collection requirements will correspond with current DHS reporting policies on incidents/injuries, restraints, medical emergencies, etc. | | | | | | | | |
| 75.4a | The IM system and reports generated from the same will be accsessible by county case managers and, where applicable, facility staff. | | | | | | | | |
| 75.4b | Data from the IM system will be retained and made accessible for at least a rolling 5 year period. | | | | | | | | |
| 75.4c | The Department will allocate the necessary financial and personnel resources required to develop, implement and adequately maintain the IM system outlined in 75.5. | | | | | | | | |
| 75.5 | The Department will establish and maintain State and regional IM quality assurance committees to review IM data on a monthly basis. This review will include: 1) identifying individuals at heightened risk and determining intervention strategies; 2) reviewing IM data by county, region and provider to determine if trends or patterns exist and necessary corrective measures; and 3) maintaining meeting minutes detailing attendance (person/title); chairperson; individual and aggregate data review; issues and trends identified (individual and systemic); corrective measures to be taken; dates by which such corrective measures are to be completed; responsible parties, and follow-up of the previous month's action plans. | | | | | | | | |

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| 75.6 | The Department will develop and implement an electronic data collection system which tracks the status of all corrective action plans generated by State and regional IM quality assurance committees, following up with the appropriate provider or county to ensure task completion. | | | | | | | | |
| **76. Approximately seventy five (75) individuals are targeted for long term monitoring.** | | | | | | | | | |
| 76.1 | CSS will identify individuals with clinical and situational complexities who have been served by CSS and who would likely benefit from more intensive monitoring. | | | | | | | | Sample of 75 individual. Appendix to new community review protocol. |
| 76.2 | Seventy five individuals who are significantly at-risk for institutionalization or loss of home due to behavioral or other challenges will be identified for intensive monitoring and, if needed, intervention with additional supports and services. | | | | | | | | |
| 76.3 | These 75 individuals will be identified by CSS in collaboration with lead agency case managers based upon multiple hospitalizations or other transfers within the system, serious reported incidents, repeated failed placements, other challenges identified in previous monitoring or interventions and cost of placement. The status of these individuals will be reviewed at least semi-annually by CSS. | | | | | | | | |
| 76.4 | An appendix to the community review protocol described in EC 74 will be developed for this process (with the appendix approved by the Court Monitor). | | | | | | | | |

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| **77. CSS mobile wrap-around response teams are located across the state for proactive response to maintain living arrangements.** | | | | | | | | | |
| 77.1 | Describe locations of the 9 teams that have been established in 23 locations throughout the state. | | | | | | | | |
| 77.2 | Provide CSS with administrative / managerial support for the 9 teams to insure sufficient data collection and central data management | | | | | | | | |
| 77.3 | Document responses from CSS to individual's satisfaction sureys. | | | | | | | | |
| **78. CSS arranges a crisis intervention within three (3) hours from the time the parent or legal guardian authorizes CSS' involvement.** | | | | | | | | | |
| 78.1 | Strategically establish nine teams in 23 locations throughout the State to respond within 3 hours of a request for service. CSS admissions contacts the person's case manager as soon as they learn of a potential or actual crisis situation. | | | | | | | | |
| 78.2 | Streamline authorization procedure to facilitate CSS' response to reported crises as quickly as possible. | | | | | | | | |
| **79. CSS partners with Community Crisis Intervention Services to maximize support, complement strengths, and avoid duplication.** | | | | | | | | | |
| 79.1 | Continue ongoing collaboration with the Metro Crisis Coordination Program (MCCP), whose intent is to provide a crisis safety net range of services for persons with developmental disabilities or related conditions; MCCP is a collaborative effort of seven counties in the Twin Cities metropolitan area. (metrocrisis.org) | | | | | | | | |
| 79.2 | Continue collaboration with the local mental health authorities (LMHAs) (also known as community mental health centers) which are authorized by state Statute to provide services to a specific geographic area of the state. LMHAs can be available to county case managers directly or via CSS if necessary. | | | | | | | | |

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| 79.3 | Continue collaborations with county boards, which are statutorily responsible for a system of locally available and affordable adult mental health services, including 24/7 crisis intervention. [MN Stat §245.466). Enforce cooperation by country boards as needed. | | | | | | | | |
| 79.4 | CSS will continue to serve people in counties without sufficient appropriate services. | | | | | | | | |
| 79.5 | Continue quarterly meetings with MCCP. | | | | | | | | |
| **80. CSS provides augmentative training, mentoring and coaching** | | | | | | | | | |
| 80.1 | CSS Staff will offer and provide training, as requested or determined to be lacking, on coaching, mentoring and Augmentative training. | | | | | | | | |
| 80.2 | CSS will update training manual as necessary. | | | | | | | | |
| 80.3 | CSS will have sufficient administrative/ managerial staff to track/analyze training as well as mentoring and coaching services provided. | | | | | | | | |
| **81. CSS provides staff at community based facilities and homes with state of the art training encompassing person centered thinking, multi- modal assessment, positive behavior supports, consultation and facilitator skills, and creative thinking.** | | | | | | | | | |
| 81.1 | CSS determines locations for teams and/or home-based staff.<br>CSS creates position descriptions that identify the necessary knowledge, skills, and abilities.<br>CSS hires or trains staff with necessary qualifications and skills to provide training. See EC 61 and 62 regarding staff training. | | | | | | | | |
| 81.2 | CSS insures that all vacant trainer positions are filled as efficiently as possible and with appropriately qualified staff. | | | | | | | | |

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| 81.3 | Training curricula are reviewed routinely to insure consistency with best practices | | | | | | | | |
| **82. CSS' mentoring and coaching as methodologies are targeted to prepare for increased community capacity to support individuals in their community.** | | | | | | | | | |
| 82.1 | CSS will mentor and develop coaches in the community with a vision to support individuals in communities. (12/31/12) | | | | | | | | 1.Training records. 2. Satisfaction surveys from |
| 82.2 | Track success of mentoring / coaching via data regarding such issues as frequency of need for out of home crisis intervention, number of transfers to more restrictive placements, frequency of behaviors dangerous to self or others, frequency of interactions with the criminal justice system, sudden increases in usage of psychotropic medications. | | | | | | | | Data regarding success of mentoring and coaching |
| 82.3 | Provide additional administrative/ managerial support to CSS sufficient to enable timely and complete data collection, entry and analysis. | | | | | | | | CSS personnel listing |
| **83. An additional fourteen (14) full time equivalent positions (15 FTE) were added between February 2011 and June 30, 2011, configured as follows: Two (2) Behavior Analyst 3 positions; One (1) Community Senior Specialist 3; (2) Behavior Analyst 1; Five (5) Social Worker Specialist positions; and Five (5) Behavior Management Assistants** | | | | | | | | | |
| 83.1 | Review position descriptions, update as necessary. | | | | | | | | |
| 83.2 | Work with DHS Human Resources on advertising positions. | | | | | | | | |
| 83.3 | Hire these additional staff, and fill any vacancies in functionally equivalent positions, with the required qualifications. As necessary to fulfill this Implementation Plan, add additional positions. | | | | | | | | |

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| **84. None of the identified positions are vacant.** | | | | | | | | | |
| 84.1 | Fill as quickly as possible and with qualified applicants all vacancies in these and other functionally equivalent positions. Provide sufficient salary, bonus and other structures and incentives to ensure that the positions are filled. | | | | | | | | Vacancy reports. |
| 84.2 | CSS will keep all of the required and functionally equivalent positions filled. | | | | | | | | |
| **84A. All staff who hold the title of Behavior Analyst have the requisite educational background, experience, and credentials recognized by national associations such as the Association of Professional Behavior Analysts.** | | | | | | | | | |
| | DHS will hire only behavioral analysts who meet the requirements of the settlement agreement and accepted professional standards. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION X.B. SYSTEM WIDE IMPROVEMENTS – OLMSTEAD PLAN | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **85. An Olmstead Planning Committee was established by February 5, 2012** | | | | | | | | | |
| **86. The Committee's public recommendations were issued by October 5, 2012.** | | | | | | | | | |
| **87. By August 5, 2013, the State and the Department developed and implemented a comprehensive Olmstead plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the "Most Integrated Setting," and which is consistent and in accord with the U.S. Supreme Court's decision in *Olmstead v. L.C.* , 527 U.S. 581 (1999).** | | | | | | | | | |
| **88. The Olmstead Planning Committee is comprised of no less than fifteen** | | | | | | | | | |
| 85 to 88.1 | The Olmstead Plan required by EC 87 is separately addressed; it is subject to the Court's review and approval pursuant to the Order of August 28, 2013 and the Order of December 5, 2011 adopting the Settlement Agreement. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION X.C. SYSTEM WIDE IMPROVEMENTS – RULE 40 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **89. By February 5, 2012, the Department convened a Rule 40 Advisory Committee with the designated membership approved by the parties.** | | | | | | | | | |
| **90. The function, operations and the product, of the Committee are to study, review and advise the Department on how to modernize Rule 40 to reflect current best practices, including,** | | | | | | | | | |
| **91. The Committee's review of best practices included the Arizona Department of Economic Security, Division of Developmental Disabilities, Policy and Procedures Manual, Policy 1600** | | | | | | | | | |
| **92. The Committee issued a public notice of intent to undertake administrative rule making by February 5, 2012.** | | | | | | | | | |
| **93. DHS did not seek a waiver of Rule 40 for the Facility.** | | | | | | | | | |
| | The Rule 40 Advisory Committee recommendations were fully accepted by the Department of Human Services. The modernization of Rule 40 and adoption of the replacement rule is separately addressed; it is subject to the Court's review and approval pursuant to the Order of August 28, 2013 and the Order of December 5, 2011 adopting the Settlement Agreement. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION X.D. SYSTEM WIDE IMPROVEMENTS – MINNESOTA SECURITY HOSPITAL | | | | | | | | | |
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| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **94. Beginning at least by February 5, 2012, the State takes best efforts to ensure that there are no transfers to or placements at the Minnesota Security Hospital of persons committed solely as a person with a developmental disability.** | | | | | | | | | |
| **95. Beginning no later than July 1, 2011, there are no transfers or placements of persons committed solely as a person with a developmental disability to the Minnesota Security Hospital (subject to the exceptions in the provision).** | | | | | | | | | |
| 95.1 | Before any admission to Minnesota Security Hospital, each proposed admission will be reviewed by Minnesota Security Hospital Admissions officials, by DHS Community Support Services, and also by DHS Jensen Implementation Team to assure that no persons with a sole diagnosis of developmental disability will be transferred or placed at the Minnesota Security Hospital. | | | | | | | | |
| 95.2 | DHS will communicate to all County Attorneys and state courts responsible for commitments, and to all county directors and case managers, that, pursuant to the order of the federal court approving this Plan, no person with a sole diagnosis of developmental disability may be transferred or placed at the Minnesota Security Hospital. Such communication will be made from the Commissioner within 30 days of the order approving this plan and, in addition, by DHS staff who become aware of any such proposed commitment or transfer. | | | | | | | | |

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| 95.2 | The Jensen Implementation Team will document any proposed transition to or placement at MSH of any person committed solely as a person with a developmental disability, including but not limited to any diversion efforts prior to transfer or placement and any subsequent placements. | | | | | | | | |
| **96. There has been no change in commitment status of any person originally committed solely as a person with a developmental disability without proper notice to that person's parent and/or guardian and a full hearing before the appropriate adjudicative body.** | | | | | | | | | |
| 96.1 | The Jensen Implementation Team will document any changes in commitment status of a person originally committed solely as a person with a developmental disability. The documentation will include any notifications and a description of any hearing, and copies of petitions and other papers submitted in connection with notification and/or hearing. | | | | | | | | |
| **97. Beginning no later than December 1, 2011, all persons presently confined at Minnesota Security Hospital who were committed solely as a person with a developmental disability and who were not admitted with other forms of commitment or predatory offender status set forth in paragraph 1, above, are transferred by the Department to the most integrated setting consistent with *Olmstead v. L.C.* , 527 U.S. 581 (1999).** | | | | | | | | | |
| 97.1 | Provide current census, and identifying information, of any people living at MSH committed solely as a person with a developmental disability. | 12/15/13 | | | | | | | |
| 97.2 | Provide documentation of any transition/ placement from MSH since 12/5/2011 of any persons committed solely as a person with a developmental disability. Any such transfer/placement shall be to the most integrated setting consistent with *Olmstead v. L.C.*, 527 U.S. 581 (1999). | 12/15/13 | | | | | | | |

| SETTLEMENT AGREEMENT SECTION X.E. SYSTEM WIDE IMPROVEMENTS – ANOKA METRO REGIONAL TREATMENT CENTER | | | | | | | | | |
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| | REQUIRED TASKS | DUE DATE | AMENDED DUE | RESPONSIBLE PARTY(s) | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | VERIFYING DOCUMENTATION |
| **98. Beginning no later than January 5, 2012, all AMRTC residents committed solely as a person with a developmental disability and who do not have an acute psychiatric condition are transferred from AMRTC to the most integrated setting consistent with *Olmstead v. L.C.* , 527 U.S. 581 (1999).** | | | | | | | | | |
| 98.1 | Before any admission to Anoka Metro Regional Treatment Center, each proposed admission will be reviewed by Anoka Metro Regional Treatment Center officials, by DHS Community Support Services, and also by DHS Jensen Implementation Team to assure that no persons with a sole diagnosis of developmental disability will be transferred or placed at the Anoka Metro Regional Treatment Center. | | | | | | | | |
| | DHS will communicate to all County Attorneys and state courts responsible for commitments, and to all county directors and case managers, that, pursuant to the order of the federal court approving this Plan, no person with a sole diagnosis of developmental disability may be transferred or placed at the Anoka Metro Regional Treatment Center. Such communication will be made from the Commissioner within 30 days of the order approving this plan and, in addition, by DHS staff who become aware of any such proposed commitment or transfer. | | | | | | | | |
| 98.2 | 95.2 The Jensen Implementation Team will document any proposed transition to or placement at Anoka Metro Regional Treatment Center of any person committed solely as a person with a developmental disability, including but not limited to any diversion efforts prior to transfer or placement and any subsequent placements. | | | | | | | | |

| SETTLEMENT AGREEMENT SECTION X.F. SYSTEM WIDE IMPROVEMENTS – LANGUAGE | | | | | | | | | |
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| | **REQUIRED TASKS** | **DUE DATE** | **AMENDED DUE** | **RESPONSIBLE PARTY(s)** | **RESOURCES REQUIRED (w/date added)** | **ACTIONS TAKEN (w/date added)** | **ANTICIPATED OBSTACLES (w/date added)** | **STATUS w/date (Complete/Incomplete)** | **VERIFYING DOCUMENTATION** |
| **99. The term "mental retardation" has been replaced with "developmental disabilities" in any DHS policy, bulletin, website, brochure, or other publication.** | | | | | | | | | |
| 99.1 | All references to outdated terminology used to describe persons with Developmental Disabilities have been updated with clarification on the Departments use of people first language inserted in areas where historical documents are found. In addition to, or in lieu of, updating each webpage, DHS shall maintain the previously established "disclaimer" language to explain the presence in historical documents of outdated terminology. | | | | | | | | Memorandum from Medical Director/s to all staff. Web searches. |
| **100. DHS drafted and submitted a bill for the Minnesota Legislature that will require the replacement of terms such as "insane," "mentally incompetent," "mental deficiency," and other similar inappropriate terms that appear in Minnesota statutes and rules.** | | | | | | | | | |
| 100.1 | Completed. On the removal of inappropriate terms that appear in Minnesota statutes and Rules, see 2013 legislation at Chapter 62 and Chapter 59, Article 3, section 21 signed by the Governor on May 16, 2013. This legislation will not be repealed or replaced. | | | | | | | | State Register/Revisor of Statutes 2013 Laws of Minnesota, Chapter 62 2013 Laws of Minnesota. |

| Closure of MSHS-Cambridge, and Replacement with Quality Community Services | | | | | | | | | |
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| **101. MSHS-Cambridge will be closed, with the need for any successor/replacement facilities based on a comprehensive written needs assessment.** | | | | | | | | | |
| 101.1 | Prior to the opening of more than 2 Cambridge replacement sites or taking any steps which would obligate DHS to open more than 2 Cambridge replacement sites, and/or prior serving a total of more than 4 people within the replacement sites, conduct a comprehensive needs assessment determining if further facilities are necessary. This written needs assessment must include; a) extensive analysis of the flow of referrals to the Cambridge site and any replacement site over the past year; b) consideration of where those diverted from the service have been served, and how sucessfully they have been served; and c) capacity of community providers and existing services to meet the needs of people in crisis. The needs assessment will also include input from community providers, CSS, AMRTC, county programs, and existing DHS services, and advocacy groups, including self-advocates. | Prior to opening a third Cambridge replacement site AND/OR serving more than 4 people. | | | | | | | Comprehensive Needs Assessment |

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| 101.2 | Prior to the opening of more than 2 Cambridge replacement sites or taking any steps which would obligate DHS to open more than 2 Cambridge replacement sites, and/or prior serving a total of more than 4 people within the replacement sites, conduct an analysis of other possible "temporary crisis" possibilities for people who need a temporary residential service due to behavioral crisis. Among the options which will be considered are, for example, highly specialized family foster care, respite identified within existing residential programs, "quick response respite" operated within rental apartments or scattered apartment sites as well as reinforcing the capacity of statewide existing respite services. | Prior to opening a third Cambridge replacement site AND/OR serving more than 4 people. | | | | | | | Review of Residential Alternatives |
| 101.3 | Complete a Cambridge Relocation Plan consistent with the requirements of this Implementation Plan, Evaluation Criteria 1 through 100. | | | | | | | | |
| 101.4 | Submit the Cambridge Relocation Plan to the Court for review and approval. Among other things, the plan will include tasks and deadlines, will define the specialty services to be provided, will describe how protections, services and supports will be ensured both structurally and through individual program plans, will define measurable outcomes and goals, and will rename MSHS-Cambridge. | | | | | | | | |
| 101.5 | Frequent and on-going progress updates will be provided to staff, individuals, and stakeholders on the Cambridge replacement plan. | | | | | | | | |
| 101.6 | Consult Agency Communication Specialist and others on communication planning. Develop and implement a communication plan. | | | | | | | | |
| 101.7 | Submit to the Legislature a legislative placeholder to assist with any obstacles encountered. | | | | | | | | |

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| **102. Identified deficiencies in MSHS-Cambridge operations will be corrected.** | | | | | | | | | |
| 102.1 | Correct all deficiencies identified in the Court Monitor's June 11, 2013 Status Report on Compliance and in his September 23, 2013 Recommendation to the Parties: Transition Planning and the Re-Purposing of MSHS. | | | | | | | | |
| **103. Staff hired for new positions as well as to fill vacancies, will only be staff who have significant experience in community based, crisis, behavioral and person centered services and whose qualifications are consistent with the Settlement Agreement and currently accepted professional standards. Staff reassigned from MSHS-Cambridge will receive additional orientation training and supervision to meet these qualifications within 6 months of reassignment.** | | | | | | | | | |
| 103.1 | Hire, for new positions as well as to fill vacancies, only staff who have significant experience in community based, crisis, behavioral and person centered services and whose qualifications are consistent with the Settlement Agreement and currently accepted professional standards. Staff reassigned from MSHS-Cambridge will receive additional orientation training and supervision to meet these qualifications within 6 months of reassignment. Revise job descriptions as necessary to reflect these requirements. | | | | | | | | |
| 103.2 | Work with Human Resources to expedite hiring in various locations throughout the state(to follow our services). | | | | | | | | |
| 103.3. | Fill 2 new CRS Positions, as well as vacancies in any functionally equivalent positions, with staff whose qualifications and experience are consistent with the Settlement Agreement and the criteria listed in EC 57.5. | | | | | | | | |

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| 103.4 | Pursue additional Behavior Analyst Positions and hire, for these and any other functionally equivalent positions, only staff with qualifications consistent with EC 103 and 103.1 and current acceptable professional standards. Revise job descriptions as necessary to reflect these requirements. | | | | | | | | |
| 103.5 | Review/Revise Position Descriptions to be consistent with the Settlement Agreement and current accepted professional standards. | | | | | | | | |
| 103..6 | Define Staffing/Management Structure: conceive base staffing levels and potential auxiliary staffing needs, finalize staffing/management structure, finalize organizational chart. | | | | | | | | |
| 103.7 | Establish Vocational Staff Positions and hire only staff whose qualifications, experience and training (including post hiring) are consistent with the criteria listed in EC 57. | | | | | | | | |
| 103.8 | Increase flexibility of staffing to enhance Person Centered Services, in accordance with the provisions of ECs 3, 56 through 60 and 107. | | | | | | | | |
| 103.9 | Enhance diversion as well as transition efforts through an additional staff position to assist with housing, employment and other related areas. | | | | | | | | |

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| **104. Criteria for future sites are that a Comprehensive Needs Assessment supports that this service is needed and best met by creation of 3-4 homes , and subject to the assessments required in EC 101 above.** | | | | | | | | | |
| 104.1 | Review database of where most of our referrals reside to strategize location of future sites; create regionalized temporary housing | | | | | | | | |
| 104.2 | For the purposes of short term/crisis residential services, and for short term/residential services (both repurposing existing MSOCS homes and also Leasing Homes, acquire 3 to 4 homes for the initial relocation of Cambridge, provided Comprehensive Needs Assessment supports that this service is needed and best met by creation of 3-4 homes , and subject to the assessments required in EC 101 above. | 12/31/2013 for 2 homes 3/31/14 for 2 additional homes | | | | | | | |
| **105. Staff will be provided laptops, vehicles and other devices, and office space, to facilitate mobility.** | | | | | | | | | |
| 105.1 | For mobile staff and management, provide laptops, vehicles, and mobile communication devices. | | | | | | | | |
| 105.2 | Provide satellite office space for staff. | | | | | | | | |
| **106. Provide integrated vocational options and customized employment.** | | | | | | | | | |
| 106.1 | Obtain from other organizations for integrated vocational referrals. | | | | | | | | |
| 106.2 | Expand integrated vocational options (including work experience and training if individually appropriate) through person centered exploration. | | | | | | | | |
| 106.3 | Utilize customized employment framework consistent with best practices. Create Vocational Menu, Choices, " Informed Choice," and "honor each resident's choice.", if consistent with best practices in customized employment, and conducted in an integrated, individualized fashion. | | | | | | | | |
| 106.4 | Hire sufficient vocational staff. | | | | | | | | |

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| 106.5 | Maintain and expand Job Club and "I Want to Work" employment objectives as options to be considered during person centered employment exploration. See 10.3. | | | | | | | | |
| **107. All requirements in this Implementation Plan are fully met for each individual served in the area of Person Centered Planning.** | | | | | | | | | |
| 107.1 | All requirements in this Implementation Plan are fully met for each individual served in the area of Person Centered Planning. | | | | | | | | |
| **108. All requirements in this Implementation Plan are fully met for each individual served in the area of Transition Planning.** | | | | | | | | | |
| 108.1 | All requirements in this Implementation Plan are fully met for each individual served in the area of Transition Planning. | | | | | | | | |
| 108.2 | In all forms and processes, all discharge language is changed to "transitional" language. | | | | | | | | |
| 108.3 | Once the most integrated residential setting is identified, work with individuals and their teams to implement the transitional portfolio to assure a good quality of life for the individual. The State shall provide adequate and appropriate protections, supports, and services. | Ongoing for each person served effective 11/30/14 | | | | | | | |
| **109. Community Support Services will be integrated with all DHS services, based upon strong regional networks and community connections.** | | | | | | | | | |
| 109.1 | Integrate all DHS services under this Implementation Plan closely with CSS. | | | | | | | | |
| 109.2 | Meet with CSS: review role in pre and post services. | | | | | | | | |
| 109.3 | CSS will provide augmentative service supports, consult, and training to those supporting the person. See also ECs 80, 81,82. | | | | | | | | |
| 109.4 | Create stronger diversion supports through CSS' increased staffing and centralized data analysis related to effectiveness of mentoring/ coaching. See EC 82. | | | | | | | | |

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| 109.5 | Provide supplemental staffing to CSS to strengthen diversion services. See ECs 80 through 84 related to staffing and monitoring the impact of CSS services. | | | | | | | | |
| 109.6 | Create with CSS statewide resources based upon strong regional networks and community connections. | | | | | | | | |
| 109.7 | Clarify relationships and communication strategies between DSD, DHS, CMHS, DCT, SOS, CBS, CSS, CPN, MSOCS (and successor divisions/departments) to facilitate regional and statewide networking. | | | | | | | | |
| **110. All sites, programs and services established or utilized under this Implementation Plan shall be licensed as required by state law.** | | | | | | | | | |
| 110.1 | All sites, programs and services established or utilized under this Implementation Plan shall be licensed as required by state law. | | | | | | | | |
| **111. Cambridge admissions are closed, new sites ar developed only as needed, and current Cambridge residents transition to permanent community homes.** | | | | | | | | | |
| 111.1 | The physical sites for Community Sites A & B would be modified /repaired/ prepared for occupancy, if Comprehensive Needs Assessment determines the need for Community Site B | | | | | | | | |
| 111.2 | If the Comprehensive Needs Assessment determines additional group living arrangements are needed, Community Sites C & D would be modified/repaired/prepared for occupancy | | | | | | | | |
| 111.3 | New admissions to Cambridge will stop and divert to new home(s) when A and/or B are established, depending on location. | | | | | | | | |
| 111.4 | Individuals currently supported at Cambridge will transition to permanent community based homes and supports (not to the new sites being developed under this Plan for temporary and crisis homes). Individuals currently supported at Cambridge will not move more than once. | | | | | | | | |

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| **112. Training plan for community staff strongly emphasizes providing tools and support services in a person's home as quickly as possible. Staff will also be trained in delivering community based programs and processes.** | | | | | | | | | |
| 112.1 | All staff training is consistent with the requirements of Jensen Settlement Evaluation Criteria 61,62,64, related tasks and any other related Evaluation Criteria. Training for staff strongly emphasizes providing tools and support services in a person's home as quickly as possible. Staff will also be trained in delivering community based programs and processes. | | | | | | | | |
| 112.2 | 245D Training, and training under the "Rule 40 Plan" will be completed by all staff involved in serving individuals in the replacement facilities, services, protections and supports. | | | | | | | | |
| 112.3 | Training is planned and scheduled for all transitional phases of the relocation, emphasizing support to staff and services before, during, and after the move. | | | | | | | | |
| **113. Create and implement a plan (and submit to the Court for review and approval) that would maintain therapeutic follow-up with persons served to provide a safety network, as needed, to help prevent re-institutionalization and other transfers to more restrictive settings.** | | | | | | | | | |
| 113.1 | Create a communication system that provides coordinated long term follow-up to persons served by DHS and CSS in an effort to track and monitor the transition process. Person centered documentation derived from this communication system will provide valuable information to the long term monitoring process described in ECs 75 and 76. | | | | | | | | |
| 113.2 | Create a plan (and submit to the Court for review and approval) that would maintain therapeutic follow-up with persons served to provide a safety network, as needed, to help prevent re-institutionalization and other transfers to more restrictive settings. | | | | | | | | |

# COMPREHENSIVE PLAN OF ACTION
# PART II
# (Rule 40 Modernization)

## I. INTRODUCTION

On December 5, 2011, the United States District Court for the District of Minnesota adopted the Settlement Agreement in this class action. The settlement was intended to bring significant improvements to the care and treatment of individuals with developmental and other disabiltiies in the State of Minnesota. Significant progress has been made; however, as the Court has found, the pace of progress has been slow and there have been delays in implementation. There have been a variety of areas of non-compliance. The Court and Court Monitor responded first by coaxing DHS several times to adopt an implementation plan and then, by Order of August 28, 2013, the Court required submission of an implementation plan for the Court's review and approval.

*"Ensuring that the Minnesotans who receive services are treated with respect and dignity is a key element of the mission of the Department of Human Services (the Department or DHS). As an agency with responsibilities for the administration and oversight of services, as well as a provider of services, we are committed to fulfilling our mission consistent with the current best practices and principles that support inclusive community living and quality of life. To that end, DHS will prohibit procedures that cause pain, whether physical, emotional or psychological, and establish a plan to prohibit use of seclusion and restraints for programs and services licensed or certified by the department. It is our expectation that service providers, including state operated services, will seek out and implement therapeutic interventions and positive approaches that reflect best practices."*

*"Current best practices include, but are not limited to, the use of positive and social behavioral supports, prohibitions on use of restraints and seclusion, trauma informed care, and the development of community support plans that are consistent with the principles of the "most integrated setting" and "person centered planning," consistent with the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999). * * * To achieve these changes across our service system, we will create a culture that honors the trust placed in us both as a provider and as a department responsible for the administration and oversight of many of the services that support citizens."*

Quotations from Department of Human Services, *Introduction to Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40 (Final Version - July 2013)* at page 1.

## II. PURPOSES

The purpose of this Implementation Plan is to "modernize Rule 40 to reflect current best practices, including, but not limited to the use of positive and social behavioral supports, and the development of placement plans consistent with the principle of the 'most integrated setting' and 'person centered planning, and development of an "*Olmstead* Plan"' consistent with the U.S. Supreme Court's decision in Olmstead v. L.C, 527 U.S. 581 (1999)." Settlement Agreement, Sec. 10.C. The Plan addresses the elimination of seclusion, restraints and other restrictive procedures, and also the use of positive and social behavioral supports and development of person-centered placement plans. In addition, the Plan includes provisions for training, monitoring, quality assurance, and other measures to facilitiate and sustain its continuing implementation.

Rule 40 is abolished under this Plan of Action

In addition to, and apart from the terms of this Plan (which are and remain independently in effect), the Department of Human Services is adopting a new Rule which shall be consistent in all respects with the requirements of this Plan of Action.

## III. SCOPE AND MANAGEMENT

This Plan will apply to all entities which are identified as "Providers" in the Plan. Providers include, but are not limited to, Home and Community-Based Services (HCBS) which are the federally approved waiver plans governed by United States Code, title 42, sections 1396 et seq., including the waivers for persons with disabilities, including the brain injury (BI) waiver plan; the community alternative care (CAC) waiver plan; the community alternatives for disabled individuals (CADI) waiver plan; the developmental disability (DD) waiver plan; the elderly waiver (EW) plan; or successor plans respective to each waiver; or the alternative care (AC) program. Providers include intermediate care facilities for individuals with developmental disabilities (ICF-DD). Providers are also those entities, day and residential, which serve individuals with mental illness and/or developmental disabilities and which are operated, regulated or licensed by the Minnesota Department of Human Services, and which provide residential or non-residential services. Providers may be owned or operated by the State through DHS, or an individual, corporation, partnership, voluntary association, other organization, or controlling individual.

While the principles are the same as those recognized by the Department of Human Services *(see* Section I above on elimination of restraints and seclusion), it is recognized that there are complexities in application of the provisions in this Plan to large facilities such as Anoka Metro Regional Treatment Center and Minnesota Security Hospital, and in the mental health context. Consequently, the applicability of this Plan to those Providers is limited at this time as provided in this Plan; for those Providers, the Plan provides a period of time for study and to consider the particulars of implementation.

The Department of Human Services shall ensure Providers' compliance with this Plan by all necessary means, including but not limited to incentives, rule, regulation, contract, and grant or withholding of funds.

The Department of Human Services will establish a Jensen Implementation Team ("Team") comprised of a minimum of four full-time professional staff, with clerical assistance, which will be responsible for management and coordination of this Plan, established through the Rule 40 modernization process, and the Primary Plan of Action. The Team will have a designated leader skilled in leadership in the field of developmental disabilities, and will have sufficient resources to fulfill its responsibilties. The Team will also be responsible for the Department of Human Services elements of the Olmstead Plan. The Team shall also be responsible for monthly updates to the Court and Court Monitor, and for promptly providing all information requested by the Court Monitor. The monthly updates will be provided a week in advance in draft to the Court Monitor,Plaintiffs Class Counsel, the Ombudsman for Mental Health and Developmental Disabilties, and the Executive Director of the Minnesota Governor's Council on Developmental Disabilties.

The fundamental imperatives of this Plan are embodied in the Evaluation Criteria which are highlighted and indicated by whole arabic numbers. The Evaluation Criteria are intended to be permanent. The Evaluation Criteria are in most cases accompanied by Required Tasks (arabic decimal numbers) which describe actions to be taken to fulfill the Evaluation Criteria. Status of compliance with the Required Tasks will be reported by DHS monthly. The Required Tasks may be modified for good cause shown in accordance with the procedure established by the Court.

Should terminology or definitions change over time, the Plan will be deemed to include in its scope the terminology or definition closest to that which exists at the time of approval of the Plan, construed to have the broadest coverage.

## IV. QUALITY ASSURANCE AFTER THE CONCLUSION OF ACTIVE JUDICIAL OVERSIGHT

DHS will create and implement a plan that will effectively monitor compliance with the Court's orders, including but not limited to the Evaluation Criteria, and provide for quality assurance, after the conclusion of the Court's active judicial oversight. Also, that plan will provide for maintenance of a system of therapeutic follow-up with persons served to provide a safety network, as needed, to assure appropriate transition planning, protections, services and supports, and help prevent re-institutionalization and other transfers to more restrictive settings. A proposed Plan shall be submitted to the Court in 20 months for review and approval. At least 60 days before submission of the proposed Plan, DHS shall provide a draft to the Court Monitor, Plaintiffs Class Counsel, the Ombudsman for Mental Health and Developmental Disabilities and the Executive Director of the Governor's Council on Developmental Disabilities.

## V. RULE 40 REPLACED

Among other things, upon approval and adoption by the Court, this Plan replaces Minnesota Rule 40 ("Use of Aversive and Deprivation Procedures in Licensed Facilities Serving People with Developmental Disabilities"). Minn. Rule 9525.2700-9525.9810. The effective dates for the"Permitted and Prohibited Techniques" section for specified categories of Providers shall be as stated below.

**VI. REPORTING, REVIEWS, OVERSIGHT AND QUAILTY ASSURANCE**

**1. REPORTING. ESTABLISH REPORTING FORM FOR USE OF RESTRAINTS, SECLUSION AND OTHER RESTRICTIVE PROCEDURES; FORM IS REQUIRED OF ALL PROVIDERS.**
**Note: The requirement to report does not imply approval of prohibited procedures. Collection of comprehensive data is essential to quality assurance, monitoring and improvement in services to individuals.**

**The purpose of reporting and notifications is to reduce and eliminate the use of restraints, seclusion and other restrictive procedures. Use of all restraints, seclusion and other restrictive procedures -- and the other reportable events noted below -- will be reported by all Providers which will provide notifications as stated below. Reporting will include all permitted and unpermitted use of restraints, seclusion and other restrictive procedures, and will include any person's voluntary use of restraints. The reporting will be electronic or by mail. The reporting will include the ability for the reporter to request additional help. These requirements are in addition to and separate from other reporting requirements such as the Vulnerable Adult Act or Maltreatment of Minors Act.**

**The reporting shall include: 1. All the people involved in the emergency use of restraint, seclusion or other restrictive procedure (e.g., staff, person, other clients, etc.); 2. Type(s) of procedure used; 3. Start and end time of procedure including back-to-back uses of one or more procedure and when release attempts were made; 4. What de-escalation measures were taken to avoid the use of the procedure (a. What techniques tried; b. When were they tried; c. How long were they tried); 5. What was learned; 6. Outcome of the procedure (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).**

**The reporting shall also include these events when used in response to mood and behavior: 1. The person's hospitalization; 2. Emergency responder/law enforcement/911 calls regarding a person; 3. Any violations of the licensing or other regulatory standards such as use of a prohibited procedure with a person; 4. PRN use of medications; 5. death; 6. elopements.. The report shall also state whether there is any reason for the reporter to believe that neglect or abuse may have occurred, and shall also state whether there is any perceived need for staff retraining.**

**Notifications shall be provided to: 1. The chief executive officer of the entity; 2. The designated internal reviewer within the organization; 3. The Jensen Implementation Team; 4. The person's family or guardian; 5. The person's Case Manager; 6. The Court Monitor; 7. The MN Ombudsman for Mental Health and Developmental Disabilities, and 8. DHS Licensing. The notification shall include the name, address and telephone numbers of all those who are notified, and shall include a complete copy of the report under this requirement.**

**There will be a written Quarterly Review and Analysis of all Reports which will provide analysis of the data and trends for individuals, entity types, procedures and other variables, with appropriate tables and charts, and provide policy and practice recommendations. In addition, there will be written immediate alerts/reviews for deaths, hospitalization (including emergency room) due to serious physical injuries, allegations of abuse or neglect, and elopements. The written quarterly reviews and the immediate alerts/reviews will be provided to the Commissioner and Deputy Commissioner, the DHS Internal Reviewer, the Jensen Implementation Team, and the Court Monitor, and it will be a public and web-posted document.**

| | EVALUATION CRITERION, with Required Tasks | DUE DATE | AMENDED DUE DATE | RESPONSIBLE PARTY | RESOURCES REQUIRED (w/date added) | ACTIONS TAKEN (w/date added) | ANTICIPATED OBSTACLES (w/date added) | STATUS w/date (Complete/Incomplete) | Verifying Documentation |
|---|---|---|---|---|---|---|---|---|---|
| 1.1 | Establish reporting form consistent with this Evaluation Criterion EC 1 and obtain Court Monitor approval of form. | | | | | | | | |
| 1.2 | Ensure that Providers utilize the Reporting Form and provide the required notifications. The form and instructions will be available on the DHS Website, on paper, and in other formats conducive to its use. | | | | | | | | |

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| 1.3 | Prepare and disseminate a written Quarterly Review and Analysis of all Reports which will provide analysis of the data and trends for individuals, entity types, procedures and other variables, with appropriate tables and charts, and provide policy and practice recommendations. In addition, there will be written immediate alerts/reviews for deaths, hospitalization (including emergency room) due to serious physical injuries, allegations of abuse or neglect, and elopements. The written quarterly reviews and the immediate alerts/reviews will be provided to the Commissioner and Deputy Commissioner, the DHS Internal Reviewer, the Jensen Implementation Team, and the Court Monitor, and it will be a public and web-posted document. | | | | | | | | |
| 1.4 | Add to the scope of the Single Statewide Common Entry Point the Reporting under this EC 1, with the Report Form included in such reporting. | | | | | | | | |

**2. MONITORING AND OVERSIGHT BY ENTITES TO REDUCE AND ELIMINTATE RESTRICTIVE PROCEDURES.**

**NOTE: The goals of successful monitoring, reporting, and oversight are: a) improved skills and growth of articulated desired life aspects of the persons by providing resources and non-punitive support to providers; b) improved quality of life by improving quality of a person's care and support; c) Improved safety of persons and others, and 4) reduced emergency use of manual restraint.**

**Within one (1) year from approval of this Plan, no Provider shall utilize mechanical or manual restraint on a programmatic basis. Within one (1) year from approval of this Plan, no Provider shall utilize seclusion, time out or other restrictive procedures. Within one (1) year from approval of this Plan, no Provider shall utilize manual restraints except in an emergency.**

**Providers will monitor persons during all uses of any restrictive procedure. When possible, a staff member who is not implementing the restraint should monitor the person.**

**Providers will utilize the Reporting Form to perform and document an internal review following each use of a restrictive procedure and other reportable events, to determine what happened, and what can be learned from the situation. The internal review will also consider 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 restrictive procedure as possible but no more than 24 hours afterward. The internal review and its documentation shall be completed within five days.**

**DHS will establish Quality Assurance mechanisms for external review and analysis of entites' use of restrictive procedures. The purpose of this mechanism is to ensure the protection of persons' rights and safety. The following outcomes and indicators will be measured and reported:**
**1. The use of emergency use of manual restraint; 2. The use of positive support strategies; 3. Trend analysis to determine where changes are necessary; 4. Indications that persons' recovery, growth, or skill development is progressing; and 5. Indications the new standards are accomplishing what they were intended to accomplish.**

| | **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) | **Verifying Documentation** |
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| 2.1 | Within one (1) year from approval of this Plan, no Provider shall utilize mechanical or manual restraint on a programmatic basis. Within one (1) year from approval of this Plan, no Provider shall utilize seclusion, time out or other restrictive procedures. Within one (1) year from approval of this Plan, no Provider shall utilize manual restraints except in an emergency. | | | | | | | | |
| 2.2 | Establish obligation for entites to perform the required monitoring and internal review. | | | | | | | | |
| 2.3 | DHS will establish a design and implement a policy for the QA mechanisms, which will include, among other things, visits to locations where indivdiuals live and spend their days. | | | | | | | | |

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| 2.4 | 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. Persons receiving waiver services and PCA services will be assessed annually for quality of life indicators via an assessment tool which has been tested and found to be reliable for the purposes in this Evaluation Criterion. independently, DHS will utilize data gathered from National Core Indicator Process (NCI). The QA mechanism will integrate the results from site visits, the quality of life tool and the NCI process, and will issue quarterly summary reports and an annual report. | | | | | | | | |

## VII. PERMITTED AND PROHIBITED TECHNIQUES

**3. PERMITTED TECHNIQUES.**

**The following techniques, although they might entail some physical contact with the person, are 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. NOTE: These standards allow for accommodations which do not contradict their intent. For example, certain therapies (deep pressure interventions) for persons with disabilities may appear as manual restraint but are not. Subject to the limited temporary exception in the last provision of this Evaluation Criterion, only "permitted techniques" may be used by or within an entity.**

**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.**

**Damage to property may not be the sole basis for a restrictive procedure, nor may 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.**

| | **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) | **Verifying Documentation** |
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| 3.1 | Develop and implement policy and procedures for all Providers to address the use of PERMITTED techniques, which policy and procedures will list permitted techniques, define when manual restraint may be used, specify that refusal to receive or participate in treatment does not constitute an emergency permitting manual restraint, and specify that damage to property may not be the sole basis for a restrictive proceddure, nor may 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. | | | | | | | | |
| 3.2 | Providers will comply with the policy and procedures, and will utilize only permitted techniques. | | | | | | | | |
| 3.3 | See EC 5 for transtion from temporary limited use of restraint. | | | | | | | | |

**4. PROHIBITED TECHNIQUES**

**The following techniques are 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; 26. 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; and 27. All other techniques which are likely to cause physical or psychological pain or suffering.**

| | **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) | **Verifying Documentation** |
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| 4.1 | Develop and implement policy and procedures for all Providers (except Anoka Metro Regional Treatment Center -- aside from Unit D of Anoka -- and Minnesota State Hospital, and Mental Health Providers) to to prohibit the listed techniques, and all other techniques which are likely to cause physicial or psychological pain or suffering. EC 3 and 4 apply to Unit D (Developmental Disabilities Unit) at Anoka without qualification. | | | | | | | | |
| 4.2 | Providers will comply with the policy and procedures, and will utilize only permitted techniques, subject to Required Task 4.1.. | | | | | | | | |
| 4.3 | With regard to Anoka Metro Regional Treatment Center, Minnesota Security Hospital, and Mental Health Providers, DHS will promptly undertake a four month effort, with the assistance of consultants approved by the Court Monitor, to engage in conversations, and to develop training, policy and procedures, to implement the purposes, and to develop the plan to which it committed itself in its "Introduction" to the Rule 40 Advisory Committee report, namely, "to establish a plan to prohibit use of seclusion and restraints for programs and services licensed or certified by the department," quoted above at Section I. | | | | | | | | |

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| 4.2 | During the planning period under 4.3 above, EC 1, EC 2 (except 2.1), and EC 3 will apply to Anoka Metro Regional Treatment Center, Minnesota Security Hospital, and Mental Health Providers. Also, see 5.1, 22.1, 23.1 and 25.1, | | | | | | | | |

## VIII. POSITIVE BEHAVIOR SUPPORT TRANSITION PLAN

**5. POSITIVE SUPPORT TRANSITION PLAN (PSTP)**

**At the entity level, each person's team shall 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. It is recognized that mechanical and manual restraint are not treatment and are not therapeutic. The PSTP is intended to eliminate such use promptly and with professional care.**

**The plan shall be developed using positive approaches and be person-centered, and will 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 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.**

**The Positive Strategies section fills the role of an "intervention plan" that equips and prepares providers to positively and effectively help the person make progress in their personal repertoire towards the life they desire to live. The Positive Strategies section will also a) accommodate the need for rapid and persistent changes; and b) focus on quality of life improvement and not just whether target symptoms are alleviated.**

**DHS will prepare and establish a template for a PSTP, instructions, and training for providers and the persons' team members on establishment and implementation, and monitoring of PSTPs.**

| | **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) | **Verifying Documentation** |
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| 5.1 | There is an individual PSTP for 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, with the PSTP compliant with the requirements of EC 2. | | | | | | | | |
| 5.2 | DHS establishes a plan for review and monitoring of each person's PSTP, with initiation of the monitoring of the first plans and for completion of the monitoring. The monitoring shall be by clinical professionals skilled in positive behavioral supports who shall provide recommendations for adjustments in the plan. The monitoring professionals shall have available to them senior Ph.D. level professionals to provide mentoring and feedback. | | | | | | | | |
| 5.3 | The transitional use of mechanical restraints shall be short-term, temporary, and only in strict accordance with the PSTP and 22.1, 23.1 and 25.1 below. | | | | | | | | |
| 5.4 | Effective immediately upon the Court's approval of this Plan, no Provider shall utilize mechanical or manual restraint on a programmatic basis. This provision applies to Anoka Metro Regional Treatment Center, Minnesota Security Hospital and Mental Health Providers. | | | | | | | | |

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| 5.5 | Positive strategies section of a person's plan: The positive strategies section fills the role of an "intervention plan" that equips and prepares providers to positively and effectively help the person make progress in their personal repertoire towards the life they desire to live. The positive strategies section shall be based upon best practices across disciplines. | | | | | | | | |

## IX. POSITIVE BEHAVIOR SUPPORT MANUAL

**6. POSITIVE BEHAVIOR SUPPORTS MANUAL**

**To support Providers who provide services, DHS will develop a Positive Behavior Supports Manual which will illustrate what the standards mean and intend and will include application of the standards in mental health, developmental disabilities and other applicable situations.**

**The preparation of the manual shall include review of the Georgia and Vermont positive support manuals and recommend adoption with modifications of the work of these states.**

**Among other things, the manual shall include:**
**• Proper screening tools or checklists to determine when functional assessment/functional behavioral assessments are necessary;**
**• Based upon individual need there will be assessments in the areas of medical, habilitation/rehabilitation therapies, dental, mental health, or other necessary therapies. These assessments may be concurrent with a functional assessment/functional behavior assessment.**
**• Once the various assessments have concluded, an 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. Entites shall 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.**
**• A positive strategies section which 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.**
**• A non-exhaustive list of permitted positive support strategy examples.**
**• 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.**

| | **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) | **Verifying Documentation** |
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| 6.1 | Develop a Positive Behavior Supports Manual | | | | | | | | |
| 6.2 | The manual will include proper screening tools or checklists to be used to determine when functional assessment/functional behavioral assessments are necessary. | | | | | | | | |
| 6.3 | The manual will provide for the use of existing mental health and developmental disabilities crisis services for children and adults and mobile crisis teams. | | | | | | | | |
| 6.4 | The manual will provide a non-exhaustive list of permitted positive support strategy examples | | | | | | | | |

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| 6.5 | The manual will provide for assessment:<br>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 assessmet. | | | | | | | | |
| 6.6 | The manual will provide for post-assessment integration and analysis:<br>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. | | | | | | | | |
| 6.7 | DHS will make the manual available state-wide on DHS' website, and on paper and by alternative means (at no cost), and will require Providers to participate in training on the contents of the manual, and will provide technical assistance and content consultation by senior professionals in positive behavior supports. | | | | | | | | |
| 6.8 | DHS will require Providers to utilize the manual in provision of supports and services to the indivduals they serve. | | | | | | | | |
| 6.9 | Providers will utilize the manual in provision of supports and services to the individuals they serve. | | | | | | | | |

## X. TECHNICAL ASSISTANCE

**7. It is intended that Providers succeed with these standards in this Plan. There shall be widespread availability of resources, training and technical assistance for Providers as a key component to support the culture change which is necessary for success. Sustaining the changes after the initial rollout and implementation of the the standards in this Plan is an essential part of "implementation" and is consistent with the overarching goal to achieve success. Therefore, technical assistance will be oriented toward sustaining compliance and will be available to individuals receiving services, Providers, Provider staff, families, guardians, conservators, case managers, and others. DHS will include, among new sources of technical assistance, the existing -- and augmented -- Community Support Services (CSS), Metro Crisis Coordination Program (MCCP), Community Outreach for Psychiatric Emergencies (COPE) and Adolescent Crisis Services.**

**Generally, DHS will offer resources and technical assistance before applying sanctions.**

| | **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) | **Verifying Documentation** |
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| 7.1 | Hire staff for Community Capacity Teams (CCT). The Community Capacity Team will include staff with: clinical backgrounds, DHS systems/policy backgrounds, service delivery, background in county services, and policy and data analysis backgrounds. DHS will define the functions, competencies and responsibiltiies of the CCT. | | | | | | | | |
| 7.2 | Initiate CCT on-site support to entites. | | | | | | | | |
| 7.3 | Initiate Monthly Technical Assistance Webinars with providers and lead agencies. | | | | | | | | |
| 7.4 | Collect and report in writing quarterly on analysis of data to measure impact of technical assistance, with recommendations for improvement. | | | | | | | | |

## XI. TRAINING: GOALS, PARTICIPANTS AND EVALUATION

**8. The goals of training are: 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 being taught (use PBS in training approach).**

**Training will be provided to: 1. Providers' staff; 2. Provider executives, managers and owners; 3. Case managers; 4. Family members, legal guardians and conservators; 5. Persons receiving service; and 6. DHS policy staff.**

**There will be 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: (that is, do outcomes make training sustainable?).**

| | **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) | **Verifying Documentation** |
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| 8.1 | Develop and implement a policy to address training goals and requirements, including required hours and topics of training for the identified categories of training participants. | | | | | | | | |
| 8.2 | Develop and implement systems for evaluation of training, reporting on the evaluation, and responsive adjustments to the evaluation systems. | | | | | | | | |
| 8.3 | Develop a Comprehensive Training plan to include: On-line training, webinars and in-person training. | | | | | | | | |

| XII. TRAINING: POSITIVE SUPPORT STRATEGIES | | | | | | | | | |
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| **9. Positive support strategies training will be provided to build repertoires of personal effectiveness in Providers' settings. Provider staff will be trained, competent, and use positive support strategies. DHS will make training affordable and accessible; this means, for example, providing interactive online curriculum when possible and appropriate.** | | | | | | | | | |
| | **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 | **Verifying Documentation** |
| 9.1 | Initiate webinars for providers, families, lead agencies (case managers). | | | | | | | | |
| 9.2 | Initiate regional in-person training for providers. | | | | | | | | |
| 9.3 | Based on feedback received from face to face and webinar training, develop on-line training for providers. | | | | | | | | |
| 9.4 | Collect and report, in writing, quarterly on analysis of data to measure impact of this training, with recommendations for improvement. | | | | | | | | |

## XIII. TRAINING: PERSON-CENTERED PLANNING APPROACHES

**10. Person-centered planning is central to this Plan.Those managers, staff and others who serve individuals will have training and achieve competence in person-centered planning and thinking. 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.**

| | **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) | **Verifying Documentation** |
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| 10.1 | Provide Person Centered Thinking and Person Centered Planning Training 2-day workshops for providers, case managers and others | | | | | | | | |
| 10.2 | Initiate Person Centered Thinking (PCT) training for providers, case managers and others. | | | | | | | | |
| 10.3 | Initiate Person Centered Planning (PCP) training for providers, case managers and others. | | | | | | | | |
| 10.4 | 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 | | | | | | | | |
| 10.5 | Initiate statewide videoconferences on the principles and concepts of person-centered thinking, planning, and organizational and systems change. | | | | | | | | |

## XIV. TRAINING: EVALUATION OF EFFECTIVENESS

**11. The effectiveness of training will be be measured through demonstrated competency of the skills in the setting in which services are provided. Training will be evaluated based on five levels: 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 through such questions as "do outcomes make training sustainable?"**

| | **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) | **Verifying Documentation** |
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| 11.1 | Implement an objective and independent evaluation of the Minnesota Positive Behavior Support Initiative (MNPBSI) training programs. | | | | | | | | |
| 11.2 | Arrange for and implement an objective and independent evaluation of the training under this Plan, with recommendations for improvement. | | | | | | | | |

## XV. TRAINING: BUILD IN-STATE TRAINING CAPACITY

**12. In-state training capacity for person centered thinking and person centered planning will be increased. The number of in-state 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. Hands-on training including mentoring of staff will be components of this training. The training will be competency-based.**

| | **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) | **Verifying Documentation** |
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| 12.1 | Develop in-state trainer capacity in the areas of PCT and PCP. | | | | | | | | |
| 12.2 | Recruitment of trainees. | | | | | | | | |

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| 12.3 | Implement training: PCT Trainees will receive at least 75 hours of training; PCP Trainees will receive an additional 50 hours of training. 10 trainers will be trained in PCT and 5 in PCP in each of 2014, 2015, 2016 and, 2017. | | | | | | | | |
| 12.4 | Implement Community of Practice and other means to facilitate continued contact, learning and mutual support among those trained to be trainers. | | | | | | | | |

| XVI. TRAINING: COLLEGE OF DIRECT SUPPORTS |
|---|
| **13. Core training will be provided to: 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).**<br><br>**Core training topics will include (in random 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.**<br><br>**In addition to core training, there will be additional tiered training requirements for people based on the level of responsibility and qualifications.**<br><br>**First Tier: 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 how and when to communicate with the person's family, 6. Monitoring and training staff documentation and reporting; 7. Diagnosis and medications; 7. When to utilize crisis resources.**<br><br>**Second tier: 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.**<br><br>**Third tier: for behavior staff who oversee positive support sections. 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. Design and use of data systems to measure effectiveness of care; 6. Understanding resources of the human services system, its procedures and people in the local system.**<br><br>**Fourth tier: for provider executives, managers and owners (non-clinical roles). 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.** |
| **14. TRAINING TOPICS FOR 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)** |
| **15. 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.** |

**16. TRAINING TOPICS FOR PERSONS RECEIVING SERVICES: 1. Their rights under this Implementation Plan and under the applicable bill of rights; 2. Person-centered planning; 3. Permitted and prohibited procedures; 4. Access to training offered under Core Training topics.**

**17. TRAINING TOPICS FOR DHS POLICY STAFF: 1. Core Training topics; 2. Same training topics as 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.**

| | **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) | **Verifying Documentation** |
|---|---|---|---|---|---|---|---|---|---|
| 13 to 17.1 | Develop training modules for all required topics and categories of trainees 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, for all categories and with the content specified above. | | | | | | | | |
| 13 to 17.2 | Obtain an independent evaluation of the existing College of Direct Supports (CDS) module content and make recommendations to DHS and DSD about course content, suggesting what existing information should be modified and what new content should be developed. | | | | | | | | |
| 13 to 17.3 | Fully implement the required training on an ongoing basis. | | | | | | | | |
| 13 to 17.4 | Develop and implement a marketing plan for CDS | | | | | | | | |

## XVII. PERSON CENTERED PLANS

**18. Every individual served by an entity for whom a Positive Behavior Support Plan is professionally appropriate shall have a separate person-centered section in that plan; the person-centered planning shall be done with a competent facilitator who has been trained, and has experience, in person-centered planning tools. In addition, a person-centered plan shall be available upon request to all individuals served by an entity.**

| | **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) | **Verifying Documentation** |
|---|---|---|---|---|---|---|---|---|---|
| 18.1 | The Positive Support Behavior Manual and Positive Behavior Support Transition plan provisions shall incorporate this provision. | | | | | | | | |
| 18.2 | Providers serving individuals shall implement this provision. | | | | | | | | |

## XVIII. VARIANCES

**19. The Commissioner will not grant variances to the requirements set forth in this Plan.**

| | **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) | **Verifying Documentation** |
|---|---|---|---|---|---|---|---|---|---|
| 19.1 | The Commissioner will not grant variances to the requirements set forth in this Plan, except pursuant to Section XXI below. | | | | | | | | |

| XIX. INCENTIVES AND RESOURCES | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **20. Additional incentives and resources will be provided to Providers and others to support and facilitate implementation of this Plan.** | | | | | | | | | |
| | **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) | **Verifying Documentation** |
| 20.1 | 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. | | | | | | | | |
| 20.2 | As part of the DHS Critical Access Study, evaluate expansion of community capacity for the provision of behavioral support and clinical consultation services, and provision of additional resources which may include, but is 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. | | | | | | | | |

| XX. CLINICAL SUPPORT | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **21. Action will be taken to increase availability of credentialed clinical support for Providers serving individuals with behavioral support needs.** | | | | | | | | | |
| | **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) | **Verifying Documentation** |
| 21.1 | Actions will be taken in the following regards:<br>a. Credentialing for the role of clinician (i.e., the person who develops and writes the behavior support plan) must be up-graded from the skills of the current workforce who are writing behavior support plans<br>b. Define the credentials/training needed for the clinician<br>c. Define the training needed for support staff to implement behavior support plans<br>d. Require "large" agencies to hire clinicians<br>e. Smaller agencies need to have easy and affordable access to clinical support ( e.g., regional clinicians)<br>f. During transition time for Rule 40, (smaller) agencies need to have access to clinicians who can consult on challenging individuals (e.g., those in long-term restraint; those who need seat belt clips; those in room time-out and seclusion programs) | | | | | | | | |

| XXI. TEMPORARY CONDITIONAL WAIVERS | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **22. A temporary waiver may be granted for certain strategies, based on detailed proposal when there is adequate program support by a qualified clinician.** | | | | | | | | | |
| | **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) | **Verifying Documentation** |
| 22.1 | A service provider may apply for a temporary waiver for certain strategies and under certain conditions (discussed below at 25.1), if they believe that it is not possible to reduce to zero the use of a prohibited procedure for an individual by the start date of Rule 40. Temporary waivers may only be sought if there is adequate program support by a qualified clinician. A detailed proposal, with guidelines defined by the External Program Review committee, would be needed to request a temporary waiver. There will be no permanent waivers available. Temporary waivers are predicated on the goal of reducing any currently used prohibited strategy to zero. | | | | | | | | |

## XXII. EXTERNAL REVIEW

**23. Two levels of external overview, or review, committees are needed. They will be called External Program Review Committee (PRC), and External Human Rights Committee (HRC). Regardless of the name of these committees, two committees are needed – one will focus on external reviews of individuals who meet certain criteria described below (PRC); the other will focus on a broader picture of state and agency systems-wide progress on implementation of Rule 40 (HRC).**

| | **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) | **Verifying Documentation** |
|---|---|---|---|---|---|---|---|---|---|
| 23.1 | The External Program Review Committee (PRC), and External Human Rights Committee (HRC) will have the functions and will operate as described in Section A of the attachment to this Plan ,incorporated herein. | | | | | | | | |

## XXIII. MENTAL HEALTH AND DEVELOPMENTAL/INTELLECTUAL DISABILITY COLLABORATION

**24. - Convened and coordinated by DHS, Mental Health and Developmental/Intellectual DIsabilities professionals will seek a synergistic relationship so that they can equally benefit from each other's areas of expertise.**

| | **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) | **Verifying Documentation** |
|---|---|---|---|---|---|---|---|---|---|
| 24.1 | Convened and coordinated by DHS, Mental Health and Developmental/Intellectual DIsabilities professionals will seek a synergistic relationship so that they can equally benefit from each other's areas of expertise. Each of these areas has strengths that would contribute to the practices of the other—in terms of all aspects of program development, implementation, and evaluation. Evidence-based practices from each of these areas would expand the nature and quality of supports available to meet the diverse needs of the clients that are served by DHS. | | | | | | | | |
| 24.2 | Mental Health representatives will participate in the review of all documents that will impact their practices; this will insure the use of language that represents each discipline and may facilitate education of all members of the disability community. | | | | | | | | |

| XXIV TEMPORARY TRANSITIONAL LEGACY SITUATIONS TO BE INDIVIDUALLY MONITORED BY SPECIALLY ASSIGNED STAFF | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **25. With regard to special situations which are temporarily present during the transition to implementation of this Positive Behavioral Supports Plan, and which are the product of legacy use of various restraint and other aversive methods (which are forbidden under this Plan), the short-term carefully monitored approaches in the attachment to this Plan, incorporated herein, will be utilized. BECAUSE THIS IS A TEMPORARY SITUATION AND INVOLVES RISKY AND POTENTIALLY DANGEROUS TECHNIQUES, DHS SHALL DEVOTE SPECIALLY-ASSIGNED, TRAINED AND DEVOTED STAFF TO THE INDIVIDUAL MONITORING OF THE SITUATIONS DESCRIBED HERE.** | | | | | | | | | |
| **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) | **Verifying Documentation** |
| 25.1 | With regard to special situations which are temporarily present during the transition to implementation of this Positive Behavioral Supports Plan, and which are the product of legacy use of various restraint and other aversive methods (which are forbidden under this Plan), the short-term carefully monitored approaches in the Section B of the attachment to this Plan, incorporated herein, will be utilized. BECAUSE THIS IS A TEMPORARY SITUATION AND INVOLVES RISKY AND POTENTIALLY DANGEROUS TECHNIQUES, DHS SHALL DEVOTE SPECIALLY-ASSIGNED, TRAINED AND DEVOTED STAFF TO THE INDIVIDUAL MONITORING OF THE SITUATIONS DESCRIBED HERE. | | | | | | | | |

## ADOPTION OF NEW RULE

**21. DHS publishes a new rule, incorporating and fully consistent with the requiremens of this Plan, 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.**

| | 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) |
|---|---|---|---|---|---|---|---|---|---|
| 21.1 | In addition to, and apart from the terms of this Plan (which are and remain independently in effect), the Department of Human Services will adopt a new Rule which shall be consistent in all respects with the requirements of this Positive Behavioral Supports Plan. | | | | | | | | |
| 21.2 | Develop a draft Rule for review and comment before public distribution by the Court Monitor, Plaintiffs' Class Counsel, the Ombudsman for Mental Health and Developmental Disabilities, and the Executive Director of the Governor's Council on Developmental Disabilities. | | | | | | | | |
| 21.3 | Solicit broad public input from all classes of persons and entities affected by the proposed rule. | | | | | | | | |
| 21.4 | Meet publication deadlines. Publish notice of public hearing and proposed rule in State Register and broadly disseminate to affected classes of persons and entities. | | | | | | | | |
| 21.5 | State Administrative Law Judge holds public hearing; post-hearing statutory requirements are met. | | | | | | | | |
| 21.6 | DHS publises a new rule, incorporating and fully consistent with the requiremens of this Plan, 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. | | | | | | | | |

**ATTACHMENT**
**TO COMPREHENSIVE PLAN OF ACTION: PART II**

## *Section A: External Overview Committees*

Two levels of external overview, or review, committees are needed. They will be called External Program Review Committee (PRC), and External Human Rights Committee (HRC). Regardless of the name of these committees, two committees are needed – one will focus on external reviews of *individuals* who meet certain criteria described below (PRC); the other will focus on a broader picture of state and agency *systems-wide* progress on implementation of Rule 40 (HRC).

***External Program Rights Committee.*** External Program Rights Committees (PRCs) will serve a variety of functions and its focus will change across time as implementation of Rule 40 proceeds. The number of PRCs that are needed will be determined by the population distribution. The chairs of the PRCs will report back to the designated person at DHS.

- All committee members should have expert credentials (to be defined) in their own discipline
- Guidelines for the committee should be developed (e.g., general procedures, schedule of meetings, electing a chair).
- Serving on the committee should be considered a prestigious service to the disability community. A call for participants should be disseminated and interested parties will submit a letter of interest and their credentials/ resume/vita. Members may also be recruited (based on clinical and leadership skills), or may be nominated.

Initially, the committee will focus on addressing requests for temporary waivers. This committee will be made up of experts across disciplines (with permanent seats for PBS experts and a DHS representative, and with other seats designated for experts determined by the individual who is under consideration such as mental health representative, occupational therapist; nurse). The committee's purposes are to:

(a) develop guidelines for proposal submissions for temporary waivers (e.g., history of problem behavior; history of behavior support programs; FBA data and hypothesis; proposed strategies; timelines for fading out restraint or seclusion strategies)
(b) ensure that proposal was developed under the guidance of an approved clinician
(b) review proposals for temporary waivers
(c) offer any clinical recommendations or suggestions, and evaluate deadlines for continued progress evaluation, and

(d) maintain ongoing meetings with the proposers to evaluate progress

- Following full implementation of this Plan, the focus of the PRC will be to:

  (a) continue to monitor progress on individuals who were on Rule 40 temporary waivers;
  (b) design guidelines defining criteria for mandatory submission of individual cases to the Committee (e.g., use of 2 crisis management strategies; use of 3 PRNs for individual who cannot communicate a request or rejection)
  (c) design guidelines to seek support from the PRC

***External Human Rights Committee.*** There will be one External Human Rights Committee (HRC) based in the DHS. The HRC will be comprised of a DHS representative, and others to include, for example: PBS experts, an MH expert, a community provider, and so on. It will be chaired by a representative of the DHS.

The (HRC) will focus on the broad implementation and evaluation of this Plan's implementation. By looking at the data across agencies, regions, and state-wide, trends of progress can be evaluated. For example, are there certain agencies that are submitting extensive numbers of proposals for temporary waivers, or seeking clinical support, or experiencing greater numbers of crisis or PRNs (see PRN section of this report). If so, is it because they have more challenging clients? Or because they do not have the appropriate clinical support? Are there certain regions of the state where it is apparent that there is insufficient access to appropriate clinical support? Are there certain procedures or regulations that are apparently not sufficiently operationalized? What types of training needs are indicated?

# Section B: Addressing Specific Temporary Situations

**1. Mechanical Restraint:**

***a) The use of mechanical restraints such as seat belt clips.***

**Issue:**

Seat belt clips, reportedly because of fear of liability, are being used, and may even becoming standard practice by some practitioners. Some suggest that all seat belts are restraints, therefore seat belt clips would not be that different in intent. Data are not available to understand the pervasiveness of this practice, and if it is indeed becoming standard practice in some agencies. Comprehensive behavioral assessments do not appear to be used to develop effective interventions to make use of clips either unnecessary or a temporary intervention.

**Recommendations:**

- Seat belt clips should be prohibited
- A temporary waiver can be sought by provider, for an individual, *only if* it has been demonstrated (through data, history, etc.), that a dangerous situation is likely to occur
- A proposal must be submitted to the PRC to request a temporary waiver for an individual. The intent of the proposal would be to terminate the use of seat belt clips. The proposal, written with the support of a trained clinician, must include for example: goal of plan; FBA data; a description of the function-driven intervention; schedule for program reviews; and timelines for program implementation and completion (i.e., absence of seat belt clip).

***b) The use of mechanical restraint that some may refer to as sensory (blanket wrapping, arm wraps).***

**Issue:**

There is a belief that some individuals may benefit from sensory interventions. There seem to be three reasons that sensory interventions are used. First, it is thought that the intervention will meet some sensory deficit or need of an individual, and will thus be generally incompatible with display of problem behavior. Second, there are some individuals who reportedly request such interventions. Third, the sensory intervention is applied contingent on the problem behavior or at the precursor level of the problem behavior. This third reason appears to be an attempt to offset the behavior from escalating into a major episode. Some of the sensory interventions may be benign-- such as using a brush to comb someone's arm, or focused deep massage. However, other interventions have the function of restraining the person – such as being wrapped in a blanket, or laying underneath a weighted blanket.

**Recommendations:**

- If it is believed that the individual is requesting the use of such sensory interventions (that limit physical movement), he or she should be a participant in the development of the plan. Together the clinician and the individual will collaboratively develop the plan. This discussion must be done when the person is in a calm state, and not when the individual is in crisis, or exhibiting any precursors to crisis. This collaborative development should be documented.
- If the person requests to have a plan that includes sensory restraint, it must be conducted in a way that allows the individual to easily release him or herself independently. If the person is not able to independently and easily terminate the restraint, then it should be prohibited.
- If the individual is not able to participate in such a collaborative discussion of the use of such sensory interventions, any procedure that limits the individual's physical movements should be prohibited.

- Any use of sensory interventions should be based on the outcome of a validated occupational therapy assessment. If a sensory technique is recommended, it should not include any restriction to the individual's physical movements.
- Data should be recorded to evaluate the use of *any* type of sensory intervention. These data should be used to support or obviate the use of the intervention.

***c) The use of mechanical restraint for persons with long histories of SIB and the issues created if the restraints were removed.***

**Issue:**

It was reported that there are some individuals who have been in mechanical restraints for 20 and 30 years. Data are not available to understand the pervasiveness of this practice, so it is unknown how many individuals are in this or similar situations. Likely this situation persists because of a negative reinforcement paradigm—that is, with the person in restraints an aversive situation (self-injury) is avoided, and the individual and others in the environment appear to be safe. Another reason that this behavior (keeping someone in restraints) appears to be maintained is that some feel that with these mechanical restraints in place, physical restraint is avoided—thus avoiding the potential injury to staff and the individual that may occur if the SIB increases. It was reported that the facilities that employ such practices are reluctant to terminate the restraints, as they believe that the behavior will become dangerous and restrictions on restraint will prohibit them from maintaining a safe environment. There are also reports that such facilities will refuse to accept individuals who have the types of behaviors that they think can only be maintained with restraint, and will "return" individuals who they deem unable to support.

While concerns for safety must be taken seriously, it must be concluded that the needs of some individuals are not matched with the appropriate clinical supports that they require. Safety is of primary importance, but quality of life is of parallel importance. Either expert support must be provided in the facilities where such long term restraints are used, or the individuals need to be moved to an environemtn in which they can receive competent clinical support and thus have a chance to live with an improved quality of life.

**Recommendations:**

- Mechanical restraints should be prohibited
- If the mechanical restraints cannot be terminated by the Rule 40 deadline, a proposal must be submitted to the PRC to acquire a temporary waiver for an individual. The intent of the proposal for a waiver would be to terminate the use of mechanical restraints, according to a sound function-driven intervention. The proposal, written with the support of a trained clinician, must include the elements designed by the PRC, such as: goal of plan; FBA data; a description of the function-driven intervention; schedule for program reviews; and timelines for program implementation and completion.

- Bringing support to a person where they are is the ideal; however, that assumption is based on the idea that they are in an environment that can appropriately support them. If the person is living in a low quality of life situation, and/or the residence is unable or unwilling to provide competent supports, then the individual should be moved to a home (or work, or school) where they can have both a safe life *and* a higher quality of life.

**2. Seclusion and time-out**

**Issue:**

Next to restraint, it was reported that "time-out" is the second most used intrusive strategy. Four levels of "time-out" have been identified. The first two levels (i.e., contingent observation and exclusionary time-out) were not reported as problematic in their implementation or description. However, it should be noted that if an individual is unwilling to engage in either of these two forms of time-out, it may be a trigger for escalation if the staff do not back off. The bigger issue, however, is with the two more intrusive strategies, identified as "room time-out" and "seclusion." One issue is that this distinction might not be clear to service providers. From the material provided it appears that the difference between these two levels is that in one strategy the room is locked to keep the person from leaving (i.e., seclusion), and in the other situation the room is not locked (room time-out). In both of these instances, however, the person is prevented from leaving the room. It is also unclear how a person could be prevented from leaving the time-out room "by staff" rather than by a mechanism. Does this mean that if the individual tries to leave the room the staff will then restrain him or her?

A second issue is in the "popular" use of the term time-out, and all its variations. It is critical that these terms are not confused with the strategy of giving an individual time to "cool-off" and "regroup." If this were the intent of isolating the person, it would not need a room that is guarded, with or without locks. This type of "relaxation" strategy, appropriate for some individuals based on the results of an FBA, should be called something completely different (e.g., re-grouping time; relaxation) to insure that it is seen as a constructive strategy, not to be confused with any time-out strategies. The new term should be defined without any overlap with isolating a person in a room. The focus of this strategy would be on acquisition of skills that the person is learning that will help them relax (e.g., for example: counting to 10; deep breathing).

**Recommendations:**

- Two levels of time-out (both room time-out and seclusion) should be prohibited across all programs and for individuals of all ages and disabilities.
- It is difficult to imagine a need for a temporary waiver, but if a provider, under the guidance of a trained clinician, believes that they require one, then a temporary waiver would be submitted to the PRC. The PRC will evaluate the request.

- Coin a term and design a definition for the strategy of teaching someone to relax -- as in deep breathing or counting to ten.
- This relaxation goal should be on the treatment plan, and represent a skill to be increased (e.g., will learn to count to 10; will ask for a break and select where he would like to sit for the break)
- As a treatment goal, data will be recorded, it will be evaluated on a scheduled basis, and be taught through a systematic teaching strategy (e.g., such as practicing the deep breathing skill at the beginning of each problematic routine; video modeling of yoga).

**3. Use of other behavioral strategies**

**Issue and Recommendations:**

Several behavioral strategies were discussed briefly regarding their appropriateness, or conditions under which they may or may not be appropriate. Strategies included extinction and satiation.

- Extinction: This strategy may appear benign, but it is a potentially inappropriate strategy for a number of reasons. First, if it is implemented regarding a behavior that is not attention-maintained, it will likely either have no impact, or may escalate the behavior. Second, if it is done in the absence of instruction in an alternative behavior, then it is not giving the individual any means of communication to have their needs met. Three, potential extinction induced increases in aggression or behavioral intensity can be dangerous for the individual and others in the environment.
- Satiation: The use of satiation was discussed, but it appears as though it was *overcorrection* that was at issue. Both r*estitutional overcorrection* (repairing the damage caused by the problem behavior by returning the environment to a condition even better than it was before the problem behavior), and *positive practice overcorrection* (the individual is required to repeatedly perform a correct form of the problem behavior, or a incompatible behavior, for a specified duration of time or numbers of responses), are punishment strategies. I believe the two terms "resititution" and "positive practice" are euphemisms for a coercive intervention and should be prohibited.

These are just two examples of a huge menu of potential behavioral strategies—and it is my opinion that even if these two were explicitly addressed, there will always be other strategies that will arise. Further, even a benign strategy can be used in a way to cause humiliation or pain to an individual (e.g., preventing an individual from engaging in a non-dangerous ritual). Thus, general guidelines for using/rejecting a strategy should be based on a set of criteria (see questions below). This would be the first step for an agency—if it is unclear how to interpret the strategy, then it should be submitted to the PRC for review.

- Is the intent of the strategy educative or punitive?
- How will the strategy be perceived by the individual?

- If it is educative, is it based on the results of an FBA, resulting in a function-driven plan?
- Would a person who did not have a disability find it humiliating, painful, or uncomfortable?
- If implementation of the strategy was conducted in public, would it be questioned or seem extraordinary?

**4. PRN vs. Chemical Restraint**

**Issue:**

There seem to be several issues that complicate discussion of the use of PRNs. First, a distinction should be made between psychotropic medications and other PRN medications (e.g., Tylenol, inhaler). The discussion that follows relates only to psychotropic medications. Second, the prescription of medications, in whatever form, falls under the responsibility of the prescribing physician; however, the collaboration between physicians and other providers is not as effective, or synergistic, as it could be. Third, designing regulations concerning PRNs appear to attempt to include all individuals-- those with skills and abilities to understand and advocate for themselves, and those who appear not to have these skills. Consideration of the diversity of abilities is important when considering medication issues:

- Some individuals are able to request PRN as needed
- Some individuals are able to reject an offer of a PRN by staff
- Individuals who are not able to communicate at this level, in either requesting or rejecting the offer or use of a PRN, are more vulnerable to the medication being used as a chemical restraint.

One issue that was discussed is that the individual who has skills to engage in a private relationship with his or her psychiatrist has the right to do so and should be encouraged to do so. The nature and level of involvement of staff in these situations, and the level of involvement of staff when the individual does not have these abilities, needs to be carefully thought out. Two concerns must be considered:

(a) Does the psychiatrist (or whoever is writing the prescription) have all the information that is necessary in make informed decisions with the individual?
(b) Does the psychiatrist understand the types of nonmedical supports and strategies that are implemented in the facility (e.g., behavior support plan; individual and family counseling; community supports), and how the individual is progressing given these supports and strategies.

**Recommendations:**

- Some individuals are able to request PRN as needed; this self-management of one's own mood and behavior is to be encouraged.
- Some individuals are able to reject an offer of a PRN by staff; this refusal is to be respected.
- Psychiatrists should receive copies of all meeting minutes, behavior support plans and data on an on-going basis. Data will include (minimally) the number of PRNs that were offered, accepted, and rejected, and the number of target behaviors displayed.
- Individuals who are not able to communicate at this level, in either requesting or rejecting the offer of a PRN, are more vulnerable to the prescription being used as a chemical restraint; thus, this is where safeguards are needed.
- If the individual is unable to communicate at this level, the use of the PRN medication must be reviewed by the PRC. Any use of PRN medication must be accompanied by a function-based Behavior Support Plan, which will be submitted to and monitored by the committee. Data on both the use of the medication, and the target behaviors will be monitored on a scheduled basis.
- A protocol needs to be designed for materials that will be brought to psychiatry appointments. These may include for example, behavior support plans, notes, and graphed data.