Minnesota Department of **Human Services**

Rule 40 Advisory Committee Meeting Summary: 8.6.12

Attending:

Committee members: Steven Anderson, Kay Hendrikson, Barbara Kleist, Pat Kuehn, Traci Lisowski, Tim Moore, Andrew Pietsch, Kelly Ruiz, Bonnie Jean Smith, Gloria Steinbring and Colleen Wieck

DHS Staff: Rick Amado, Donovan Chandler, Lori Dablow, Stacy Danov, Gail Dekker, Katherine Finlayson, Dan Hohmann, Jill Johnson, Nancy Jurgensen, Jennifer Kirchen, Bob Klukas, Sandra Newbauer, Larraine Pierce, Dean Ritzman, Lauren Siegel, Michael Tessneer and Suzanne Todnem

Other State Staff: Michelle Ness (Minnesota Department of Health)

Other Organizations and guests: Mark Anderson (Barbara Schneider Foundation), Rick Cardenas (Advocating Change Together), Brad Hansen (The Arc Greater Twin Cities), Renee Jenson (Barbara Schneider Foundation), Sharon Mack (TBI Advisory Council) and Sue McGuigan (TBI Advisory Council)

Committee Charge The Rule 40 Advisory Committee was formed as part of a settlement agreement. The committee will study, review and advise the Department of Human Services on how to modernize Rule 40 to reflect current best practices. This was the sixth meeting of the Rule 40 Advisory Committee, which met from 9:00 a.m. to 3:30 p.m.

Presentations The Committee heard a brief update from Mike Tessneer regarding the scope and direction of the department. Tessneer emphasized that the standards this committee recommends may apply across disabilities but that the policy implementation method is not yet clear in terms of whether the policy will be in rule, statute, or manual or a mix of these methods. The scope of the standards for this committee to recommend is limited to situations involving disruptive or challenging behaviors because aversive and deprivation procedures are generally prohibited. After the committee recommends standards, those standards will be reviewed by other stakeholder groups in addition to the department.

Nancy Jurgensen from the Disability Services Division of the Department of Human Services presented on the MnCHOICES assessment tool. MnCHOICES has been in development for a number of years and combines four currently used assessments and processes into this one common assessment. The four assessments and processes are:

- Developmental disability screening
- Long-term care consultation assessment
- Personal care assistance assessment
- Private duty nursing assessment, included in future enhancement

The MnCHOICES assessment tool is organized according to domain headings. Each domain heading has categories within each domain. Each category includes the questions that should be asked of each person and questions that will be prompted only as appropriate based on earlier responses. The assessments will be conducted in a conversation style where the person being assessed leads the conversation. The assessor will have a laptop at the assessment to complete the form offline.

Jurgensen demonstrated portions of the MnCHOICES online assessment tool and focused on examples of person-centered questions and positive supports, the behavior/emotion section and quality of life questions used throughout the assessment tool. Committee members expressed some concerns with the assessment because some terms have a laymen's meaning that is different from a clinical meaning. Committee members noted aspects of MnCHOICES they liked such as its breadth and it is a good fact-finding tool. Jurgensen invited their input and recommended they share that information with her directly or through Suzanne. For additional information or submit input, please visit the [MnCHOICES website](#).

Discussion

Positive support strategies work group

Tim Moore and Kelly Ruiz provided a report out to the advisory committee describing main points discussed at the positive support strategies work group meetings. Committee members added and modified items on the work group summary handout. Please see the revised positive support strategies work group handout to see the committee's recommendation. [See revised handout](#).

Person-centered planning work group

Sue McGuigan and Sandra Newbauer provided a report out to the advisory committee describing main points discussed at the person-centered planning work group meetings. Committee members added and modified items on the work group summary handout. Please see the revised person-centered planning work group handout to see the committee's recommendation. [See revised handout](#).

 Future meetings

1. September – We will review these three work group reports: Emergency Use of Restraint, Training and Implementation. The committee will move toward final recommendation on these three topics. This meeting will begin at 9:00 a.m. and my run until 4:00 p.m.

2. <u>October</u> – We will review one work group report: Monitoring, Oversight and Reporting. Committee members will move toward final recommendation on this topic. Committee members will also review and respond to some draft statute language.

Reminder The September meeting is scheduled for September 7, 2012, the **first FRIDAY** of the month, and will be held in room 3148 at the Lafayette building located at 444 Lafayette Road, St. Paul, MN 55155.

Questions or comments As always, if committee members or observers have questions, please email them to the Rule 40 email box at DHS.rule40@state.mn.us

Visit our website at [Rule 40 Advisory Committee](#)

Rule 40: Positive Support Strategies
<u>Revised</u> following August 6, 2012, Advisory Committee Meeting

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

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

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

III. *Positive Strategies Framework has these components:*
   A. Contextual values (person-centered values)
   B. Assessment
   C. Bridge between assessment and intervention plan
   D. Intervention plan: one plan across disciplines; plan focuses on skill building across disciplines
   E. Data, reporting and monitoring
   F. Consultation support for providers
   G. Professional credentials
   H. Reference to manual for guidelines and standards

IV. *Functional Behavior Assessment Components*
   A. Undertake a medical, dental, and mental health diagnostic assessment to rule out those causes. However, do not wait for a mental health diagnostic assessment to begin a functional behavior assessment (can be concurrent).

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

V. *When would a functional behavior assessment (FBA) be needed or triggered?*
   A. When emergency restraints are used.
   B. When someone has a history of having restraints used on them.
   C. When a person is asked to leave the place they're living in due to challenging behaviors or if this is being considered.
   D. When a person is asked to leave a day program or service due to challenging behaviors or if this is being considered.
   E. When a person has a history of behaviors of concern.
   F. When a decision has been made on a person's behalf that gets in the way of the person's ability to live their life.
   G. When a person engages in criminal conduct or potentially criminal conduct.
   H. When a person is taking psychotropic medications.
      1. Upon admission to a new provider, if the person is taking psychotropic medications, or
      2. If the person is taking psychotropic medications to manage behavior
      3. To assure person still building capacity where possible
   I. At the person's annual review.
   J. At the time of a MnCHOICES annual reassessment
   K. If an FBA is done by a school, it needs to be comprehensive, not just for school.

<ol type="1" start="1">
And/or this should be done when the person is at risk of or is suspended from school

<ol type="A" start="12">
<li value="12">Incidents are defined in Licensing standards. A pattern of incidents could be one trigger for an FBA.
Give providers a screening tool. There are, for example, known behaviors with certain conditions like brain injury.
<ol type="1">
It would be case managers' responsibility to use the screening tool at annual review to ask about behaviors.

The 245B risk management assessment could be another trigger to ask whether an FBA is needed.
Consider the community's response to any behavior as part of the norm. What is a reasonable person's view of a certain behavior? For example, is a thrown plate always a crisis?
Pattern of incidents (to be defined) – for early detection of need
Checklist – providers could possibly use a checklist/flow chart that would determine when an FBA or other diagnostic is necessary as a screening tool.

VI.   *The assessment and positive strategies plan must include:*

<ol type="A">
The FBA must be done with a team.
There are five components of a positive strategies plan:
<ol type="1">
Contextual strategies
Antecedent strategies
Prompting and instructional strategies
Reinforcement strategies
Positive responses to problem behavior
<ol type="1">
Note that a crisis plan is separate from the positive support plan.

Desired outcomes should drive the intervention plan.
A clear and measurable description of the challenging behavior, description of events, times and situations that predict the occurrence and non-occurrence of the challenging behavior, and a description of consequences that maintain the challenging or problem behavior: reinforcement, punishment.
The planner must develop a hypothesis about why this behavior happens and what sustains it.
Through direct observation, the planner identifies and confirms the function of the challenging behavior. It is assumed that the person uses the challenging behavior to control their world or to communicate something. The planner must get to specifics about what is being controlled and/or what is being communicated and the function of the challenging behavior.
Others, in addition to the planner, can be trained to gather the data that either supports or does not support the hypothesis.
The plan must use person-first language.

VII.   *What positive support strategies look like:*

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

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

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

G. Note that some credentials don't fit will with all disciplines and populations.. For example:
   1. Mental health uses peers with mental illness to create peer-developed plans (wellness reaction plan).
   2. How well does this approach apply to crisis respite providers or residential providers?
H. Be thoughtful about the cost factor of these requirements: training, experience, ability to pass a competency test, level of person who can conduct an FBA.

IX. *Outcomes and Evaluation*
A. Use evidence-based practices
B. The person is growing and developing/gaining skills
C. Implement changes one at a time and evaluate outcome

D. Note that an FBA and positive strategies plan is not a one-time event, but a process that must be reviewed (and possibly on-going) and outcomes evaluated to measure progress toward plan goals.

E. Use MnCHOICES annual reassessment as a way to conduct such a review and evaluation.

X. *Crisis response*

A. Remember that CCS and MCCP provide crisis services in Minnesota. A lot of funding goes into this. We should use the existing structure.

B. But we need to make sure they collect data to ensure their plans are working.

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

A. When and to whom?

B. Recommendation or mandatory instruction from external reviewer

C. Reporting – what, when and to whom?

D. Look at required credentials and experience for an FBA and to develop and monitor and evaluate a positive supports plan.

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

A. Mental Health: Functional Assessment

B. Developmental Disabilities: Functional Behavior Assessment

C. Education: Behavior Plan for IEP school services

D. Minnesota Health Care Programs (MHCP): Individual Behavior Plan (IBP)

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

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

Minnesota Department of **Human Services**

Rule 40: Person-Centered Planning- July 16ᵗʰ and 27ᵗʰ
<u>Revised</u> following August 6, 2012, Advisory Committee Meeting

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

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

II.   Components of a Person-Centered Plan (PCP)
   A. Facilitation of a Person-Centered Plan
      1. The person's voice is most important. The person must be involved and at the center of the planning process, as well as invited to identify their circle of support to also be included in the process.
      2. The PCP facilitator must be independent (meaning the facilitator has no other role in the person's life unless chosen to play this role by the person) and certified by a recognized professional group such as MAP, ELF, etc This facilitator must use agreed-upon, evidence-based PCP tools and keep documentation of the PCP process. The county case manager would have a list of certified facilitators.
         a. The provider should not facilitate the creation of a PCP because it is the PCP is broader than a care plan, it is not the provider's role and it would be a conflict of interest.
         b. See the Michigan document on the independent, external facilitator. (See July advisory committee meeting handout #13)

   B. Indicators that the plan is person-centered: The plan must:
      1. Encompass the person's quality of life, not just quality of care.
      2. Gather and consider history of the person from family, friends and certain professionals, as well as by truly listening to the person and their needs.
      3. Be individualized based on the person's strengths, needs, culture, and preferences.
      4. Build on the person's natural skills, talents and interests.
      5. Be reflective of the person's goals (e.g., at one year, five years, and beyond), and dreams for the future, as well as written in first-person.

6. Address skill development to achieve the person's goals in the PCP; skill development is tied to the person's valued outcomes.
7. Take into account what should be avoided/what the person doesn't want in their life.
8. Collectively find a balance between the person's desires and safety concerns.
9. Be an action plan with steps to be taken, along with realistic timelines and measurement for goals.
10. Have "dignity of risk"
    a. Identify the supports needed to accomplish the PCP.
    b. Refer to Michigan document section on "Wellness and Wellbeing" as resource.

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

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

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

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

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

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

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

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

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

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