External Program Review Committee (EPRC): Annual evaluation report

Positive supports: Strategy 2C

January 2020

Disability Services Division
External Program Review Committee
540 Cedar Street
St. Paul, MN 55101
(651) 431-4974

PositiveSupports@state.mn.us

https://mn.gov/dhs/partners-and-providers/program-overviews/long-term-services-and-supports/positive-supports

Contents

For accessible formats of this information or assistance with additional equal access to human services, write to positivesupports@state.mn.us, call 651-431-4974, or use your preferred relay service. ADA1 (2-18)

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

Examples of work completed

The External Program Review Committee (EPRC) is tasked with annually evaluating progress and determines if there are additional measures to be taken to reduce the use of mechanical restraint. Due to the small number of providers using mechanical restraint, the committee is able to monitor progress on an individual level.

For the EPRC to give the commissioner a recommendation to approve the use mechanical restraint, service providers must demonstrate that the restraint is necessary to protect the person, as well as demonstrate good faith effort(s) to eliminate the restraint. Complete details about the requirements can be found under Minn. R. 9544.0130. Good faith effort can be demonstrated in many ways and is different for each person depending on their needs. Here are some examples of good faith efforts demonstrated by providers who have submitted requests for approval to use mechanical restraint:

- Collection of context, antecedent, behavior and consequence data to identify what might trigger or reinforce a behavior
- Assessment of the function[1] of a behavior(s) that includes biological, psychological, environmental and quality of life factors
- Development of person-centered plans that identify things that are important to each person and important for them
- Consultation with experts on positive supports
- Medical appointments and consultation with specialists
- Medication reviews
- Work with occupational therapists to address sensory needs
- Coordination with Technology for Home to develop new methods for supporting independence and choice
- Meetings with committee representatives to discuss plans of care
- Increased community inclusion such as attending music events, spending time with friends and family, visiting parks, celebrating birthdays, etc.
- Home modifications and redesigns
- Vehicle modifications
- Increased or changes to staff training
- Routinely reporting updates to committee representatives
- Routinely updating plans of care to reflect changes and current best practices that are specific to the person
- Purchase of items such as interactive toys, sensory chews, headphones, tablets, etc.
- Coordination with schools and other service providers
- Teaching or reinforcement of safe behaviors that can replace interfering behaviors
- Use of augmentative and alternative communication devices
- Increased quality of life, such as supporting relationships with friends and family, supporting people to belong to their communities, supporting people to express their gifts and talents, etc.

[1] Behavior is related to many things. It always has a purpose or a function. This does not mean that the behavior is voluntary or used consciously. Examples of purpose and function are getting something, avoiding something undesirable or enjoying something. Some behaviors, like unexplained movements or sounds, can be neurologically based and cannot be changed with behavioral interventions. These behaviors often just "seem to happen." While the person has no control over these behaviors, sometimes the person or staff find that certain stimuli in the environment may trigger their occurrence.

Past recommendations

Below are the five recommendations made by the committee in their 2018 annual evaluation report:

1. The committee will continue to provide technical assistance to teams for cases that have had little movement toward phasing out mechanical restraints. The committee encourages evidence-based practices and places an emphasis on quality-of-life measures that align with the person's values.
2. One type of assistance the committee has and will continue to offer is help with finding more highly trained positive support behavior professionals who can support the current service provider.
3. The committee will continue conversations with teams and help them improve their data-collection and analysis methods.
4. The committee will review best practice literature on seat belt buckle restraints. The committee will review Minnesota data already collected, analyze the information and share the results.
5. The committee recommends DHS and other state representatives implement the Olmstead Plan Workplan – Direct Care and Support Services Workforce to continue to address the direct support staff workforce shortage.

Actions taken on the recommendations

Throughout 2019, the EPRC has continued supporting teams and has provided suggestions on how to move towards eliminating the use of restraint. For detailed case examples, see the "Examples of work completed." More generally speaking, the committee has taken the following steps to make this happen:

- Every document submitted by expanded care teams, such as Positive Support Transition Plans and functional behavior assessments, has been individually reviewed by committee representatives. After each review, the committee provides recommendations on how to improve the assessments/evaluations and subsequent support plans.
- A committee representative has visited every person and their provider. Regular ongoing support has been offered to each provider.
- Every provider has been contacted through multiple means of communication to promote regular interaction, including onsite visits, email, phone and standard mail.
- Every provider is either receiving support from additional services or has shown significant decreases in the use of the prohibited procedures. Additional services include things like Positive Support Services, Technology for Home, person-centered planning services and Community Support Services.
- Committee members have been working in pairs, and each pair is serving as an ongoing resource for support and technical assistance for each service provider. The pairs have in-depth knowledge on each person they are assigned to.

The committee also reviewed the best practice literature on seat belt restraints since that is the most common restraint currently being used. However, there is limited information available on this topic. Additionally, the committee reached out to other states and discovered other states do not require state-level approval to use seat belt restraints. The committee also reviewed data from specific people who have approval to use these devices (as a means to phase them out), and discovered that many of these people's family members do not support discontinuing the use of seat belt restraints due to a variety of concerns such as safety, loss of services and reduced community inclusion and outings.

Finally, as recommended, DHS has continued to implement the Olmstead Plan Workplan — Direct Care and Support Services Workforce to address the direct support staff workforce shortage. Some of their accomplishments include:

- Partnered with the Institute on Community Integration to conduct a study of direct care workers
- Continued implementation of the workplan passed by the Olmstead subcabinet in October 2018
- Continued Direct Care Workforce Shortage Cross-agency Steering Team meetings to monitor the plan and share best practices
- The Metropolitan Center for Independent Living (one of the members of the above mentioned group) received a Bush Foundation Grant for over $200,000 to address workforce shortage issues

Data on requests for approval

Overall, the use of mechanical restraint in Minnesota has significantly decreased since the implementation of the Positive Supports Rule. The remaining people are closely monitored by the committee and have many competent professionals working to find alternatives.

Year	Total approvals granted	New approvals	Renewed Approvals	Approval ended
2014	28	28	0	0
2015	23	4	19	9
2016	18	5	13	10
2017	13	2	11	4
2018	12	0	12	1
2019	13	3	9	2

Assessment of trends

Seatbelt harnesses and guards

Over time, members of both the Interim Review Panel and External Program Review Committee noticed teams struggle more with phasing out the seat belt harnesses/guards than phasing out mitts, arm splints or helmets. For example, of the seven people who had approval for a seat belt harness/guard in 2014, four still had approval in 2018. In comparison, of the 21 people who had approval for other types of mechanical restraint in 2014, only two still had approval in 2018. As of December 31, 2019, 6 of the 10 approved requests for prohibited procedures are for seat belt harnesses or guards.

One explanation for the observed difference between seat belt restraints and other restraints is the setting. It is unsafe for staff to unbuckle to assist a person in a moving vehicle. Pulling over can be dangerous or impossible on busy roads. Often staff are unable to sit in the back seats, either because the person has a history of aggressing towards other passengers or because the vehicle does not have backseat space for staff due to adaptive seating. Even when staff do sit next to the person, the emergency use of manual restraint is often not an option because staff cannot adequately position themselves to implement a hold safely. Unbuckling and other challenging behaviors can be distracting to the driver, which puts passengers, other vehicles and pedestrians at risk.

Providers have conducted functional behavior assessments that have indicated some of the difficulties around driving for some people include not knowing where the vehicle is going, finding the motion disruptive, not wanting to leave where the person had just been, noises and motion sickness. Understanding the safety necessity of wearing a seat belt can be an abstract topic in conversation. Hence, it takes many teaching trials with repeated practice. It also requires understanding of long-term and low-likelihood cause-and-effect relationships. Although this is an unusual type of

mechanical restraint, providers are still exercising due diligence, considering unsafe vehicular behavior as challenging behavior and completing all necessary documentation to be compliant with best practices and regulation.

The legal constraint of seat belt laws put service providers in a difficult position when the person does not remain buckled. According to the Minnesota Office of Traffic Safety, "Minnesota's seat belt law is a primary offense, meaning drivers and passengers in all seating positions — including in the backseat — must be buckled or in the correct child restraint. Law enforcement will stop and ticket unbelted drivers or passengers. A seat belt ticket is $25 but can cost more than $100 with fees." Service providers also are legally liable for the health and safety of the people served. State law requires service providers:

- Follow procedures to ensure safe transportation, handling and transfers of the person and any equipment used by the person, when the license-holder is responsible for transportation of a person or a person's equipment
- Be prepared for emergencies and follow emergency-response procedures to ensure the person's safety in an emergency.

It is important to highlight that the inability to use seat belt harness/guards might contribute to reduced community participation, which is contrary to the Olmstead vision. The EPRC continues to closely monitor this area and provides recommendations as appropriate to each person.

Future recommendations

- Continue the past recommendation to collaborate and build connections with expanded care teams so the subcommittee can continue to assist with the development of effective fading plans on mechanical restraint. Also, continue to help service providers connect with other professionals that can inform supports and services.
- Update the Positive Supports Rule (MN Rule 9544) assessment, commonly referred to as the PSR 100 available on TrainLink, to ensure it accurately measures the ability of qualified professionals to conduct functional behavior assessments that inform Positive Support Transition Plans. The PSR 100 is currently the commissioner's assessment required under Minn. R. 9544.0020 Subp. 47 and Minn. R. 9544.0040 Subp. 1.
- Re-review quality of life measures in Positive Support Transition Plan Reviews, DHS form 6810A, and evaluate if there are additional tools or methods for creating a more comprehensive picture of each person's life.
- Continue the past recommendation that DHS and other state agency representatives implement the Olmstead Workplan that addresses the workforce shortage, which was developed by the Direct Care Workforce Shortage Cross Agency Steering Team.

Background

What this report covers and doesn't cover

This report covers the use of mechanical restraint reviewed and monitored by the committee, then approved or denied by the Commissioner of Human Services. It does not include:

- Use of mechanical restraint by service providers who meet the requirements to do an 11-month phase out via a Positive Support Transition Plan, DHS-form 6810. Committee review and commissioner approval are not immediately required when providers meet certain requirements under Minn. Stat. 245D.06, subd. 8 and the Positive Support Transition Plan Instructions, DHS-form 6810B. However, if providers need more than 11 months to safely phase out restraint, they must contact the committee for a review and seek commissioner approval.
- Use of mechanical restraint in secure, locked treatment facilities that serve people who are mentally ill and dangerous. Mechanical restraint used within these facilities is outside the committee's purview, and therefore committee review and recommendation for approval or non-approval is not required. Restraint use is monitored through other means. For example, the Minnesota Sex Offender Program and the Minnesota Security Hospital have licensed, professional teams (psychologists, psychiatrists, social workers, vocational and recreation counselors) on-site who develop and monitor patient-centered treatment plans and review each use of mechanical restraint by staff. DHS Licensing also reviews use of mechanical restraint in these facilities and monitors for compliance with state statute and rule.
- Uses of mechanical restraint implemented outside the guidelines provided in rule or statute. Those reports are handled by either DHS positive supports staff or Licensing.

The purpose of the committee

The committee is responsible for the duties and responsibilities listed under Minn. Rule 9544.0130. The duties include:

1. Making recommendations to the commissioner about policy changes related to the requirements in Minn. Rule 9544
2. Making recommendations to the commissioner to approve or deny request for the emergency use of procedures
3. Reviewing reported emergency use of manual restraint and providing guidance to the license holder on how to reduce the use of restraint

This report focused on work completed under #2: making recommendations to approve or deny requests, which currently only includes mechanical restraint because no other prohibited procedures were requested in 2019. This work is conducted by a subcommittee that includes positive support specialists, mental health professionals and licensed health professionals. The member profiles are listed below.

Subcommittee representatives

Laura Daire has a Bachelor of Science in biology and psychology. With over 10 years of experience in the field, she has worked as a direct support professional in residential and day treatment programs for people with intellectual disabilities. She currently serves as an assistant executive director for a residential provider. In this role, she has had the opportunity to teach those she serves positive support strategies that have given them the tools to go from a life with minimal community integration to spending time with their families and friends, maintaining gainful employment and minimizing challenging behaviors.

Dr. Danielle Bishop is a clinical pharmacist with board certification in the area of psychiatric pharmacy. As a member of the EPRC, she works to identify opportunities where medication optimization may lead to positive outcomes. She has provided pharmaceutical care for over 15 years in both community-based and inpatient mental health settings. Team-based, person-centered care and evidence-based psychopharmacology have been focuses throughout her career to ensure safe and effective use of medications.

Barbara White is currently a surveyor with licensing and certification for the Minnesota Department of Health, with over 15 years of experience evaluating services to individuals with developmental disabilities at group homes. She is a registered nurse with over 40 years of experience, working in acute care and community based mental health services. She worked as a consultant nurse with Community Support Service through DHS and provided person-centered positive support planning for clients with developmental disabilities.

Dr. Dan Baker is with the Minnesota Department of Human Services, where he serves as the Positive Support Compliance Specialist and Internal Reviewer with Quality Assurance and Disability Compliance Services. He is involved with the design, development and monitoring of treatment programs to align with the Positive Supports and a person-centered culture. His clinical focus is on positive behavior support, models of community and educational support, transition services and mental health services for persons with disabilities. He is a Certified Compliance and Ethics Professional.

Stacy Danov, Ph.D., LP, has experience working as a Psychologist implementing person-centered practices and positive behavior supports and in Minnesota. She completed her doctorate in Educational Psychology from the University of Minnesota. She also has a certificate in Autism Spectrum Disorders from the University of Minnesota. She currently works for DHS on the Community Capacity and Positive Supports Team as the Clinical Coordinator. Her work includes providing clinical direction and leadership in the design, development and monitoring of improved supports and services that are consistent with evidence based practices. She is a certificated Person-Centered Thinking and Person Centered Planning Picture of a Life trainer. She presents locally and nationally on her work in positive behavior supports and person-centered practices including presentations for the Home and Community Positive Behavior Support Network of APBS. She is a founding member of the Minnesota Positive Behavior Support Network and is an active member of the Learning Community for Person Centered Practices.

Melanie Eidsmoe has a Bachelor of Arts in sociology and social work and is a Licensed Social Worker. With over 14 years of experience in the field, she has worked as a direct support professional and supervisor in residential programs for people with intellectual disabilities. She currently serves as an assistant director for a residential provider. In her roles, she has had the opportunity to implement and teach positive support strategies. She has successfully provided people with the tools they need to go from a life with minimal community integration to spending time with their families and friends doing things that are important to them.

Kim Frost is a Board Certified Behavior Analyst with 20 years of experience in the field of intellectual and development disabilities. She started volunteering at the Delaware Psychiatric State Hospital in 1997, where she was first exposed to monitoring patient behavior and evaluation of progress. She then began her career working in a group home with disabled adults that had recently transitioned from a state run institution to a community-based home. It was through that experience that she first learned about the importance of choice and person-centered planning. For the following five years, she decided to switch her focus and began training as an early intervention behavior therapist for children on the autism spectrum. She was then exposed to applied behavior analysis, which paved the road to where she is today: working with adults with intellectual and developmental disabilities in a Day Training & Habilitation setting.

Stacie Enders is not a committee member but works as the DHS coordinator for the committee through the Community Capacity and Positive Supports team. She holds an undergraduate degree in middle school education and a graduate

degree in public administration. She has over a decade of experience promoting the use of positive supports for people with developmental disabilities as a schoolteacher, home and community-based service provider, and Minnesota DHS employee. Her work was recognized by the Arc of Denton County, Texas as the 2014 Community Support Person of the Year.

Linda Wolford currently serves as the Interagency Coordinator for the Community Capacity and Positive Supports team of the Disability Services Division and is a backup for Stacie Enders on staffing this committee. She has an undergraduate degree in criminal justice studies and Masters in Counseling Psychology with a rehabilitation emphasis. She coordinates employment, workforce shortage and other Olmstead initiatives across DHS and other state agencies. In addition, she currently is the co-chair of the Employees with Disabilities Employee Resource Group for DHS. She formerly worked at DHS doing home care policy, working on employment initiatives and consumer directed personal care assistance services under several federal grants. She has completed two years of training in person-centered coaching. In her over 30-year career, she has worked in the fields of disability and diversity in higher education, for the State and for several nonprofits. She has also provided training and consultation on disability at both the local and national levels.