Minnesota Department of **Human Services**

Rule 40: Implementation Work Group Summary – <u>REVISED</u>
Rule advisory committee's recommendation to DHS

Attended one or both work group meetings:
Rick Amado, DHS-SOS; **Mark Anderson**, Barbara Schneider Foundation; **Don Chandler**, DHS-SOS; **Erwin Concepcion**, DHS-SOS; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, OMHDD; **Brad Hansen**, Arc Greater Twin Cities; **Anne Henry**, Rule 40 Advisory Committee Member, Minnesota Disability Law Center; **Renee Jenson**, Barbara Schneider Foundation; **Jill Johnson**, DHS-CMH; **Bob Klukas**, DHS-rules; **Pat Kuehn**, Rule 40 Advisory Committee Member, Ramsey County; **Chris Michel**, OMHDD; **Tim Moore**, Rule 40 Advisory Committee Member, U of M; **Dean Ritzman**, DHS-DSD; **Lauren Siegel**, DHS-DSD; **Mike Tessneer**, DHS-Compliance **Charles Young,** DHS-DSD; **Suzanne Todnem,** DHS-DSD, project lead; **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. Initial implementation – the process and key elements
   A. Overarching process
      1. Preparations – now, getting the conversations started
      2. Legislation, rulemaking, manual, waiver amendments
      3. Pre-implementation
      4. Adherence to new standards
      5. Evaluation
      6. Maintenance
   B. Getting culture change buy-in from all parties including: (who)
      1. Agency
      2. Provider executives and owners
      3. Provider management
      4. Direct care staff
      5. Persons, families, guardians, parents
      6. Counties
      7. Community, including advocacy groups, psychiatrists, medical doctors
   C. Culture change – how and why we get it
      1. Communicate with II.B.1-7:
         a. What is permitted under the new rule or statute
         b. What is prohibited under the new rule or statute
         c. Dates/deadlines for implementing the transition, based on data and evidence
         d. Benefits of the change (including financial, moral, professionalism, etc.)
      2. Emphasize the purpose of implementing the new policy is to increase safety for everyone involved in crisis situations
      3. Provide a historical perspective to explain why this change is necessary
      4. Change the conversations in the industry; use precise and careful language
         a. E.g., eliminate the phrase "inappropriate behavior" to recognize the function of ALL behavior
      5. Change the service framework (from paternalistic to choice)

6. Use stages of change model: Pre-contemplation, Contemplation, Preparation, Action, Maintenance, Relapse Prevention
7. Emphasize skill building and creation; replacement of current tools
8. Share success stories – including the most challenging situations
9. Use and align funding with goals of the change
10. Promote and encourage organizational development

D. Provide resources and technical assistance
1. Crisis resources
2. On-site mentors
3. Telepresence, online training and other technology utilized
4. Functional Behavior Assessment
5. Experts available to work through individual cases (not just hotline access)

E. Incentives – for the provider and the person served
1. Rewards
2. Honors
3. Money
4. Certification
5. Based on outcomes; pay for performance

F. Expectations
1. Ramp-up approach, graduated implementation process
2. Be prepared for imperfect implementation; "hiccups"
3. Providers and staff must know:
    a. New requirements
    b. Deadline(s) for implementation (process)
4. Implementation deadline dates will be informed by data and not arbitrary

G. Implementation process values
1. Transparency – the process should be transparent to providers, persons, stakeholders, the public, etc.
2. Alignment – use positive practices with the providers
3. Collaboration; team approach; avoid "us-them" atmosphere; DHS helps providers and persons
4. Flexibility, including accommodating different learning styles and access needs
5. Recognize varied levels of provider competencies
6. Oversight and accountability
7. Attainable while continuously striving to outperform previous accomplishments
8. Teaching – provide resources in a way where the provider learns, gains competence

H. Timing options
1. Various delay/gap approaches between implementation of new standards and enforcement of new standards
2. Stages by provider; providers develop implementation plan for themselves:
    a. State sets deadline for systems change
    b. Baseline data from providers to DHS by Date A
    c. Provider creates their own implementation plan by Date B, includes a plan for each person in care and what training is necessary
    d. All plans must be implemented by Date C unless provider asks for and receives a variance

I. Evaluation
1. Use formative data to make changes
2. Use implementation science experts

III. Sustaining the changes

A. Provide resources and technical assistance

B. Define future role of CSS, MCCP, COPE and Adolescent Crisis Services

C. Building capacity

1. Train trainers
2. Coordinate with educational institutions on courses and degrees to create a new generation of professionals aligned with the needs of the new standards in Minnesota

Note

There are additional comments and additional recommendations below from the September advisory committee meeting. Additional Recommendations added new items to the recommendations of the work groups. Sometimes Comments are repeated as Additional Recommendations; this is intentional. The requested changes to the summary and recommendation above have already been directly implemented above.

IV. Additional comments on recommendation summary

A. Committee is making large, expensive recommendations. Among all your recommendations, what is non-negotiable vs. nice to have? What are the costs/fiscal note of these recommendations?
    1. Response: Difficult to respond to this, because changing a culture does take resources.
    2. Response: When comparing costs, remember to include not just direct costs, but also downstream costs, such as fewer emergency hospital admissions.

B. There should be an interdisciplinary steering committee to guide the implementation of these changes.
    1. The steering committee should focus on language and terms to be used in conversations to change culture.
    2. Yet, practices must change, not just conversations. Our approach to change doesn't have to be sequential; we can promote change on multiple levels at the same time.
    3. Research other states' approach to large-scale culture change.

C. Address safety concerns.

D. Consider the readiness of providers to make change. Types may include:
    1. "We are there already!" (Early adopters)
    2. "We work with people with challenging behaviors and do Rule 40 plans. We do it right and don't need to change anything." (Yet this is a real change that they may not accept the need for.)
    3. "This change doesn't affect us because we don't serve people with challenging behaviors." (This group may not realize that the people they serve, even if they are not challenging, are not getting the supports they need.)

E. Concern about reaction from parents and guardians. Communicate with them about the change early and often.
    1. What is the family's incentive to adopt the changes? Does any incentive to change go only to providers? Can some incentives go to the person? Incentives would help the family.

F. Transparency requires data. We need to know how many people are having restraints used on them, how often restraint is used, where it's happening, what injuries are caused by restraint, etc.
    1. We also need to know about the person's plan, positive and negative impact of changes.

G. Establish a way for providers to mentor providers. Create a technical assistance (TA) team. Highlight providers who do well.

H. Incentives need to reach direct service staff. It's not okay for any financial incentive to go only to the pocket of the CEO.
I. DSD should have someone lead the implementation of these changes who has experience managing large system change and social policy implementation.
J. Community buy-in must include psychiatrists and MDs regarding the use of medications.

V. Additional recommendations

A. DSD and the steering committee should look to other states for implementation approaches.
B. DSD should have help developing a data and research design to measure its success as it implements the new policies.
C. Providers' organization implementation plans must include how they will transition persons from Rule 40 programmatic use of restraints.
    1. There needs to be oversight of providers' plans.
    2. There needs to be support for providers who currently use Rule 40s.
D. Engage parents, guardians early and ongoing to address concerns that some parents may have about these changes. See II.B.5. above
E. Engage advocacy groups, too. See II.B.7. above
F. Community education and outreach must include psychiatrists and MDs regarding the use of medications.
G. Implementation must address providers at all stages of readiness for change.