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September 30, 2015

ECF Filed
The Honorable Donovan W. Frank
United States District Court - District of Minnesota
Warren E. Burger Federal Building
316 North Robert Street
St. Paul, MN 55101

Re: Jensen et al v. Minnesota Department of Human Services et al
Court File No: 09-CV-1775 DWF/FLN
Our File No.: 7400-001

Dear Judge Frank:

On behalf of the Settlement Class, we provide our comments involving the *Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40* ("Recommendations") pursuant to the Independent Court Monitor's August 18, 2015, memorandum (NOTICE: CPA Deadline Regarding Positive Supports Rule (Rule 40 Modernization)),[1] and Comprehensive Plan of Action, Evaluation Criterion Number 103, which provides:

> Within thirty (30) days of the promulgation of the Adopted Rule, Plaintiffs' Class Counsel, the Court Monitor, the Ombudsman for Mental Health and Developmental Disabilities, or the Executive Director of the Governor's Council on Developmental Disabilities may suggest to the Department of Human Services and/or to the Olmstead Implementation Office that there are elements in the Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40 (Final Version - July 2013) which have not been addressed, or have not adequately or properly been addressed, in the Adopted Rule. In that event, those elements shall be considered within the process for modifications of the Olmstead Plan. The State shall address these suggestions through Olmstead Plan sub-cabinet and the Olmstead Implementation Office. Unresolved issues may be presented to the Court for resolution by any of the above, and will be resolved by the Court."

[1] Advising that for tracking and resolution purposes suggestions involving the Recommendations would best be filed through the ECF system.

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Initially, we enclose the Consultants' September 8, 2015, letter to the Olmstead Subcabinet chair and DHS commissioner which included highlighted sections of the Recommendations. The Consultants suggested the highlighted sections be discussed with DHS to determine if they have been considered and adopted during implementation of the Positive Supports Rule. We agree with the Consultants' submission in this regard.

In addition, we note the rule Positive Supports Rule allows for ongoing use of restraint on people with disabilities. As a result, we reiterate our strong concerns and objections, expressed to the Rule 40 Committee, *Olmstead* Committee, *Olmstead* Subcabinet, the State, DHS, counsel, the Independent Court Monitor and the Court over many years, involving the ongoing use of restraint and seclusion:

> **From:** Shamus O'Meara
> **Sent:** Tuesday, March 11, 2014 8:27 AM
> **To:** Baltes, Christina (DHS); David Ferleger
> **Cc:** Wieck, Colleen (ADM); Opheim, Roberta (OMHDD); Barry, Anne (DHS); Akbay, Amy K (DHS); Bartolic, Alex E (DHS); Alpert Steve H. Esq.; Ikeda Scott; Aaron Winter (aaron.winter@ag.state.mn.us); Gray, Gregory N (DHS); Friend, Maggie A (DHS); Booth, Peg (DHS)
> **Subject:** RE: For discussion at our next Parties Meeting March 10 2014
>
> All:
>
> As we have repeatedly stated, and most recently reiterated in our February 25 letter to the Court, copy enclosed, the Settlement Class continues to oppose any proposed provision, or interpretation of any provision, whether contained in proposed amendments to Minn. Stat. 245, proposed Olmstead Plan, proposed Rule 40 changes, proposed Comprehensive Plan of Action, or anywhere else, that allows for the use of restraint or seclusion on people with developmental disabilities, whether as part of a "transition," "waiver," "exemption," "exception," "conditional use," "variance," "temporary use," or "study period," for any provider, or anyone else. The use of transition periods, waivers, exemptions, exceptions, etc. that provide for the continued use of restraint and seclusion directly violates the civil rights of people with developmental disabilities. The Settlement Class objects to any proposed provision that seeks to allow for the continued use of restraint and seclusion. This has been the repeated, reiterated position of the Settlement Class throughout the pendency of this matter. Such provisions are not best practice, do not protect anyone, have no positive or redeeming qualities, and would directly contradict the Settlement Agreement's elimination of restraint and seclusion, and the spirit and intent of the Settlement Agreement. Insistence of these provisions would only facilitate the ongoing dangerous use of aversive, abusive procedures that have been eliminated by the Class Action Settlement as well as best practices that focus on Positive Behavioral

> Interventions and Support of individuals with developmental disabilities rather than restraining and secluding them in violation of their rights.
>
> Thank you,
>
> Shamus
>
> * * *
>
> Following recent DHS rulemaking communications and continued attempts to expose people with developmental disabilities to restraint and seclusion, we also must reiterate that the Settlement Class does not support or condone any proposed Plan provision, or interpretation of any Plan provision, that allows for the use of restraint or seclusion on people with developmental disabilities, whether as part of a "transition," "waiver," "exemption," "exception," "conditional use," "variance," "temporary use," or "study period," for any provider, or anyone else. The use of transition periods, waivers, exemptions, exceptions, etc. that provide for the continued use of restraint and seclusion directly violates the civil rights of people with developmental disabilities. The Settlement Class objects to any proposed Plan provision that seeks to allow for the continued use of restraint and seclusion. This has been the repeated, reiterated position of the Settlement Class throughout the pendency of this matter. Such provisions are not best practice, do not protect anyone, have no positive or redeeming qualities, and would directly contradict the Settlement Agreement's elimination of restraint and seclusion, and the spirit and intent of the Settlement Agreement. Insistence on these provisions would only facilitate the ongoing dangerous use of aversive, abusive procedures that have been eliminated by the Class Action Settlement as well as best practices that focus on Positive Behavioral Interventions and Support of individuals with developmental disabilities rather than restraining and secluding them in violation of their rights.

February 25, 2014, Settlement Class Counsel Letter to Court at 3-4 [Doc. 276].

As we have repeatedly conveyed, the *Jensen* Class Action Settlement Agreement, and its prohibition against restraint and seclusion, is the agreed upon, Court ordered baseline upon which DHS conduct must be measured, including the best practices promised in the Settlement Agreement to which DHS expressly agreed. We remain hopeful that DHS and the State of Minnesota will take all necessary actions to timely, effectively and appropriately develop working plans that will successfully implement the *Olmstead* Plan in a manner that supports, protects and serves people with disabilities and their families consistent with all applicable laws and the promises they have made under the *Jensen* Settlement Agreement.

Thank you.

Respectfully submitted,

O'MEARA, LEER, WAGNER & KOHL, P.A.

/s/ Shamus P. O'Meara

Shamus P. O'Meara
SPO:tlb

Enclosure

cc: Mr. David Ferleger, Independent Court Monitor
DHS Counsel
Dr. Colleen Wieck
Ms. Roberta Opheim

State of Minnesota

Office of the Ombudsman for Mental Health and Developmental Disabilities

121 7th Place E. Suite 420 Metro Square Building, St. Paul, Minnesota 55101-2117
Voice: 651-757-1800 or Toll Free: 1-800-657-3506 TTY/Voice – Minnesota Relay Service 711
"Giving voice to those seldom heard"

September 8, 2015

Ms. Mary Tingerthal, Commissioner
Minnesota Housing Finance Agency
400 Sibley Street
Suite 300
St. Paul, Minnesota 55101-1998

Ms. Lucinda Jesson
Minnesota Department of Human Services
Elmer L. Andersen Building
540 Cedar Street
St. Paul, Minnesota 55164-0967

Dear Commissioner Tingerthal and Commissioner Jesson:

The Jensen Settlement Agreement Comprehensive Plan of Action contains Evaluation Criterion #103 which states:

> "Within thirty (30) days of the promulgation of the Adopted Rule, Plaintiffs' Class Counsel, the Court Monitor, the Ombudsman for Mental Health and Developmental Disabilities, or the Executive Director of the Governor's Council on Developmental Disabilities may suggest to the Department of Human Services and/or to the Olmstead Implementation Office that there are elements in the Rule 40 Advisory-Committee Recommendations on Best Practices and Modernization of Rule 40 (Final Version - July 2013) which have not been addressed, or have not adequately or properly been addressed, in the Adopted Rule. In that event, those elements shall be considered within the process for modifications of the Olmstead Plan. The State shall address these suggestions through Olmstead Plan sub-cabinet and the Olmstead Implementation Office. Unresolved issues may be presented to the Court for resolution by any of the above, and will be resolved by the Court."

This joint letter is provided in response to EC 103 and is being submitted within 30 days of the promulgation of the Adopted Rule.

We reviewed the Advisory Committee Report and highlighted the sections of the Report which should be discussed with DHS to determine if these recommendations have already been considered and adopted during implementation of the Positive Support Rule. We believe this task can be completed in a meeting with DHS officials and Olmstead staff members.

Thank you in advance for all of the work that has been achieved in moving toward positive supports.

Sincerely,

Roberta C. Opheim
Ombudsman for Mental Health &
Developmental Disabilities

Colleen Wieck, Executive Director
Governor's Council on Developmental
Disabilities

cc: David Ferleger, Court Monitor

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

Final Version -July 2, 2013

Overview of Advisory Committee Recommendations

The recommendations are provided here in a narrative format. For additional detail, please see the recommendation outlines[1] or meeting notes available on the Rule 40 website.[2]

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

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

Scope

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

General Recommendations

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

1. The positive practices manual should provide examples to illustrate what the standards mean and intend. The examples should include application of the standards in mental health situations.
2. The Plan - Advisory committee members discussed and decided that instead of creating confusion over different plan names and what elements would go in which plans, they recommend one plan for each person affected by this policy. Throughout this document, you

will see references to different plan sections, all of which may be part of the one plan for each person. All plans and sections would be developed using positive approaches and be person-centered. Within each plan, there will be different sections that address the individual needs and desires of the person for whom the plan is designed. Each plan will be comprised of, among other things, the following required components :

a) Person's goals – lists the person's goals
b) Positive strategies – describes what positive strategies will be used with the person, describes what is important to the person
c) Person's needs – describes what is important for the person
d) Intervention – describes what to do in a crisis short of emergency use of manual restraint

3. Committee members recommend the Department establish a small group of stakeholders to review the Georgia and Vermont positive support manuals and recommend adoption with modifications of other states' work.

Positive Support Strategies

Advisory committee members recommend:

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

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

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

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

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

Committee members recommend a positive strategies section:

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

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

Person-Centered Planning

Person-centered planning means a process for planning and supporting the person receiving services that builds upon the person's capacity to engage in activities that promote community life and that honors the person's preferences, choices, and abilities.[3] The person is always at the center of the process and their choices should be reflected in the selection of services and supports. Even in instances when a person is subject to legal restrictions, such as conservatorship, guardianship or commitment, the person should be given maximum authority possible within the legal restrictions. Person-centered planning is not a one-time event. The case manager plays a critical role in a person accessing resources for person-centered planning.

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

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

Permitted Techniques

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

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

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

1. Physical guidance such as hand-over-hand contact to facilitate a person's completion of a task or response that is directed at learning a skill when the person does not resist or the resistance is minimal as determined by the support team. The support team is the service planning team identified in Minnesota Statute section 256B.49, subdivision 15, or the interdisciplinary team identified in Minnesota Rules, part 9525.0004, subpart 14, whichever applies
2. Corrective verbal feedback
3. Physical contact, with no resistance from the person, to calm or comfort the person in distress
4. Minimal physical contact or physical prompt necessary to redirect a person's behavior when the behavior does not pose a serious threat to the person or others AND the behavior is effectively redirected with less than 60 seconds of physical contact by staff OR the physical contact is used to conduct a necessary medical examination or treatment by a licensed health professional
5. Response blocking
6. Mechanical devices for medical conditions
7. Temporary withholding or removal of objects being used as a weapon
8. Emergency use of manual restraint

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

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

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

Prohibited Techniques

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

1. Use of mechanical restraint
2. Prone restraint
3. Manual restraint except in the case of emergency
4. Seclusion
5. Time out and room time out
6. Chemical restraint
7. Use of painful techniques
8. Use of faradic shock
9. Deprivation or restriction of rights
10. Use of punishment of any kind
11. Any program that requires the person to earn normal goods and services or interferes with their fundamental rights.

12. All level programs that move a person down the hierarchy of levels or use a response cost procedure.
13. Speaking to a person in a manner that ridicules, demeans, threatens, or is abusive or other inappropriate vocalizations;
14. Requiring a person to assume and maintain a specified physical position or posture as an aversive procedure, for example, requiring a person to stand with the hands over the person's head for long periods of time or to remain in a fixed position;
15. Totally or partially restricting a person's senses, including a pillow or blanket over a face;
16. Presenting intense sounds, lights, or other sensory stimuli as an aversive stimulus;
17. Using a noxious smell, taste, substance, or spray, including water mist, as an aversive stimulus;
18. Forced exercise;
19. Using a person receiving services to discipline another person receiving services;
20. Any hyperextension or twisting of body parts;
21. Tripping or pushing;
22. Any exacerbation of any medical or physical issue;
23. Containment that is medically contraindicated; and
24. Containment without monitoring
25. Physical intimidation or show of force

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

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

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

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

Emergency Use of Manual Restraint

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

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

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

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

Temporary Use of Mechanical Restraint for Self-Injurious Behavior

Some committee members acknowledge that sometimes, albeit rarely, situations arise where temporary use of mechanical restraints for self-injurious behavior should be permitted. Some advisory committee members recommend that a provider may temporarily continue the use of mechanical restraints when:

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

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

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

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

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

committee members recommend that data be collected, analyzed and shared publicly while in compliance with HIPAA privacy.

Staff Training

Staff training is very important to the advisory committee. Training, and more importantly demonstrated competence, are keys to successful culture change. The overall goal of training is to produce highly competent staff who understand the new culture of how to work with persons with disabilities. The advisory committee values making training affordable and accessible. This means providing interactive online curriculum when possible and appropriate. The committee recommends the effectiveness of training be measured through demonstrated competency of the skills in the setting in which services are provided.

The advisory committee established the following broad goals of training:

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

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

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

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

Core training topics include, in non-priority order[4]: (BETH—CAN YOU DOUBLE CHECK THESE TOPICS?)

1. De-escalation and crisis management[5]
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
21. Emergency use of manual restraint techniques and monitoring its use for signs of distress that require cessation.

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

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

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

[4] The Advisory Committee did not set training topic priorities and recommends that additional work be done to establish priorities.

[5] The core elements of the Jensen Settlement Agreement were shared with the committee and adopted by it. The committee chose to use different topic headings. For example, the Settlement Agreement requires Therapeutic Interventions training while the committee's equivalent topic is de-escalation and crisis management.

6. Diagnosis and medications
7. When to utilize crisis resources

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

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

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

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

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

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

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

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

1. Continuing Education Units to keep current on innovations and evolving knowledge
2. Available resources
3. Case management monitoring and oversight roles and responsibilities
4. The monitoring and oversight roles and responsibilities of providers, licensing and others
5. In-depth person-centered planning and how to talk teams through it

6. The different approaches of person-centered planning (e.g., Planning Alternatives for Tomorrow with Hope (PATH), McGill Action Planning System (MAPS), Essential Lifestyle Planning (ELP), Personal Futures Planning (PFP), Person Centered Thinking (PCT))
7. Different components of the individual plan

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

1. Resources about the system
2. Voluntary informed consent and the difference between substitute decision making versus making a decision in a person's best interest
3. Positive support strategies
4. Person-centered planning
5. De-escalation strategies

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

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

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

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

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

The advisory committee recommends evaluation of training. Committee members discussed and recommended using the Donald Kirkpatrick five levels of evaluation.[6] 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

[6] See Appendix G.

5. Measurement of return on investment for training: Do outcomes make training sustainable?

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

Reporting and Notifications

Advisory committee members strongly value the role of reporting and oversight. The purpose of reporting and notifications is to reduce and eliminate the use of restraints. The advisory committee recommends a format for reporting that can be submitted electronically or by mail. The committee further recommends that the electronic form includes the ability to request additional help and requires the reporting of all permitted and unpermitted use of restraints. A person's voluntary use of restraints must also be reported.

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

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

Emergency Use of Manual Restraints

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

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

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

Notifications. The advisory committee recommends notifications go to:

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

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

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

Other Events

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

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

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

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

Monitoring

Goals and Values

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

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

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

Restraint Monitoring

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

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

Internal Review

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

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

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

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

External Review

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

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

Oversight

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

1. The use of emergency use of manual restraint
2. The use of positive support strategies
3. Trend analysis to determine where changes are necessary
4. Indications that persons' recovery, growth, or skill development is progressing and
5. Indications the new standards are accomplishing what they were intended to accomplish

Licensing

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

Data

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

Committees and Teams

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

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

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

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

Implementation

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

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

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

Initial Implementation

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

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

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

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

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

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

External experts Michael Mayer and Derrick Dufresne prepared a document for the Rule 40 Advisory Committee to use titled "Considerations for Committee Work Regarding Minnesota Rules 9525.2700-9525.2810 (known as Rule 40): A Review of the States and Related Resources."[7] Among other things, Mayer and Dufresne recommended applying all related rules to all settings that are designated for the support of people who have developmental disabilities, creating a technical assistance and training network to assure that staff are competent and ongoing training requirements that include demonstrations of competency. Mayer and Dufresne emphasized the importance of training, technical assistance and oversight.

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

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

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

Providing incentives to providers, persons served and family members. The advisory committee realizes there are many challenges in some of the incentive ideas they recommend. Committee

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

members recommend that the department offer incentives to providers to spur compliance. Possible incentives include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sustaining the Changes

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

1. Continue providing resources and technical assistance;

2. Consider the future roles of Community Support Services (CSS), Metro Crisis Coordination Program (MCCP), Community Outreach for Psychiatric Emergencies (COPE) and Adolescent Crisis Services;
3. Continue to build capacity of an array of competent providers throughout the state;
4. Persons, self-advocates, family members, guardians, conservators and community members should continue to have an active role in sustaining the changes as referenced in the above "creating culture change" section;
5. Continue to use and update best practices as they change over time; and
6. Michael Mayer and Derrick Dufresne recommended[8] establishing ongoing training requirements that include competency demonstrations in specified areas such as:
    a. Primary preventative measures rather than restraint;
    b. Interventions that are less intrusive than restraints;
    c. Effective ways to de-escalate situations to avoid restraints; and
    d. Crisis intervention techniques that utilize alternatives to restraint.
7. Examine the need for additional professionals including behavior analysts, mental health professionals, and rehabilitative therapists to effectively implement the policies, assessments, service provision, technical assistance and evaluation recommended.
8. Recommend that the Commissioner pursue changes necessary to assure health care coverage including Medicaid payment for the services and professionals needed to implement the Committee's recommendations.

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

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

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

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

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