Minnesota Department of **Human Services**

Rule 40 Advisory Committee Meeting Summary: 2.8.13

Attending:

Committee members: Steven Anderson, Kay Hendrikson, Anne Henry, Pat Kuehn, Tim Moore, Kelly Ruiz, Annie Santos, Bonnie Jean Smith, Gloria Steinbring and Colleen Wieck

DHS Staff: Rick Amado, Alex Bartolic, Stacy Danov, Gail Dekker, Jill Johnson, Jennifer Kirchen, Bob Klukas, Sandra Newbauer, Larraine Pierce, Dean Ritzman, Michael Tessneer, Suzanne Todnem, and Charles Young

Other Organizations and guests: Mark Anderson (Barbara Schneider Foundation), Rick Cardenas (Advocating Change Together), Joe Fuemmeler (Chrestomathy, Inc.), Brad Hansen (The ARC Greater Twin Cities), Renee Jenson (Barbara Schneider Foundation), Gail Lorenz (Barbara Schneider Foundation), Chris Michel (Office of Ombudsman for Mental Health and Developmental Disabilities), Michelle Ness (MDH), Kelly Ryan (Chrestomathy, Inc.) and Cheryl Turcotte (Office of Ombudsman for Mental Health and Developmental Disabilities)

Committee Charge. The Rule 40 Advisory Committee was formed as part of the Jensen Settlement Agreement. The committee will study, review and advise the Department of Human Services (DHS) on how to modernize Rule 40 to reflect current best practices. This was the eleventh meeting of the Rule 40 Advisory Committee, which met from 9:00 a.m. to 3:00 p.m.

Presentations. The Committee heard a brief update from Alex Bartolic.

Alex Bartolic. Alex Bartolic praised the committee for their work and noted that after many revisions, the committee's "Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40" (recommendations) document looks very good as it nears completion. The department will revise the document after today's meeting to reflect comments about the document. The department will offer committee members a chance to review the finalized document before publishing the document. Committee members will have a brief opportunity to respond to targeted questions about the revised document before publication. Ms. Bartolic shared information about the department's next steps that are relevant to the committee's work. The department is proposing bills at the legislature that ask for:

1. Broader rulemaking authority than the current Rule 40;

2. Funding to provide a statewide license that will give long-term service and support providers (waiver providers, home care, ICF/DD, etc.) access to all of the online training curriculum that is available through the College of Direct Supports;

3. The authority to collect data on an interim basis, and to build a centralized system to capture incident reporting, including any emergency use of manual restraints, using the common entry point vulnerable adult system;

4. Full-Time Equivalent position to work on psychotropic medications;

5. Staff to provide technical assistance to providers that are encountering challenges or to address challenges, such as when a person is ready to be discharged from a facility to a community setting, but no appropriate placement is available for the person. The department will try to help persons avoid civil commitment and will also monitor instances in which a person has two or more emergency room visits that are unrelated to a known medical condition; and

6. Funding to provide training and technical assistance on person-centered approaches and positive practices.

The Governor's budget will leverage training on person centered practices and positive strategies that are funded through the Money Follows the Person grant. The department is preparing a Request for Proposal (RFP) to identify providers and lead agencies, who want to benefit from more intensive training and technical assistance as a step in building a culture change throughout the system.

Ms. Bartolic addressed concerns about the applicability of Minnesota Statutes, Chapter 245D, where some of the committee's recommendations will be placed. Minnesota Statutes Chapter 245D applies to home and community based services. Other divisions in the department will review their own regulations and compare them to the committee's recommendations. It is likely that Minnesota Statutes, Chapter 245A will eventually include more components related to the committee's recommendations.

Ms. Bartolic explained that although the modifications to Minnesota Statutes, Chapter 245D has been submitted to the Revisor, the department is still working with stakeholders and considering changes they recommend as possible author amendments during the legislative process. Ms. Bartolic reminded the group that the current proposed Minnesota Statutes, Chapter 245D language includes policy elements from the committee's recommendations and are intended to support the intentions and principles outlined and agreed upon by the committee.

The implementation plan for changing current treatment practices is still in development as the department carefully crafts a design to add new standards and repeal old standards without

creating regulatory gaps during the regulatory change process. There are also shifts in how people choose to receive services with the continued interest in self-direction and different approaches to support that aren't reliant on licensed settings. With all the moving parts, the implementation plan must be thoughtful and well-coordinated.

Survey results

Committee members had been asked to respond to a survey to measure their levels of support for each section of the committee's recommendations draft. Suzanne Todnem went over the survey responses with the committee members at the meeting to explain which items DHS thought should be discussed further at this meeting.

Recommendations draft

Committee members received a revised draft of the "Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40" document on January 29th. Ten of the fourteen committee members completed the survey mentioned above.

Committee members were given time to review the document and then asked to complete a survey to help DHS better understand the following:

- where there is consensus on the document and the recommendations among committee members and
- where we need additional discussions in order to finalize the committee's recommendations at the February 8th meeting.

Based on the survey results, two agenda items emerged:

1) use of seat belt restraints and

2) use of arm limiters and mechanical restraints or devices for self-injurious behaviors. Because this was the last Rule 40 advisory committee meeting, the discussion was focused on the committee members. The discussion process was:

1. Round-robin comments from committee members;
2. Committee member discussion, time-limited;
3. Non-member input, time-limited;
4. Committee member discussion; and
5. Committee members move to a final recommendation

<u>Seat belt restraints discussion</u>

The survey results indicated general endorsement of permitting the use of seat belt restraints. However, because there were two votes for "Agreement with reservations" and two votes for "Formal disagreement without support," the topic was added to the agenda. At the meeting, one committee member requested a correction of her survey vote that changed one of the formal

disagreements to a vote of full endorsement. Despite the stronger endorsement by committee members, committee members still felt the topic warranted discussion.

The advisory committee initially recommended a complete ban of all use of mechanical restraints except for medical conditions that required medical restraints. Initially use of seat belt restraints was raised as a possible exception to the ban. Committee members discussed the issue on multiple occasions in the past, but had not come to consensus on a clear recommendation. Coupled with the survey results, the issue was revisited for final recommendation.

Committee members engaged in lengthy discussion about this recommendation. Discussions examined and weighed the conflicting aspects of using seat belt restraints. Substantial discussion revolved around best practices. Subject matter experts attending the meeting informed the committee that best practice is to start where the person is and move the person to a better quality of life by utilizing person-centered practices. These could include using the seat belt clip for a period of time. However, the use of a seat belt clip must be applied using person-centered practices. Some committee members stated more data on the current use of seat belt clips would be helpful.

In the end, committee members recommended permitting the use of seat belt restraints within certain parameters:

1. Use takes place within a plan to eliminate the use of seat belt restraints;
2. Use for transition purposes only;
3. Use will be carefully defined (especially as it applies to children who are subject to different seat belt laws);
4. Use of seat belt restraints would be in the context of and subject to all the other committee recommendations including:
    a. Person-centered planning standards
    b. Positive support strategies standards
    c. A person-centered plan to eliminate the dependency on seat belt restraint use
    d. Staff are trained and have demonstrated competence
    e. Restrictive procedure reporting standards
    f. Monitoring of use and of the person standards
    g. Review standards
5. Seat belt restraints would not be used to force a person to go somewhere they did not want to go (exceptions include a medical emergency in which an ambulance was not used.). The

seat belt restraints would only be used to transport a person lawfully to a place they wish to go.

6. Use of seat belt restraints could not be for:
    a. Staff convenience
    b. In lieu of adequate staffing
    c. Punishment

Arm limiter discussion

Based on the survey results, committee members endorsed permitting use of arm limiters. The department posed a question to committee members: In terms of creating policy, DHS wanted to ask the advisory committee whether its recommendation applies only to arm limiters, which is a specific mechanical restraint, or whether its recommendation extends to permitting mechanical restraints or devices for self-injurious behaviors, such as helmets. Are there other mechanical restraints or devices they would permit? The department understood the use of mechanical restraints or devices would be permitted only under the following conditions:

1. The person engages in repeated and serious self-injurious behaviors, that is, a behavior that causes tissue damage or internal damage, such as brain injury, internal bleeding, and so on, and would be subject to high rates of manual restraint without the devices.
2. The use of less restrictive methods than use of the restraint or device would not achieve safety for the person.
3. The use of a mechanical restraint or device cannot be used:
    a. For staff convenience
    b. In lieu of adequate staffing
    c. As a punishment
    d. To coerce or force a person to do something the person does not want to do or to prevent the person from doing something the person does want to do, apart from preventing further self-injury.
4. The application of a mechanical restraint or device is the minimum needed (by type and by length of time) to prevent further self- injury by the person.
5. There is a written, person-centered plan with positive support strategies to wean the person off of all restraints. The goal is to eliminate the use of the restraint or device as soon as possible.

6. The provider must document implementation of the plan and the results.

7. The provider must follow all reporting and review requirements.

8. Only designated staff with the appropriate level of training and demonstrated competence may apply the restraint or device.

9. Progress in meeting goals of the plan is overseen by an appropriate, highly qualified professional.

10. If progress toward meeting the goals of the plan plateaus, the provider is responsible to consult with an appropriate professional. The provider is responsible to make changes to the person's plan as recommended by the professional, to train staff in the changes, and to implement the changes.

Committee members discussed whether their recommendation was limited to arm limiters or possibly to other mechanical restraints to prevent self-injury, such as helmets. One challenge committee members encountered was if they were to broaden their recommendation to allow the use of other mechanical restraints used to limit self-injurious behavior, would the committee need to recommend a list of acceptable mechanical restraints or to describe acceptable restraint items?

Some committee members did not want the use of mechanical restraints to be labeled a "permitted" technique. Rather, the use of mechanical restraints would be a "limited transitional use" technique that providers would be allowed to use within certain parameters. There was concern that using the word "permitted" for such mechanical restraints created a slippery slope and communicated an unintended message to providers.

The committee opened the discussion up beyond just arm limiters to the use of mechanical restraints for self-injurious behavior. This created some confusion and the distinction between the two was unclear.

It was clear that the committee members agreed that there should be some allowance for addressing life-threatening and serious self-injurious behavior that includes some use of mechanical devices. The challenge is how to describe it. The committee members elected to state their intent and declare that more work should be done.

The committee's intent regarding mechanical restraints for self-injurious behavior:

1. Arm limiters may be used if a person engages in repeated and serious self-injurious behaviors. Serious self-injurious behavior is a behavior that causes tissue damage or internal damage, such as brain injury or internal bleeding, such that without the use of arm-limiters, the person would be under continuous manual restraint.
2. The goal is always to eliminate the use of any restraint
3. This is done by:
    a. Applying best practices
    b. Working from a person-centered plan to move the person off the restraint
    c. Using positive supports

    d. Meeting the person where they're at
4. The use of restraints is reported
5. The use of restraints is reviewed internally and externally
6. Oversight of progress toward meeting goals of person-centered plan is by an "appropriate professional." The term "appropriate professional" must be defined.
7. Consultation is available to the provider and provider must seek consultation if person "plateaus." The term "plateau" must be defined.
8. The use of any mechanical restraint or device is not permitted:
    a. For staff convenience
    b. In lieu of adequate staffing
    c. As a punishment
    d. To coerce or force a person to do something they don't want to do or to prevent them from doing something they do want to do, apart from preventing further self-injury.
9. The provider must document implementation of the person-centered plan and its results.
10. Only designated staff with the appropriate training and demonstrated competence may apply the restraint or device.
11. The application of a mechanical restraint or device is the minimum needed, by type and by length of time, to prevent further self-injury.

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

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