



Minnesota Department of **Human Services**

**Rule 40 Advisory Committee Meeting  
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September 7, 2012, 9:00-4:00  
444 Lafayette Road, Room 3148**

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Minnesota Department of **Human Services**

**Rule 40 Advisory Committee  
444 Lafayette Road, Room 3148  
September 7, 2012  
Agenda**

- I. Opening (9:00-9:15) Gail Dekker
  - A. Introductions
  - B. Agenda review and handouts
  
- II. Update and October meeting (9:15-9:30) Alex Bartolic
  
- III. Review Emergency Restraint work group work (Handouts 2-6) Committee
  - A. Work group representatives report to committee Kay Hendrikson, Barbara Kleist
  
- IV. BREAK (10:30-10:45)
  
- V. Review Emergency Restraint work group work (Handouts 2-6) Committee
  - A. Committee discusses to move to final recommendation
  
- VI. Review Implementation work group work (Handouts 7-11) Committee
  - A. Work group representative reports to committee Tim Moore, Pat Kuehn
  
- VII. LUNCH (12:00-12:45)
  
- VIII. Review Implementation work group work (Handouts 7-11) Committee
  - A. Committee discusses to move to final recommendation
  
- IX. BREAK (1:45-2:00)
  
- X. Review Training work group work (Handouts 12-16) Committee
  - A. Work group representative reports to committee Kelly Ruiz
  - B. Committee discusses to move to final recommendation
  
- XI. Closing (no later than 3:50-4:00) Gail Dekker
  - A. Meeting evaluation: What worked well for this meeting? What would you suggest to improve for October meeting?
  - B. Next meeting: October 22, 9:00-3:30, Lafayette room 3148



Minnesota Department of **Human Services**

**Rule 40: Emergency Use of Restraints**  
**July 16, 2012**  
**AGENDA**

**Welcome and introductions**

**Purpose**

Develop specific content of the new rule about emergency use of restraints. Consider implications for prohibited techniques.

**Product**

Content of this section of new rule (along with statute or manual content) to show entire Advisory Committee at August 6 meeting

**Givens**

1. Rule will apply to people with DD, but DHS will seek consistency for multiple service populations.
2. Rule will address behaviors, not just challenging or disruptive behaviors.
3. Rule will be accompanied by statute and manual.

**Resources**

1. Comparison Tables prepared by Dean Ritzer and Lauren Siegel.
2. Arizona materials

**Questions for the Group**

1. We're creating something new. We have been involved in various conversations about the rule and about emergency use of restraints, but we haven't all been in every conversation. So to give everyone a sense of how we each are looking at this topic:
  - A. Each person in a couple of sentences, tell us what you think emergency use of restraint looks like in the new rule. Give an example.
2. Will any mechanical restraints be permitted in emergencies? If yes, which ones?
3. What does your list of permitted emergency techniques consist of?
  - A. What about something like "techniques approved by the commissioner"?
  - B. Emergency deprivation – e.g., Shoelaces from a suicidal client?
  - C. Emergency seclusion or room time-out?
  - D. Emergency exclusionary time-out?
  - E. Emergency response cost? – e.g., can't go to the regular Saturday night movie because person acts out as everyone is heading out the door.
4. Describe what the least and most intrusive restraints look like; that is, on the spectrum of restraints, what do these look like?

**Emergency Use of Restraints Work Group**  
**Meeting Notes**  
**July 16, 2012**

Attending:

**Steve Anderson**, Rule 40 Advisory Committee; **Jane Brink**, LTC Ombudsman; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, MH-DD Ombudsman; **Anne Henry**, Rule 40 Advisory Committee; **Kay Hendrickson**, Rule 40 Advisory Committee; **Dan Hohmann**, MSOCS; **Renee Jensen**, Barbara Schneider Foundation; **Barbara Kleist**, Rule 40 Advisory Committee; **Bob Klukas**, DHS-Rules; **Annie Mullin**, Rule 40 Advisory Committee; **Dean Ritzman**, DHS-DSD; **Lauren Siegel**, DHS-DSD; **Suzanne Todnem**, DHS-DSD; **Cheryl Turcotte**, MH-DD Ombudsman; **Charles Young**, DHS-DSD; **Gail Dekker**, DHS-DSD, facilitator

**Purpose**

Develop specific content of the new rule about emergency use of restraints. Consider implications for prohibited techniques.

**Product**

Content of this section of new rule (along with statute or manual content) to show entire Advisory Committee at August 6 meeting

**Givens**

4. Rule will apply to people with DD, but DHS will seek consistency for multiple service populations.
5. Rule will address behaviors, not just challenging or disruptive behaviors.
6. Rule will be accompanied by statute and manual.

**Resources**

3. Comparison Tables prepared by Dean Ritzman and Lauren Siegel.
4. Arizona materials

**Questions for the Group**

5. Each person in a couple of sentences, tell us what you think emergency use of restraint looks like in the new rule. Give an example.

Comments

- A. One view: Narrow criteria for use of restraints
  - i. Criteria should be "danger to self or others."
  - ii. Emergencies are last resort only.
- B. Another view: Broader criteria for use of restraints
  - i. Criterion for use of restraint should include person-specific emergencies for each individual.  
Emergency should include risk for loss of housing or risk for criminal repercussions.
  - ii. There are some somewhat predictable situations. Create a crisis plan.
- C. We need a more specific term than emergency use of restraints because 245D defines emergency broadly, including natural disasters.
- D. Address personal safety issue, such as taking away or slowing down electric wheelchair when person is in danger of going down stairs.
- E. Restraints should be those that are proven by data to be safe and effective.
- F. All protections, reporting, review, and monitoring requirements apply to emergency use of restraints.

- G. It is not left to individual staff discretion to use restraints. If they use them, they must comply with all requirements of rule.
- H. Staff are trained and prepared.
- I. Trauma-informed care should be included in training.
- J. Focus should be on the person being restrained.
- K. Choice of restraint should be informed by person's trauma history.
- L. Imminent danger should be defined narrowly.
- M. Respect the person's dignity and rights.
- N. Refrain from punishing, shaming or traumatizing.
- O. The rule needs to speak to how to reintroduce the person back to the group activity
- P. The rule must also take care of others in the community.

### Follow-up Questions

#### 1. Whether property damage or threat to property is an emergency

- A. When a person engages in OCD behavior that leads them to destroy their own property, this is not an emergency. When a person engages in a chargeable or criminal destruction of property or risk of harm, then yes, this is an emergency.
  - i. Disagree; do we expect direct care staff to know what is criminal behavior?
- B. When a person threatens harm, it is not an emergency.
- C. Whose property matters for an emergency? Someone else's property only or also the person's own property? Destruction of personal property is not an emergency.
- D. When a person's wheelchair hits the facility's walls, providers have slowed the chair. This is not an emergency and should not be permitted. Address actions that affect a person's mobility.
- E. The right kind of training will preclude the need to ever use restraints.
- F. Disagree that property damage is an emergency. This is a slippery slope and needs to be off the table unless there's a personal injury to self or others.
- G. Distinguish between blocking and use of restraints. Blocking needs to be defined and should not be regarded as a restraint.
- H. Emergencies are unpredictable and permit response. Provide incentives to avoid erosion/slippery slope. Very concerned about use of predictable events being defined as an emergency.

#### 2. Whether emergencies are predictable; role of crisis plan

- A. Crisis plan may reference certain actions and restraints as a last step.
- B. Crisis plan is broader than use of restraints. Unsure about including restraints in a crisis plan.
- C. Use of emergency restraints needs to be individualized. What if a restraint is medically contra-indicated?
- D. Person's history, including the person's crisis plan, should follow the person to new providers.
  - i. This is part of trauma-informed care.
  - ii. Use of restraints should be part of history.
- E. Crisis plan should rule out certain interventions and recommend others. It is not aversive to reduce a behavior.
- F. Monitoring includes a quality assurance component. Use of restraints means that something is not working. Use of restraints must be reviewed by outsiders to make changes.
- G. We need better crisis intervention training.

#### 3. Are mechanical restraints permissible?

- A. Settlement agreement permits use of soft cuffs and Velcro straps.
- B. Vote: Should mechanical restraints be permitted?

Yes-1

No-4

C. Considerations:

- i. Require variances
- ii. Self-injurious behaviors: people may need helmets.
- iii. The interim implementation strategy must include robust training, a robust review process, positive practices developed for the person.
- iv. We need to consider and address the problem of a person moving from home or an unlicensed provider to a licensed provider. This person needs a plan or strategy for change.
- v. We need heightened scrutiny; we need a trigger.
- vi. Training needs to extend to night staff and relief staff for any plan to be effective.
- vii. What about training of parents?

4. Are seclusion and time-outs permissible?

A. Settlement agreement does not permit use of seclusion and time-outs.

B. Vote: Should seclusion and time-out be permitted?

Yes-0

No-13

C. Considerations:

- i. Define these terms and watch for consistency with mental health practice: seclusion, time out. Where is this permitted? In what situations?
- ii. Could a point of contention in hearing be that some providers believe that time-outs are safer than manual restraints?
- iii. Consider situation of preventing someone from resuming attacking a person through blocking? How to address the dilemma of protecting two or more clients' rights at the same time?
- iv. A time away after a prompt may be different—a problem solving technique. Does not deprive a person of reinforcing.
- v. No, time out is punishment.

5. Emergency Deprivation to Protect Person or Another from Imminent Harm

A. Should emergency deprivation be permitted, with full monitoring, reporting, review, etc.?

B. Vote:

Yes-4

No-1

Maybe-8

C. Considerations:

- i. I said maybe as long as it does not deprive person of things like food and water.
- ii. Can this maybe be a calming technique.
- iii. Need to consult and get outside help if this is permitted.
- iv. Need to improve training if this happens.
- v. Is temporary removal permitted in an emergency?
- vi. Does the Children's MH rule permit this?

- vii. This must be tied into person-centered planning and positive behavior supports to aid self-calming.

**Note: Group did not get to these questions.**

6. Will any mechanical restraints be permitted in emergencies? If yes, which ones?
  
7. What does your list of permitted emergency techniques consist of?
  - F. What about something like “techniques approved by the commissioner”?
  - G. Emergency deprivation – e.g., Shoelaces from a suicidal client?
  - H. Emergency seclusion or room time-out?
  - I. Emergency exclusionary time-out?
  - J. Emergency response cost? – e.g., can’t go to the regular Saturday night movie because person acts out as everyone is heading out the door.
  
8. Describe what the least and most intrusive restraints look like; that is, on the spectrum of restraints, what do these look like?



Minnesota Department of **Human Services**

**Rule 40: Emergency Use of Restraints**  
**July 26, 2012**  
**AGENDA**

- I. Welcome, introductions, housekeeping, agenda review Gail Dekker
  
- II. Starters
  - A. Purpose and product
    - 1. Develop standards on emergencies and emergency use of restraints. Consider implications for prohibited techniques.
    - 2. Some standards must be enforceable. Therefore, compliance must be observable and measurable.
    - 3. Your recommendations will go to the full Advisory Committee on August 6 for their review and acceptance or changes.
  
  - B. Givens (Revised)
    - 1. We will establish standards that will apply to people with disabilities
    - 2. Standards will be expressed in rule, statute and manual.
  
  - C. Resources Suzanne Todnem
    - 5. Comparison Tables prepared by Dean Ritzman and Lauren Siegel.
    - 6. Arizona materials
  
  - D. Review July 16 meeting notes. Gail Dekker
  
- III. Questions for the Work Group All
  - A. Definition of emergency: You discussed whether property damage or threat of property damage should be included in the definition of emergency.
    - 1. AZ includes “prevention of severe damage to property” as well as to prevent harm to self or others.
    - 2. Review meeting notes, page 2.
    - 3. Vote: Should “prevention of severe damage to property” be included in definition of emergency that could permit use of restraints?
  
  - B. What does your list of permitted emergency techniques consist of?
    - 1. Emergency deprivation. Example: taking away shoelaces from a suicidal client? Should this be permitted?
    - 2. Emergency seclusion or room time-out. Example: For certain persons, room time-out might be safer for person, other clients, and staff than manual restraint. Should it be permitted?
  
    - 3. Blocking apparatus or techniques. Example: Using a blocking apparatus or pad as defense against person hitting staff or others instead of manual restraint.



Should this be permitted?

4. Emergency exclusionary time-out? Example: Removing a person from an activity and positive reinforcement.
5. What about “techniques approved by the commissioner”? Example: This would be put in rule to keep the standards current.

C. Describe what the least and most intrusive restraints look like; that is, on the spectrum of restraints, what do these look like? Rationale: The staff and the client have to be considered when looking at what procedure is appropriate in a given emergency – so look at the range of what might be acceptable.

D. Non-emergency techniques

1. Graduated Guidance: Example: physical contact to facilitate a person’s completion of a task when resistance is nil or minimal; used as training technique. Hand-on-hand guidance, endorsed by MN DD Council on their website. Permitted in current Rule 40. Should this be permitted?
2. Physical contact or physical prompt to redirect person’s behavior when the behavior does not pose threat to self or others, the contact is used to escort or direct the person, the behavior is effectively redirected in less than 60 seconds. Should this be permitted?
  - a. What about repeat “applications” all consisting of less than 60 seconds?
3. Deprivation. Example: Just as a group is heading to a community outing, one person begins throwing objects. Staff options seem to be to hold everyone back until person stops throwing objects and risk missing the outing or let everyone else go on the outing and keep the person at home, which is a deprivation. Should this be permitted?
4. Level systems. Example, red, yellow or green access to privileges, but never for needs. Many providers use such systems. Should this be permitted?

IV. Feasibility Checklist

A. About the providers:

1. Some providers of services to people with disabilities are large corporations with many residences or day program facilities and shift staff.
2. Some providers are small family foster care providers who take one or two people into their homes. The foster parents may be the only “staff.”
3. Other providers don’t have facilities at all; they provide hourly services to people in the person’s own homes or at a residence.

B. Questions re: provider types above:

1. How well do your requirements apply to this wide variety of providers?
2. What extra support and/or exemptions, if any, should apply to family foster care or hourly service providers?

C. How are the person’s rights and safety protected?

D. How are other residents’ rights and safety protected?

- E. How well is staff safety protected?
- F. Are there more effective alternatives?
- G. Are these best practices?
- H. How do these recommendations reflect the intent of the Jensen Settlement Agreement?

V. We request that an Advisory Committee member report out on this work group for the August 6 Advisory Committee Meeting. We will supply the talking points.

VI. Final questions?

**Emergency Use of Restraints Work Group**  
**Meeting Notes**  
**July 26, 2012**

**Attending:** Rick Amado, DHS-SOS; Maria Anderson, DHS-AMH; Jane Brink, DHS-OOLTC; Stacy Danov, DHS-SOS; Alicia Donahue, OMHDD; Kay Hendrikson, Rule 40 Advisory Committee, OMHDD; Anne Henry, Rule 40 Advisory Committee, Minnesota Disability Law Center; Renee Jenson, Barbara Schneider Foundation; Jill Johnson, DHS-CMH; Barb Kleist, Rule 40 Advisory Committee, Arc of Minnesota ; Michelle Ness, MDH/OHFC; Dean Ritzman, DHS-DSD; Mike Tessneer, DHS-Compliance; Suzanne Todnem, DHS-DSD; Charles Young, DHS-DSD; Gail Dekker, DHS-DSD, facilitator

- I. Starters: Gail Dekker and Suzanne Todnem went over these:
  - E. Purpose and product
    4. Develop standards on emergencies and emergency use of restraints. Consider implications for prohibited techniques.
    5. Some standards must be enforceable. Therefore, compliance must be observable and measurable.
    6. Your recommendations will go to the full Advisory Committee on August 6 for their review and acceptance or changes.
  - F. Givens (Revised)
    3. We will establish standards that will apply to people with disabilities
    4. Standards will be expressed in rule, statute and manual.
  - G. Resources
    7. Comparison Tables prepared by Dean Ritzman and Lauren Siegel.
    8. Arizona materials
  - H. Review July 16 meeting notes.
- II. Questions for the Work Group
  - E. *Definition of emergency: You discussed whether property damage or threat of property damage should be included in the definition of emergency.*
    4. *AZ includes "prevention of severe damage to property" as well as to prevent harm to self or others.*
    5. *Review meeting notes, page 2.*
    6. *Vote: Should "prevention of severe damage to property" be included in definition of emergency that could permit use of restraints?*

Comments

1. First, we need to use terms precisely and make terms and definitions simple. Deprivation has to be used in context:
  - When deprivation is a consequence, as when a person loses something, like being secluded, this is a negative punishment.
  - Positive punishment is the opposite of taking something away, such as corporal punishment.

- Another kind of deprivation is if you must earn everything, as with tokens or levels, this is simply bad design.
- There is also deprivation of basic rights, whether as a consequence of behavior or not.

Conclusion: None of the above should be permitted.

1. "Severe property damage:" how is this measured? By the expense of the damage?
  - A. Remember Katherine Finlayson's caution against using adjectives in a rule because it is difficult for both a licensor or provider to know whether a provider is in compliance with rule requirements.
2. Do not include property damage as an emergency under the rule unless it is accompanied by imminent risk of harm to self or others. (two comments)
3. Conclusion: Do not include property damage in the definition of an emergency.
4. The definition of emergency applies only to the first episode where there is no plan, no agreed upon way to intervene. Following the first episode, the provider must create a plan to address this in the future. If there is a known or knowable history, there is a responsibility to create a plan.
5. About calling law enforcement:
  - A. Use mechanical restraints only if someone has a weapon.
  - B. Law enforcement would ideally be trained.
  - C. Providers need more training to reduce or eliminate the need to call law enforcement.
  - D. Any call to the police must be treated as any other emergency with the same, full documentation, reporting, and review requirements as any other emergency use of restraints.
- F. *What does your list of permitted emergency techniques consist of?*
6. *Emergency deprivation. Example: taking away shoelaces from a suicidal client? Should this be permitted?*

### Comments

1. Removing shoelaces is a context change in the "competing behavior model." It has these effects:
  - There is a social stigma. Everyone sees the missing shoelaces and knows what it means. This is shaming to the person. This is social punishment and is not permitted.
  - There may be a safety concern because the person is walking around in floppy shoes.
  - This is also punishment by loss.

This should not be permitted.

2. The question is, Can there be a better context change?
  - A. A provider who has been informed of the risk could say the following, "Because you say or have been suicidal, we want to provide for your safety. We will give you shoes with Velcro closures and pants with an elastic waist. And we want to talk with you about making a plan to restore other clothes to you."

- B. Concern about the above item being seen as a “programmatically use of restraint,” which the Jensen Settlement now prohibits.
- C. A person may also make a choice to use shoes with Velcro closures to prevent self-harm. This should be permitted.

7. *Emergency seclusion or room time-out. Example: For certain persons, room time-out might be safer for person, other clients, and staff than manual restraint. Should it be permitted?*

Comments

1. How do you move the person to seclusion? Moving is more dangerous than not moving the person.
2. A possible situation where a person has brittle bone syndrome who is in danger of hurting self or others. This is very difficult and the provider needs a proactive approach very early.
3. Remember that any emergency will trigger all reporting and review requirements as well as changes to the person’s plan.
4. Note that seclusion is permitted in the Children’s Mental Health Rule, but there is concern that data are not being collected to show how well it is working.
5. Seclusion is also permitted in hospitals.
  - A. However, DHS does not license hospitals and does not have authority over hospitals.
  - B. Even though seclusion is permitted in hospitals, they are moving away from using it. We need consistency across settings and services.
6. Concern about varying definitions of seclusion.

Conclusion: Seclusion should not be permitted.

8. *Blocking apparatus or techniques. Example: Using a blocking apparatus or pad as defense against person hitting staff or others instead of manual restraint. Should this be permitted?*

Comments

1. These are padded shields, similar to what is used in football practice, used to protect staff person and person who is hitting or flailing.
2. These are used at MSOCS.
3. Concern that these could be improperly used as a way to get around the prohibition of seclusion. That is, not as a “blocking” pad but to effectuate seclusion.
4. What does a staff person want when this happens? Don’t they want to get away after the first blow or two? Why would you make them stay to take more blows? The targeted staff should leave the room.
5. Some providers may have only one staff on some shifts (which is unsafe in itself) so it is not necessarily an option for the one staff to leave. How does one staff person protect the safety of a person?
6. Remember that the blocking apparatus itself could be used as a weapon.

Conclusion: Use of blocking apparatus should not be permitted.

9. *Emergency exclusionary time-out? Example: Removing a person from an activity and positive reinforcement.*

Comments

1. This could be permitted under this circumstance: The person's behavior is upsetting. The provider suggests leaving and accompanies the person. There is no use of force. The provider engages the person in a new activity, conversation, questions about what would be helpful now.
2. Redirection, de-escalation, teaching, temporary interruption are permitted activities. It's important to avoid the use of force.
3. If the person can be removed by force from an activity by the provider:
  - A. It won't help the provider. The provider will lose "therapeutic capital" with the person. This is punishment. And if it's used repeatedly, that just demonstrates that it is an ineffective response. It should not be permitted.

*10. What about "techniques approved by the commissioner"? Example: This would be put in rule to keep the standards current.*

#### Comments

1. This refers to a list of permissible activities or techniques in a manual that can be updated more easily than changing a statute or rule.
2. This would also permit an early innovator to make a request of the commissioner
3. There would need to be a process for standard review and updating of what is permitted to keep the list current.
4. Concern about "techniques approved by the commissioner" is too loose a standard, that it would be too easy to get permission.
  - A. Then tie permission from the commissioner to the reporting, documentation, review process. Require data collection for review to determine effectiveness.
  - B. These are high-risk situations. There needs to be transparency. Advocates need to be included in reporting requirements, for example.

*6. Level systems. Example, red, yellow or green access to privileges, but never for needs. Many providers use such systems. Should this be permitted?*

#### Comments

1. Have never seen a level system that did not have a punishment component. Punishment is not permitted.
2. It is not therapeutic to force a newcomer to earn privileges.
3. It does not meet CMS's requirements that services be individualized for the person because these are global requirements of all persons. It dilutes individual programming.
4. There is also a stigma for failure to earn privileges at the green level.

Conclusion: Level systems should not be permitted.

#### III. Closing:

- A. **Kay Hendrickson** and **Barb Kleist** agreed to report out on this work group at the August 6 Advisory Committee Meeting. Suzanne Todnem will supply the talking points.



Minnesota Department of **Human Services**

## Rule 40: Emergency Use of Restraints

### Attended one or both work group meetings:

**Rick Amado**, DHS-SOS; **Maria Anderson**, DHS-AMH; **Steve Anderson**, Rule 40 Advisory Committee; **Jane Brink**, LTC Ombudsman; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, MH-DD Ombudsman; **Kay Hendrickson**, Rule 40 Advisory Committee; **Anne Henry**, Rule 40 Advisory Committee; **Dan Hohmann**, MSOCS; **Renee Jensen**, Barbara Schneider Foundation; **Jill Johnson**, DHS-CMH; **Barbara Kleist**, Rule 40 Advisory Committee; **Bob Klukas**, DHS-Rules; **Annie Mullin**, Rule 40 Advisory Committee; **Michelle Ness**, MN Dept. of Health; **Dean Ritzman**, DHS-DSD; **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 is to recommend standards that will apply to persons with disabilities
- b. The standards will be expressed in statute, rule, and manual
- c. The department presented a preliminary rule draft at the July Advisory Committee meeting that included this definition of emergency based on the Jensen Settlement definition: “Emergency” means situations when the person’s conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. Person’s refusal to receive and participate in treatment shall not constitute an emergency

### II. Main discussion points

- a. Definition of emergency – in addition to “imminent danger to self or others”
  - i. Whether to include property damage
  - ii. Only unpredicted events or include “somewhat predictable” situations?
  - iii. Customized “emergency” definition for each individual – personalized crisis plan
  - iv. Narrow view (danger to self or others) vs. broad view (includes property damage, risk of criminal repercussions, and risk of loss of housing)
  - v. Includes modifying usual use of equipment such as slowing down a person’s electric wheelchair
  - vi. Replace with other terminology such as “behavioral crisis” to coordinate with 245D
  - vii. Not left to individual staff discretion
  - viii. If provider calls for police assistance in a situation, then it must be treated as any other emergency that triggers reporting, documentation, review, etc.
- b. Emergency techniques permitted, criteria
  - i. Not medically contraindicated
  - ii. Proven to be safe and effective (data required)
  - iii. Short period of time; not necessarily based on “when person is calm”
  - iv. First-time event for the person with that provider, then the provider must create a plan to address the type of incident in the future.
- c. “As approved by the commissioner” to keep standards current
  - i. This would be a list of permissible emergency techniques referred to in rule or statute; would be updated and maintained to keep standards current
  - ii. Would entail a process for standard review and updating
  - iii. Concern: too loose a standard? Sufficient transparency?
- d. Emergency deprivation, permitted?
  - i. Maybe (4 yes, 1 no, 8 maybe)
  - ii. Should be temporary

- iii. For person's safety
- e. Role of crisis plan
  - i. Broader than use of restraints; should restraints (last resort) be part of a crisis plan?
  - ii. Slippery slope?
  - iii. When must a provider develop a crisis plan for a person?
  - iv. Should follow the person to new providers
- f. Non-emergency techniques permitted
  - i. Voluntary participation, e.g., person chooses to go to his room, provider engages the person in a new activity, conversation, questions about what would be helpful
  - ii. Redirection, de-escalation, teaching, temporary interruption without the use of force (and well defined)
  - iii. Standards must include process to reintroduce the person into regular activities
- g. Non-emergency techniques prohibited
  - i. Involuntary participation, e.g., person sent to room (room time out)
- h. Other definitions
  - i. Deprivation
  - ii. Blocking apparatus (and its use) – prohibited but needs to be well-defined
  - iii. Seclusion, time out, etc. must be better defined; and allows a provider to separate two residents who are attacking each other or a resident who is attacking others

### III. Rejections

- a. Risk of criminal repercussions not involving physical danger to self or others
  - i. Not an emergency
  - ii. Concern: would require staff to know what constitutes criminal behavior

### IV. Recommendations

- a. Definition of emergency – imminent danger to self or others, property damage is an emergency if it poses imminent danger to self or others
- b. No use of deprivation as a consequence to behavior
  - i. E.g., person refuses to clean his room so can't go to the movie that night=not permitted
- c. No use of positive punishment
  - i. i.e., presenting an unfavorable outcome or event following an undesirable behavior; an aversive stimulus is added to the situation
  - ii. e.g., being scolded for doing something; spanking, corporal punishment
- d. No deprivation that requires the person to earn everything
  - i. Including token and level programs
- e. No deprivation of basic rights in any situation
- f. No mechanical restraints in emergencies
- g. No mechanical restraints for SIB with interim process to move persons away from existing mechanical dependencies (or variance with a plan), with oversight and monitoring
- h. No seclusion and time outs in emergencies (vote 0-13)
- i. No use of blocking apparatuses

### V. Other work groups

- a. Training
  - i. Crisis intervention training – need more/better
  - ii. Trauma-informed care – should be required training
  - iii. Requirements should apply to night staff and relief staff
  - iv. Providers need more training to reduce or eliminate the need to call law enforcement





Minnesota Department of **Human Services**

## Implementation Work Group

August 15, 2012

### AGENDA

- I. Welcome, introductions, housekeeping, agenda review
- II. Starters
  - A. Meeting purpose and product
  - B. Givens
    1. We will recommend standards that will apply to people with disabilities
    2. Standards will be expressed in statute, rule and manual
  - C. Resources
    1. Monitoring, Reporting and Training the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas (August advisory committee meeting handout #5)
- III. Getting started – Reminder of ideas mentioned at previous advisory committee meetings
  - A. Technical assistance and resources
    - a. CSS
    - b. Hotline?
  - B. Training (specifics handled by that work group)
  - C. Timing – Options
    - a. Delayed effective date
    - b. Immediate effective date; use variances
    - c. Staggered effective dates, i.e. phasing in of standards and requirements
  - D. Culture Change
- IV. Questions for the Work Group
  - A. In one or two sentences, what does a successful implementation process look like? *E.g., Unlimited technical assistance available to providers*
  - B. What are the main components of a good implementation plan?
  - C. What is the best way to transition providers who work with persons who have been dependent on mechanical restraints for SIB for many years?
  - D. What is the best way to transition providers who work with persons who are restrained or secluded on a weekly/daily/frequent basis?
  - E. Timing—Options to consider:
    1. Delayed effective date
    2. Immediate effective date; use variances
    3. Staggered effective dates, i.e. phasing in of standards and requirements
    4. Grace period between effective date and enforcement by Licensing Division
    5. Customized (individualized) timing option

F. Relation to Training

1. *Note: Content and topics of training for providers, counties, and others will be discussed in Training Work Group.*

2. For communication or orientation to new standards and early implementation support for providers and lead agencies, consider these possible options during implementation/early effective phase:

- a. Road shows, presentations at meetings, conferences, etc.
- b. Website
- c. FAQs (probably on website)
- d. Electronic question submission (Is anonymity important?)
- e. Videoconferencing or webinars
- f. Designated staff person available by phone or email
- g. Consultation (perhaps by CSS or others?),
- h. Model policies for use as templates by providers
- i. Policy manual
- j. Other tools or approaches?

1. Providers, which of the above would be most useful to you?
2. Counties, which of the above would be most useful to you?
3. Family members of people with disabilities, which of the above would be most useful to you?
4. Others present: what is your perspective?

V. Closing

A. Suggestions for the next meeting

1. Feasibility discussion
2. ?

B. Next meeting: Thursday, August 30, 10:00-12:00 noon in Lafayette 3146

C. Final questions?

**Implementation Work Group**  
**Meeting Notes**  
**August 15, 2012**

**Attending**

**Rick Amado**, DHS-SOS; **Jane Brink**, Ombudsman for Long-term Care (by phone); **Erwin Concepcion**, DHS-SOS; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, Office of Ombudsman for Mental Health and Developmental Disabilities; **Anne Henry**, Disability Law Center; **Chris Michel**, Office of Ombudsman for Mental Health and Developmental Disabilities; **Lauren Siegel**, DHS-DSD; **Suzanne Todnem**, DHS-DSD; **Charles Young**, DHS-DSD; **Gail Dekker**, DHS-DSD, facilitator

**Purpose**

Develop content for implementation of new standards that may be expressed as statute, rule and manual to apply to providers who serve people with disabilities.

**Product**

Recommendations to be presented to Rule 40 Advisory Committee at its September meeting for their consideration.

**Givens**

1. We will recommend standards that will apply to people with disabilities.
2. Standards will be expressed in statute, rule and manual.

**Resources**

1. "Monitoring, Reporting and Training in the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia, and Kansas" (August Advisory Committee meeting handout #5)

**Questions for the Group**

- A. *In one or two sentences, what does a successful implementation process look like? E.g., Unlimited technical assistance available to providers.*

Comments

1. It's important to distinguish between initial implementation (putting things in place) and long-term, sustained operation over time.
2. Yes, get ready and sustain. In the past, we failed (Rule 40 failed), because we dismantled regional reviews, training, etc.
3. We can address staff turnover
4. There will be 24/7 on-site support. Someone who can show up and demonstrate how to do it the new way.
5. Successful implementation will focus on workforce development, organizational development and documentation supports. This has to be easy to do.
6. It's important to communicate the changes to people about the new paradigm shift to move away from the use of controlled procedures.
7. We need to have acceptance at all levels, from the top down. DHS to provider owners to direct care staff.
8. We need proper coordination with other provider standards initiatives.
9. Funding.
10. It important to communicate to consumers and families and guardians.
11. Concern about a "we-they" tone. Can this be a shared endeavor? Recognize that we're all in this together, because we all get it and we have enough support.

12. Feature, reward, and honor providers who do this new approach well. There are some providers even now who do this well. Give them some status.
13. Communicate the financial benefits and other benefits of this change to person-centered planning and positive supports. Get data from willing Minnesota providers on fewer staff injuries, etc.
  - A. South Carolina has that info
  - B. United Kingdom, too.
14. Make sure that as many incentives as possible are lined up as much as possible.
15. Apply positive practices to this implementation.

*B. What are the main components of an implementation plan?*

(Participants' wrote comments on post-its and clustered post-its into categories. DSD named each category, which is underlined.)

1. Create a transparent implementation plan.
2. Create an organizational structure to build buy-in.
  - a. Shared vision/buy-in, enrollment [by providers into new approach]
  - b. Provider buy-in and support
  - c. Organizational development, administrative buy-in, policies and procedures, quality assurance, and supervision
  - d. Quality assurance, performance improvement
  - e. Provide background on Rule 40 history to build buy-in to new approach
  - f. Administrative buy-in
  - g. Policies and procedures that support the supports
3. Establish and communicate expectations
  - a. Graduated expectations, ramp up
  - b. Knowledge of requirements
  - c. Deadline for implementation
  - d. Dates informed by data and evidence
4. Recognize and allow for differing competencies
  - a. Recognition and provision for varied levels of provider competencies
  - b. Potential variances
  - c. Expect "hiccups"
  - d. Prepare for hiccups rather than expect them.
  - e. Grace period for providers for trial and error
5. Provide technical assistance and support
  - a. Technical assistance
  - b. Workforce development staff and support training
  - c. Support and trouble-shooting
  - d. Training: Create a shared vocabulary
  - e. Replace the old tools with new tools
  - f. Direct care staff have to feel safe with the new tools.
6. Supervision at provider level
7. Oversight at all levels
8. Align incentives

- a. Positive incentives for adoption of positive behavior supports
- b. Aligned incentives

9. Communications

- a. Provider communication/assistance
- b. Clear consistent message
- c. Go beyond communication: integration
- d. Clear expectations

10. Data

- a. Data, feedback, support
- b. Feedback loop on process, technical assistance, etc.
- c. Paperless system, electronic data submission, reporting, technical assistance

11. Service coordination

- a. Coordinating across services/teams/environments

12. Values

- a. Attainable.
- b. Rather than being limited by “attainable,” strive to continuously outperform previous accomplishments
- c. Flexibility
- d. Accountability: Who is responsible for each aspect?
- e. Transparency: Changes and implementation plan; rules, TA, data, funding info are all available

C. *What is the best way to transition providers who work with persons who have been dependent on mechanical restraints for self-injurious behavior (SIB)?*

Comments

- 1. It’s important to distinguish between physical conditions (such as seizures) vs. a response to a behavior. Are we proactive or reactive?
- 2. A way to think about this difference in managing a behavior vs. a medical condition:

	Medical	Behavioral
Proactive	<ul style="list-style-type: none"> <li>1. Anesthesia prior to surgery.</li> <li>2. Use of helmet for person with a seizure disorder.</li> </ul>	<ul style="list-style-type: none"> <li>1. Person bangs head and provider uses programmatic restraint. (No longer acceptable).</li> </ul>
Reactive	<ul style="list-style-type: none"> <li>1. Prior history of injury of life-threatening interference with a medical procedure, medical equipment or device.</li> </ul>	<ul style="list-style-type: none"> <li>1. Stopping a person from doing things we (providers) don’t want them to do after behavior has started or occurred. (No longer acceptable.)</li> </ul>

- 3. Build an exception for medical use of device or restraint, like Children’s Mental Health Rule.
  - A. A neurologist or other appropriate health care provider and a behavior specialist works with the person to build skills.
  - B. We need to create the expectation of continuing improvement to avoid complacency.

4. Provide lots of training to providers and persons receiving services.
  - a. Create DVDs that show examples of how this can work to build buy-in. DVDs are available for use anytime.
  - b. The provider needs to acquire expertise, to keep expanding or strengthening their skills and competence.
  - c. Use technical assistance for initial training, but not as a permanent crutch.
  - d. Make available on-site technical assistance for complex situations.
5. Address the interplay between disciplines: medical, behavioral, mental health, especially to deal with prescriptions, because doctors have such authority in nursing homes and assisted living settings.
6. There are also pressures from families who have resisted change in the past. "Don't take off his helmet!" Deal with their fears and their pressure on providers.

C. *What is the best way to transition providers who work with persons who are restrained or secluded on an ongoing basis?*

#### Comments

1. Provide on-site mentor to providers.
2. Telepresence is an option if the situation is less intense.
3. Cultivate and make available qualified mentors and varied approaches.
4. Conduct a functional behavior assessment (FBA) to get to the root cause of the behavior.
5. Provide the right kind of incentive. Ask providers to volunteer for change or we will find someone else to serve the person. Negotiate this with providers.
  - a. Don't pay for the old way of doing business.
  - b. Negotiate the offer of support for changes in approach by provider.
  - c. How many people are we talking about? Response: Gerry Nord at DHS-DSD would know.
6. I am concerned about the feasibility of the above suggestions. We have some minimally qualified providers, but we have let them slide because they are serving the most difficult clients that no one else is willing to take. Concerned that people will say yes to required changes and not follow through.
7. Another concern is that providers may discharge people and cherry-pick their clients. This occurs in Assisted Living where a person is discharged to the hospital and not permitted to return, so the person loses their home. There is trauma in transferring.
8. We don't want clients to lose their homes. Perhaps a solution is to pull the provider's license and find someone else to run the residence so the client doesn't lose their home.
9. We need to redirect funding and resources to support people with challenging behavior appropriately.
10. How do rise above minimum licensing standards? How to engage providers to continue to rise in competence? Some just want to stay under the radar. We must do that in a way that lowers the risk to providers.
  - a. We can ask them how confident they are.
  - b. Ask providers what help they need.
  - c. Ask them to create a plan for change—each provider makes a plan to serve each individual in these new ways.
  - d. Make sure everyone in the environment knows the rules and expectations: families, other providers, case managers. Build in transparency and support.

D. *How should we think about timing of the implementation? Options might include: (1) a delayed effective date; (2) an early effective date with a system of variances; (3) staggered effective dates with phasing in of standards and requirements; (4) a grace period between implementation and*

*enforcement of new standards by the Licensing Division; (5) A customized (individualized) timing option.*

#### Comments

1. Option 6 could be by stages by provider. They could start with their easier clients first, then with experience, move to their more difficult clients.
2. Understand what is currently happening. As a condition of being paid, providers must supply data on use of restraints, controlled restraints under current rule and emergency use of restraints under new rule. Also the use of step or level programs.
3. Here's one way to frame the timing of the change:
  - a. The state says the deadline(s) for systems changes
  - b. Providers must provide data by date A.
  - c. All providers create their own transition plan by Date B. This is a person-centered plan for each person, along with what kinds of training and technical assistance are wanted.
  - d. All plans must be implemented by Date C unless the provider has asked for and received a variance.

*E. Think about communication and training methods and approaches. Which would be most useful to providers, counties, families and guardians, persons being supported, others?*

#### Comments

1. Recognize that people have different learning styles so use multiple approaches or methods for each audience.
2. Require people to report on something as a way to get their attention.
3. Embed the technical assistance in the implementation, including the basic standards.
4. The first introduction to the change should communicate what resources are available right away, even before training. Consider:
  - a. Modules on topics
  - b. Links to resources
  - c. Have an article for family members with permission to republish. This could be sent to PACER, Access Press, etc. Tell them what this means for them.

#### **Next Meeting**

Thursday, August 30, 10:00-12:00 noon in Lafayette 3146.



Minnesota Department of **Human Services**

## Implementation Work Group

August 30, 2012

### AGENDA

- VI. Welcome, introductions, housekeeping, agenda review
- VII. Starters
  - D. Meeting purpose and product
  - E. Givens
    - 3. We will recommend standards that will apply to people with disabilities
    - 4. Standards will be expressed in statute, rule and manual
  - F. Resources
    - 2. Monitoring, Reporting and Training the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas (August advisory committee meeting handout #5)
- VIII. Advisory Committee Input (See page 2)
- IX. Questions for the Work Group
  - G. *Culture Change: What actions can all parties take that will change the current treatment or service culture that has permitted use of aversives, seclusion, and restraints?*
  - H. *Feasibility check: Recognizing that we have thousands of large and small providers, who provide residential, day, and hourly services; that the state is large geographically, that the political and financial climate are not expansive, what do you recommend to make implementation more feasible? Prompts:*
    - 1. *Looking at best practices/standards*
    - 2. *Financial reality – 12 main components prioritized (Refer to 8/15 meeting notes, pgs 2-3)*
    - 3. *Effectiveness*
    - 4. *Efficiency*
  - I. *Implementation Priorities: Remember Mayer/DuFresne advice. Prompts:*
    - 1. *Time – quick*
    - 2. *Cost – cheap or expensive*
    - 3. *Quality – effectiveness and citations*
  - J. *Recommendations to advisory committee members:*
    - 1. *Preparations (including communications)*
    - 2. *Launch (including communications)*
    - 3. *Transition (including communications)*
    - 4. *Sustainability/maintenance (including communications)*
- X. Closing
  - D. Representatives to report to advisory committee at meeting on FRIDAY, September 7.
  - E. Final questions?



**Advisory Committee Input for the Implementation Work Group to Consider:**

- I. Technical assistance and resources
  - A. CSS role?
  - B. Hotline?
  
- II. Timing – Options
  - A. Delayed effective date
  - B. Immediate effective date; use variances
  - C. Staggered effective dates, i.e. phasing in of standards and requirements
  
- III. Culture Change

**Implementation Work Group  
Meeting Notes  
August 30, 2012**

**Attending**

**Rick Amado**, DHS-SOS; **Mark Anderson**, Barbara Schneider Foundation; **Don Chandler**, DHS-SOS; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, OMHDD; **Brad Hansen**, Arc Greater Twin Cities; **Anne Henry**, Rule 40 Advisory Committee, Minnesota Disability Law Center; **Renee Jenson**, Barbara Schneider Foundation; **Jill Johnson**, DHS-Children's Mental Health Division; **Bob Klukas**, DHS- Appeals and Regulations; **Pat Kuehn**, Ramsey County; **Tim Moore**, Rule 40 Advisory Committee, University of Minnesota; **Dean Ritzman**, DHS-DSD; **Suzanne Todnem**, DHS-DSD; **Charles Young**, DHS-DSD; **Gail Dekker**, DHS-DSD, facilitator.

**Purpose**

Develop content for implementation of new standards to apply to providers who serve people with disabilities.

**Product**

This is the second meeting of this work group to draft recommendations to be presented to the Rule 40 Advisory Committee at its September 7 meeting for their consideration.

**Givens**

1. The work group is asked to recommend standards for services for people with disabilities that are licensed by the Minnesota Department of Human Services (DHS)
2. Standards may be expressed in statute, rule and manual.

**Resources**

"Monitoring, Reporting and Training the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas" (August Advisory Committee meeting handout #5)

**Advisory Committee Input for the Implementation Work Group to Consider**

- I. Technical assistance and resources
  - A. CSS role?
  - B. Hotline?
- II. Timing – Options
  - A. Delayed effective date
  - B. Immediate effective date; use variances
  - C. Staggered effective dates, i.e. phasing in of standards and requirements
- III. Culture Change

**Questions for the Work Group**

- A. *Culture change: What actions can all parties take that will change the current service culture that has permitted the use of aversives, seclusion and restraints?*

Comments

1. Provide historical perspective to build buy-in from providers. Explain why this change is required: METO settlement, Welsch settlement.
2. Also explain that the evolution of services for people with disabilities continues to evolve.

3. Recognize that culture is expressed in conversations. People are leery of fads and change. Change the context. Be precise and careful about language. Provide alternative conversations. Go from “This, too, shall pass,” to “This, too, will improve.”
4. Children’s Mental Health Division experience in rolling out a rule change: One full year of outstate visits with six staff before implementation.
5. Hold regional conversations (in-person visits) during implementation. Use people involved in writing new rule/statute. Perhaps hold separate meetings for parents, providers, etc. Gather their questions and post them with answers on a public website.
6. Recognize that we are changing the service framework from paternalistic to choice. Identify components of the old and new frameworks, such as “We know best,” to “What are your goals?”
7. Help people understand that not all behaviors are voluntary.
8. Give voice to people who have crises. This is an opportunity for others to develop empathy. Change the words we use.
9. Train providers and families that unwelcome behavior communicates and the task is to determine what is being communicated.
10. Frame implementation in a stages of change model, i.e.:
  - a. Pre-contemplation
  - b. Contemplation
  - c. Preparation
  - d. Action
  - e. Maintenance
  - f. Relapse prevention
11. Eliminate the phrase “inappropriate behavior,” because the behavior is appropriate in its context, such as the absence of skills or freedom to express one’s needs more constructively.
12. Invite providers and others who have made the change to tell their stories, to show what is possible.
  - a. Capture the skeptics who have changed their minds and practices, recognizing people listen to their peers.
  - b. Emphasize safety for staff.
13. Include the most difficult situations in such stories to prevent discounting of the stories.
14. Have expertise available—beyond a hotline—to work through individual cases.
15. Part of the message is: Tough cases can be figured out with the right team, the right resources, to inform the right treatment.
16. Refer to Renee Jenson’s article on the benefits of this change. This message is for providers, families and Legislature: that this is the safest and most-effective and most cost-effective way to interact with persons who have challenging behaviors.
17. Remember the current news stories about St. Peter in the media. Be prepared to address these. Staff need time and they need new tools to replace their old tools.
18. Be prepared to address the concerns of the community. Emphasize safety.
19. Align funds with intentions to achieve cost-effectiveness.
20. Communicate what staff can do in an emergency, but focus on making their toolbox for handling challenging behaviors bigger.

B. *Feasibility check: Recognizing that we have thousands of large and small providers, who provide residential, day, and hourly services; that the state covers a lot of territory, that the political and financial climate are not expansive, what do you recommend to make implementation more feasible? Prompts:*

1. *Best practices and standards*
2. *Financial reality: 12 main components prioritized in 8/15/12 notes*
3. *Cost: Cheap or expensive*

#### 4. *Quality: Effectiveness and citations*

##### Comments

1. Approach training by region or by organization so that all layers are trained at the same time. Once all layers are trained and have passed competency tests or demonstrated skills as required, then the new standards apply. Avoid a situation where some people in a region or organization at some levels have been trained but others have not.
2. Offer incentives. Pay for competence. Pay others less. Recognize folks who step up without discharging clients. Instead, offer them help to retain challenging clients.
  - A. Communicate that providers must evolve to stay in business. If they can't, DHS should not want their business.
3. Communicate that this is not a training but a program (long-term). DHS will identify areas that need more support.
4. For maintenance, make sure there are ongoing requirements for training as well as ongoing support
5. What can MnCHOICES do to identify and provide support?
  - A. Note that Rate-setting cannot prevent discharges.
6. Train the trainers. Make U of M training available for free to first willing providers.
  - A. Offer training to cohorts around the state.
  - B. Invite direct care staff to help train. For them to continue to train, require that they take continuing ed units.
  - C. While a train-the-trainer approach using direct care staff, note that providers are reluctant to offer training to people outside their organization without payment or reimbursement for that.
7. As training takes hold, it means more expertise is available. Create an expert panel or regional oversight and support.
  - A. Although there are not many qualified people at the moment, preserve standards. Mentor and develop more staff. Some people will claim to have skills who don't.
8. DHS must own the program and take responsibility for the program. DHS must model what the program advocates.
9. Involve the community and open the process.
10. Ask the legislature to recognize different levels of behavior analyst and offer pay differentials.
11. For provider accountability, there needs to be legislation or mechanism to hold them accountable. Concern that there will be lip-service only.
12. DHS should collaborate with colleges/universities to train new professionals by revising and updating their curriculums along this line (person-centered planning, positive supports, avoiding aversives, seclusion, restraints). Their non-alignment will be a problem.

##### C. *What are your implementation priorities?*

##### Comments

1. Recognize that current training at U of M is 15 months, taught in cohorts of 15 people at a time. This training is behavior staff at the bachelor and masters (and above) level.
2. Work with providers who are ready to change now. But unsure of scope of this. We need data.
  - a. Money Follows the Person grant has been approved, which will provide some funds for limited training of state staff and private-sector providers.
  - b. DHS should estimate scope of training need and develop a plan. Line up resources and collaborate. This is a 5-10 year culture change process and it must be sustained after the initial implementation.

3. Recognize the organizational development needs of providers. Clarify roles, communications patterns, work flow, expectations. Incorporate this into training and/or consulting support.
  - A. One way to introduce this would be to develop a DVD that is sent to all providers prior to training—pre-work before training.
4. Use a variety of media.
5. Philosophy is a leading indicator, skills are lagging indicator. Intention precedes skills.
6. Form an implementation stakeholder group and holds DHS accountable.
7. Pay attention to terminology and language challenges across disciplines. More discussion is needed within DHS and between DHS and other agencies.
  - a. Avoid jargon and use simpler language.
  - b. Avoid any message that the person with challenging behavior is doing something wrong when they are not at fault. This is especially important for parents. You are not the problem, but you are the solution.
8. State Operated Services has a two-day program with examples from multiple populations and multiple disciplines. Curriculum is from Support Development Associates (Michael Smull's organization).

D. *What are your recommendations, considering:*

1. *Preparation for implementation, including communications*
2. *Launch of implementation, including communications*
3. *Transition, including communications*
4. *Sustainability and maintenance, including communications*

Comments

1. Create an interdisciplinary steering committee for the roll-out. Take the lead on DVD for providers. Sort out and clarify use of language between disciplines and agencies.
2. The main preparation is to decide how to talk about this. Focus on safety for persons being served and for staff.
3. Research what other states have done to have a successful roll-out.
4. Use standard methods and expand.
5. Hold county information sessions for providers.
6. For county staff:
  - a. Use webinars
  - b. Go to regions with a consistent message and clear focus.
7. Encourage Advisory Committee members to start conversation around the state; once government is on message it reaches others.
8. Once the sustaining phase has been reached, the steering committee in Item #1 should evolve into a monitoring role, then to regional groups as more are involved. This group could play many functions, including post-incident review, training, and others.
9. Embed this into the Quality Council (Commission?) and other quality efforts.
10. Start training at St. Peter.

E. *What should be the future role of CSS and M CCP?*

Comments

1. They are not at the table although they were involved in many Rule 40 plans. The need to be here in an implementation role. Jim Temple, M CCP and Barb Roberts, CSS.
2. They currently have an after-the-fact role and we need to ask, How to shift emphasis to prevent incidents?

F. *How should we evaluate the implementation?*

Comments

1. There are two types of data:
  - a. Formative data: used to make changes
  - b. Summative data: used to look back

Use formative data to make changes to improve the implementation.

2. Use a U of M evaluator. Identify what changes you're looking for ahead of time. What are the marks of success? Consider impact on and measures for:
  - a. Persons being served
  - b. Staff
  - c. Organizations providing services
  - d. DHS
  - e. Cost analysis
3. At the Department of Education, Dean Fixsen from North Carolina, is the evaluator for PBIS implementation. His specialty is implementation science, translating data to practice. Check with them on culture change.
4. Seek federal block grant funding on reducing or eliminating use of restraints, seclusion. Check with Richard Seuer in Adult Mental Health.



Minnesota Department of **Human Services**

## **Rule 40: Implementation Work Group Summary**

### **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
  - i. Preparations – now, getting the conversations started
  - ii. Legislation and rulemaking
  - iii. Pre-enforcement
  - iv. Enforcement of new standards
  - v. Evaluation
  - vi. Maintenance
- b. Getting buy-in of the culture change, comprehensive approach, must include: (who)
  - i. Agency
  - ii. Provider executives and owners
  - iii. Provider management
  - iv. Direct care staff
  - v. Persons, families, guardians
  - vi. Counties
  - vii. Community
- c. Culture change – how and why we get it
  - i. Communicate
    1. What is permitted under the new rule or statute
    2. What is prohibited under the new rule or statute
    3. Dates/deadlines of implementation stages, based on data and evidence
    4. Benefits of the change (including financial, moral, professionalism, etc.)
  - ii. Emphasize the purpose, including safety of all people involved
  - iii. Provide a historical perspective to explain why this change is necessary
  - iv. Change the conversations in the industry; use precise and careful language
    1. E.g., eliminate the phrase “inappropriate behavior” to recognize the function of ALL behavior
  - v. Change the service framework (from paternalistic to choice)

- vi. Use stages of change model: Pre-contemplation, Contemplation, Preparation, Action, Maintenance, Relapse Prevention
  - vii. Skill building and creation; tool replacement
  - viii. Share success stories – including the most challenging situations
  - ix. Use and align funding with goals of the change
  - x. Organizational development
  - d. Provide resources and technical assistance
    - i. Crisis resources
    - ii. On-site mentors
    - iii. Telepresence, online training and other technology utilized
    - iv. Functional Behavior Assessment
    - v. Experts available to work through individual cases (not just hotline access)
  - e. Incentives
    - i. Rewards
    - ii. Honors
    - iii. Money
    - iv. Certification
  - f. Expectations
    - i. Ramp-up approach, graduated implementation process
    - ii. Be prepared for imperfect implementation; “hiccups”
    - iii. Providers and staff must know:
      - 1. New requirements
      - 2. Deadline(s) for implementation (process)
    - iv. Deadline dates will be informed by data
  - g. Values
    - i. Transparency
    - ii. Alignment – use positive practices with the providers
    - iii. Collaboration; team approach; avoid “us-them” atmosphere; DHS helps
    - iv. Flexibility, including accommodating different learning styles and access needs
    - v. Recognize varied levels of provider competencies
    - vi. Oversight and accountability
    - vii. Attainable while continuously striving to outperform previous accomplishments
    - viii. Teaching – provide resources in a way where the provider learns, gains competence
  - h. Timing options
    - i. Various delay/gap approaches between implementation of new standards and enforcement of new standards
    - ii. Stages by provider; providers develop implementation plan for themselves:
      - 1. State sets deadline for systems change
      - 2. Baseline data from providers to DHS by Date A
      - 3. Provider creates their own implementation plan by Date B, includes a plan for each person in care and what training is necessary
      - 4. All plans must be implemented by Date C unless provider asks for and receives a variance
  - i. Evaluation
    - i. Use formative data to make changes
    - ii. Use implementation science experts
- III. Sustaining the changes
- a. Provide resources and technical assistance
  - b. Define future role of CSS and MCCC
  - c. Building capacity
    - i. Train trainers



- ii. 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



Minnesota Department of **Human Services**

**Training Work Group  
August 17, 2012  
AGENDA**

- XI. Welcome, introductions, housekeeping, agenda review
- XII. Starters
  - G. Meeting purpose and product
  - H. Givens
    - 5. We will recommend standards that will apply to people with disabilities
    - 6. Standards will be expressed in statute, rule and manual
  - I. Resources
    - 3. Monitoring, Reporting and Training the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas (August advisory committee meeting handout #5)
- XIII. Getting started – ideas mentioned at previous advisory committee meetings (See page 3)
- XIV. Questions for the Work Group
  - A. What are the goals of training?
  - B. In one or two sentences, say what a successful training system looks like. Example: “Provider staff at all levels receive training in person-centered planning and positive support strategies.”
  - C. What are the main components of a training system?
  - D. Who or what are the qualified training resources or systems—at least to begin with, recognizing that more training resources may be developed as time goes on?
  - E. What should be the focus of training for different roles in the system, and where are credentials needed?
    - 1. Direct care staff who implement positive support plans
    - 2. Behavior staff who create positive support plans
    - 3. Behavior staff who oversee positive support plans
    - 4. Provider executives or managers or owners
    - 5. Facilitators of person-centered planning
    - 6. State agency staff: Licensing, Disability Services, others?
    - 7. Persons receiving support
    - 8. Families and guardians
    - 9. Persons who determine training standards
    - 10. Others?
  - F. What are acceptable training delivery methods? What methods are less effective and for what types of training?
  - G. What should be the indicators or measures of training effectiveness?
  - H. How should we ensure continuous learning and keep building individual and system capacity and competence?
  - I. Who is responsible to pay for which training?

XV. Closing

- A. Suggestions for next meeting?
  - 1. One topic: Feasibility of recommendations across all provider types
- B. Next meeting: Wednesday, August 29, 1:00-3:00 pm in Lafayette 4146.
- C. Final questions?

### III. Ideas Related to TRAINING Mentioned at Earlier Meetings

- A. Training topics:
  1. Person-centered planning
  2. Positive support strategies
  3. Functional behavior analysis
  4. Observation, data collection, evidence-based techniques, reporting requirements
  5. Crisis prevention/intervention strategies including de-escalation, re-direction, etc.
  6. Training on use of manual restraints in emergency
  7. Monitoring for person's safety during emergency use of restraints
  8. Trauma-informed care
  9. Description and examples of aversive, deprivation and punishment techniques and why they are prohibited.
  10. Costs to person and provider with use of restraints and aversive, deprivation and punishment techniques
  11. Importance for all in system (DHS, counties, providers, etc) to become (more of) a learning organization
  12. Rights of persons
- B. Training must be offered to staff at all levels, but extent of training on any particular topic may depend on person's role.
- C. Both public sector and private sector staff should receive training
- D. Training must be made available to persons and their families and guardians on PCP and positive support strategies, cost of restraints and aversives, etc.
- E. There is a need for consultation and technical assistance both for policy and for situations as they occur.
- F. There is a need for 24-hour consultation and assistance.
- G. Credentials and oversight of persons who provide training
- H. Recognizing staff turnover
- I. Policy and Practices manual, reviewed by a state advisory group, and updated regularly (every two years?), to keep best practices current.
- J. Need to address availability of qualified trainers, availability of training
- K. Funding of training: Could penalty assessments be used to offset some training costs?

**Training Work Group  
Meeting Notes  
August 17, 2012**

**Attending**

**Rick Amado**, DHS-SOS; **Steve Anderson**, Advisory Committee Member and Mt. Olivet & ARRM Rep; **Renee Jenson**, Barbara Sneider Foundation; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz**-Advisory Committee Member and Dakota County; **Lauren Siegel**, DHS-DSD; **Gail Dekker**, DHS-DSD, facilitator; **Charles Young**, DHS-DSD; **Suzanne Todnam**, DHS-DSD

**Purpose**

Develop content for training on the new standards

**Product**

Recommendations to be presented to the Rule 40 Advisory Committee for their consideration at the October meeting.

**Givens**

1. We will recommend standards that will apply to people with disabilities.
2. Standards will be expressed in statute, rule and manual.

**Resources**

1. "Monitoring, Reporting and Training the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas" (August advisory committee meeting handout #5)

**Questions for the Group**

- A. *What are the goals of training?*

Comments

1. To support a safe environment- safety should be a top priority.
2. Allow for the evolution of practice, as best practices are always changing. This is done by continually evaluating the training and changing it as needed.
3. Should be accessible to all people that support individuals with developmental disabilities that live in all applicable geographic locations. For this to occur the training must be person-centered and have the appropriate IT resources.
4. Should be available in multiple formats, as people learn in different ways. The emphasis should be on hands-on training as actually practicing and applying skills is the most direct way of learning methods of quality care.
5. To impact people's culturally ingrained beliefs about the value of punishment.
6. To be collaborative- in more ways than one. First, people need to learn to work together in these communities. Second, for buy-in from all levels of service, providers, staff and governing entities need to be involved in the creation and implementation of the training.
7. To benefit the individuals served. People should be trained on human relations for better service and an overall understanding that the people they are serving are just like them in many ways.
8. To be efficient and effective. An efficient and effective training will better prepare and equip someone to do their job and the subsequent feelings of competence will contribute to less staff turnover.

9. To provide people with common, industry standard language to support the entire field with more universally competent employees.
10. Support the value of training with the appropriate certifications, so those being trained are made to feel like a valued professional that is on a track to achieving more. Pay should reflect the advancement in training/certification.
11. To use what is already working, but make it more user-friendly.
12. Must have clear objectives for each training.

B. *In one or two sentences, say what a successful training system looks like. Example: "Provider staff at all levels receive training in person-centered planning and positive support strategies."*

#### Comments

1. Is available 24/7, has multiple approaches and is asynchronous.
2. The content and language is accessible so that people with less previous knowledge of the field are able to understand the material.
3. The training should be affordable.
4. The modules should have very clear objectives that subsequently build off each other to exemplify the progress an individual has made.
5. Stream-lined to be achievable, but also comprehensive.
6. The training should have tiers based on previous knowledge, but with the same overall message. The early stages could be online, but the later stages should include demonstration.
7. The training should include a competence assessment.
8. Training should take place within each org to create buy in and should have the ability to be sustainable and grow within that organization. Somehow incorporating people from other organizations in some of the trainings would be beneficial for idea-sharing.

C. *What are the main components of a new training system?*

(Participants wrote comments on post-its and clustered post-its into categories. DSD staff named each category, which is underlined.)

1. Broad goals of the training
  - a. Quality assurance
  - b. Culturally competent and responsive
  - c. Training recognizes the wide diversity of people protected by these standards
  - d. Builds capacity and community (McKnight)
  - e. Demonstrated competency-based
  - f. Training professionalizes participants
  - g. Leads to certification levels
  - h. Training incorporates the practices we are teaching (use PBS in training approach)
2. Developing the training
  - a. Identify who will be developing the training
  - b. Communication systems
3. Delivery
  - a. 24/7, a synchronized, multi-media presentation
  - b. Synchronized vertical and horizontal delivery
  - c. Multiple formats
    - d. Core vs. Advanced
  - e. Time/Hours (how much?)
  - f. Reference material

- g. Regional hubs foster sharing, support and continuous development
  - h. Mentoring, supervised practice, OJT Coaching
  - i. Time to practice learned techniques
  - j. 24 hour consultation after training
  - k. Behavior staff (i.e. BHs) need to model for and mentor staff who implement plans in community settings
4. Accessibility
- a. Initial training PCP and PBS for all caregivers
  - b. All training must be affordable and available
5. Topics of focus within the training
- a. Crisis/de-escalation
    - i. Identification of crisis.
    - ii. What does it feel like to be disabled and in crisis
    - iii. How to maintain safety in a crisis
    - iv. De-escalation techniques
    - v. Verbal and non-verbal ways to de-escalate a crisis situation
    - vi. Proactive vs. reactive strategies
  - b. Prohibited techniques/punishment and use of restraints in an emergency
    - i. Understanding of punishment
    - ii. Changing culturally ingrained beliefs about the value of punishment
    - iii. Reasons why prohibited techniques are prohibited
    - iv. Use of manual restraints in an emergency
  - c. Rights of the Person
    - i. Rights of persons being served
    - ii. Understanding regulatory obligations
    - iii. Identify all levels-macro-standards to micro-person
  - d. Basics of behavior change
    - i. The steps to take to achieve behavioral change
    - ii. Understanding of FBA
    - iii. Training specific to person with regard to function of behavior and recommendations
  - e. Trauma informed care

\*A special note about measuring something such as a training curriculum:

Input (Easiest to Measure)	Output	Outcome (Hardest to Measure)
<ul style="list-style-type: none"> <li>• The number of hours of training</li> </ul>	<ul style="list-style-type: none"> <li>• Competency test and credential</li> </ul>	<ul style="list-style-type: none"> <li>• Measured by person satisfaction and demonstrated choice activity.</li> <li>• Identify the most competent and</li> </ul>

What is measured:			<p>ask them to evaluate others less advanced, can be observation, checklists and written tests.</p> <ul style="list-style-type: none"> <li>• Some providers set up a system that supports success but checks to make sure that people are accumulating the knowledge that they are supposed to be accumulating. Need a level of management to ensure the provision of services. The outcomes for workers should be individually assessed.</li> <li>• Use a pre-test, post-test and 6-month test (to see what they have used) to demonstrate competencies and supplement that with client satisfaction, the amount of sick time and workers comp, reduced use of restraints. Highlight skills demonstration and strengths.</li> </ul>	being  of
Description Category:				

D. *Who or what are the qualified training resources or systems- recognizing that more training resources may be developed as time goes on?*

Comments

1. The Kansas PBS System is used at SOS and stored at the U of M within the College of Direct Supports. There are 16 people in a cohort, 8 students are affiliated with SOS and 8 are affiliated with private providers. This is a free program and it is not board certified. However, this program has more supervised practice and is very similar to board certification. At the end of this program, students are able to: complete competent and comprehensive FBAs, use the competing behavior model in intervention, collect reliable data, get a brief introduction to PCP and facilitate a strong team through collaborative group work. There are 9 modules in this course and class meets one time a month from 9 am to 4 pm. This curriculum can be modified as it is implemented and critiqued.
2. South Carolina has a similar system as Kansas, but it has an additional system that is focused on implementers. This system is similar to the one used at Cambridge, as it is three days, has lots of practice and the professional training is long term and comprehensive.
3. MCCP and CSS (Metro Crisis Coordination Program and Community Support Services) are currently the primary receivers of referrals for training in the counties, as money is already allocated to these programs for that purpose. To train providers outside of the county system, there would need to be contracts to pay independently. **MCCP** receives calls if people are dealing with challenging behavior. **MCCP** has a Behavior Analyst on staff that has the capacity to do an FBA and create plans for the individual. The trained county case managers within this system understand these behaviors to make better referrals. There are additional trainings available for specific populations. **CSS** is 65 to 70 hours for a case work up. **CSS** has more time to train, but is very similar to **MCCP** and it would be a good model to follow.
4. The Institute for Applied Behavior Analysis (IABA) is based in Los Angeles, California. The program is two weeks and 100 hours. Students learn about positive support strategies, FBAs (and actually complete one and evaluate another) and person-centered assessments. On the



down side, we would have to buy the system and continuously pay them to have that training come here.

5. Mount Olivet Rolling Acres and Meridian both have good entry-level training on PSS.
6. The Barbara Sneider Foundation offers an 8 hour de-escalation training that is non-violent and has lot of practical application. This training includes individuals from law-enforcement, family and people with mental illness. Barbara Sneider also has a 40 hour Crisis Intervention Team (CIT) training (a SAMHSA best practice) to prepare trainers within other organizations. This training is meant to create a culture change away from the use of seclusions and restraints. The training was a partnership with Northwestern University and there are CEUs available for those in the nursing, law enforcement and education fields.
7. Brih Design creates custom behavioral training, as does Behavioral Dimensions.
8. The Lovaas Institute does training for providers to children with autism. The Midwest location, located in Minneapolis, is equipped to do the trainings.
9. David Mandt does regional training, which will most likely cost money. He has trainings on topics such as trauma informed positive behavior support and complex behaviors.
10. Crisis Prevention Intervention (CPI) training with the Crisis Prevention Institute- is a lot like the Mandt training. There is on-site training as well as seminars and workshops of various lengths.
11. Disability Support Organizations have trainings that are related to the types of disabilities in which they specialize, but these are not as comprehensive.
12. The person-centered thinking initiative was started by SOS at the U of M and teaches person-centered lifestyle planning. Coaches are trained to work with people, supervisors are trained to oversee direct care and managers are trained to oversee the organization.

*E. What should be the focus of training for different roles in the system and where are credentials needed?*

1. Direct care staff who implement positive support plans, behavior staff who create positive support plans and behavior staff who oversee positive support plans are the three positions listed within the new waiver provider standards. We need to identify what these three positions need and what other types of positions need (including the advanced positions in an organization as well as family members and state agency staff).
2. The desire for staff to be creating PSS plans and the supervisors to oversee that process was expressed.
3. (This question may be revisited at the next meeting due to time)

*F. Who is responsible to pay for which training?*

1. SAMHSA has grants available for training
2. (Paying for training will most likely be revisited at the next meeting)

*G. What is a model for providing certification and credentials to providers?*

1. On the first page of the NADD.org page there is a link for a credential page. These credentials are competency-based, there are multiple levels with multiple disciplines.

**Next meeting**

Wednesday, August 29, 1:00-3:00 in Lafayette 4146.



Minnesota Department of **Human Services**

**Training Work Group  
August 29, 2012  
AGENDA**

XVI. Welcome, introductions, housekeeping, notes from August 17 meeting, agenda review

XVII. Starters

J. Meeting purpose and product

K. Givens

7. We will recommend standards that will apply to people with disabilities

8. Standards will be expressed in statute, rule and manual

L. Resources

4. Monitoring, Reporting and Training the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas (August advisory committee meeting handout #5)

XVIII. Getting started – ideas mentioned at previous advisory committee meetings (See page 2)

XIX. Questions for the Work Group

J. What should be the focus of training for different roles in the system, and where are credentials needed? What training should everyone have and what training would apply based on position or certification?

11. Direct care staff who implement positive support plans

12. Behavior staff who create positive support plans

13. Behavior staff who oversee positive support plans

14. Provider executives or managers or owners

15. Facilitators of person-centered planning

16. State agency staff: Licensing, Disability Services, others?

17. Persons receiving support

18. Families and guardians

a. [Outside scope of DHS?]

19. Persons who determine training standards

20. Others?

K. If, we need to stage training (due, for example, to a limited number of qualified trainers), what are your training priorities? Who should be trained first? In what topics?

L. What are acceptable training delivery methods? What methods are less effective and for what types of training?

M. What should be the indicators or measures of training effectiveness?

N. How should we ensure continuous learning and keep building individual and system capacity and competence?

O. Feasibility of recommendations across all provider types

XX. Closing

D. Need two report out volunteer(s) for Friday, September 7 Advisory Committee Meeting

E. Final questions before adjourning?

### III. Ideas Related to TRAINING Mentioned at Earlier Meetings

- L. Training topics:
  - 13. Person-centered planning
  - 14. Positive support strategies
  - 15. Functional behavior analysis
  - 16. Observation, data collection, evidence-based techniques, reporting requirements
  - 17. Crisis prevention/intervention strategies including de-escalation, re-direction, etc.
  - 18. Training on use of manual restraints in emergency
  - 19. Monitoring for person's safety during emergency use of restraints
  - 20. Trauma-informed care
  - 21. Description and examples of aversive, deprivation and punishment techniques and why they are prohibited.
  - 22. Costs to person and provider with use of restraints and aversive, deprivation and punishment techniques
  - 23. Importance for all in system (DHS, counties, providers, etc) to become (more of) a learning organization
  - 24. Rights of persons
- M. Training must be offered to staff at all levels, but extent of training on any particular topic may depend on person's role.
- N. Both public-sector and private-sector staff should receive training.
- O. Training must be made available to persons and their families and guardians on PCP and positive support strategies, cost of restraints and aversives, etc.
- P. There is a need for consultation and technical assistance both for policy and for situations as they occur.
- Q. There is a need for 24-hour consultation and assistance.
- R. Credentials and oversight of persons who provide training.
- S. Recognizing staff turnover.
- T. Policy and Practices manual, reviewed by a state advisory group, and updated regularly (every two years?), to keep best practices current.
- U. Need to address availability of qualified trainers, availability of training.
- V. Funding of training: Could penalty assessments be used to offset some training costs?

**Training Work Group  
Meeting Notes  
August 29, 2012**

**Attending**

**Rick Amado**, DHS-SOS; **Mark Anderson**, Barbara Schneider Foundation; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, OMHDD; **Dan Hohmann**, DHS-SOS; **Bob Klukas**, DHS-rules; **Pat Kuehn**, Rule 40 Advisory Committee Member; **Sue McGuigan**, TBI Advisory Committee; **Tim Moore**, Rule 40 Advisory Committee Member; **Genie Potosky**, DHS; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz**, Advisory Committee Member; **Lauren Siegel**, DHS-DSD; **Charles Young**, DHS-DSD; **Suzanne Todnem**, DHS-DSD, project lead; **Gail Dekker**, DHS-DSD, facilitator; **Dan Chandler**, DHS-SOS; **Chris Michel**, OMHDD; **Mike Tessneer**, DHS-Compliance

**Purpose**

This is the second meeting of this work group to develop content for training on the new standards.

**Product**

Recommendations to be presented to the Rule 40 Advisory Committee for their consideration at the September 7 meeting.

**Givens**

3. We will recommend standards that will apply to people with disabilities.
4. Standards will be expressed in statute, rule and manual.

**Resources**

2. "Monitoring, Reporting and Training the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas" (August advisory committee meeting handout #5)

**Questions for the Work Group**

- A. *What should be the focus of training for different roles in the system, and where are credentials needed? What training should everyone have and what training would apply based on position or certification?*
  1. *What training should everyone receive?*

Comments

- a. De-escalation training (such as avoiding power struggles, minimizing negative attention, redirection). Must include practice/demonstration of competence, not just theory.
- b. Why aversives, deprivation, and punishment are not effective or safe.
- c. Person-centered planning, including practice/demonstration of competence, not just theory.
- d. Positive support strategies, including practice/demonstration of competence, not just theory.
- e. Organizing principle for training:
  - i. Framework: Includes intro to the changes, rationale, evidence. Method of training can be online.
  - ii. Strategies and Tactics: Includes functional behavior analysis (FBA), person-centered planning (PCP), positive support strategies, de-escalation strategies, etc. Method of training requires competency demonstration.
  - iii. Policy: Includes requirements of statutes, rules, VAA, MOMA, rights, etc. Method of training can be online.
- f. Training on trauma-informed care

- g. Personal accountability of staff person, i.e., a change from blaming person or fixing person to approach that considers environments we create around the person being served. Developing a reflective or introspective approach where staff person asks, “What can I do differently?”
  - h. Person’s rights, patients’ bill of rights. Address and correct assumptions about what laws require because there is much misinformation out there.
  - i. Cultural competency, diversity understanding. Staff person should understand their own culture and its assumptions, the culture of the person being served, the culture of the service environment, such as the medical culture, the DD culture, the mental health culture, etc.
  - j. Acceptable physical restraints that can be used in emergencies with medical monitoring, including practice/demonstration of competence, not just theory.
    - i. Definition of emergency
    - ii. What procedures are prohibited
  - k. Vulnerable Adult Act (VAA), Maltreatment of Minors Act (MOMA)
  - l. Systems awareness, organizational awareness and its contributions to aggression and other challenging behaviors.
  - m. Reporting requirements, documentation requirements.
2. *What training for direct care staff who implement positive support plans, in addition to above?*

#### Comments

- a. More emphasis on Strategies and Tactics from 1.e Organizing Principle for Training above, such as positive supports, de-escalation, etc.
  - b. Concern about general level of competence of direct care staff. The need good interaction skills and skills need to be measured by outcomes—how they treat people. Includes human relations, respectful communications.
  - c. Client-specific knowledge and competence.
  - d. Strategies/skills specific to set of clients and setting
    - i. There was discussion about whether there could be general competency standards or whether competency must be person-specific.
  - e. Understanding of relationship between behavior and environment.
  - f. Employee self-care
  - g. Collegial care, for example, debriefing with each other after a crisis.
  - h. Understanding of diagnoses, medications
  - i. Staff members’ documentation and reporting requirements
  - j. When to communicate with the person’s family or person’s emergency contact(s)
  - k. When to call 911.
3. *What training for behavior staff who create positive support plans/QDDP in addition to above?*

#### Comments

- 1. More theory than for general training
- 2. More demonstrated competence for all requirements
- 3. Real experience and demonstrated competence in developing behavior plans under supervision, not just mock-ups or school assignments.
- 4. Real experience and demonstrated competence in doing an FBA appropriate for your level and situation.
- 5. Know how to research literature
- 6. Resources in their communities
- 7. Know how to train and coach direct care staff
- 8. Know how to evaluation the services they provide

9. Know how to communicate effectively
  10. Know the limits of their knowledge, when to ask for help, and whom to ask.
  11. Continuing education to stay current in field
4. *What training for behavior staff who oversee positive support plans/masters' or doctoral level?*

Comments

- a. Real experience and demonstrated competence in doing an FBA.
  - b. Tools to know relationship between behaviors and conditions under which it occurs.
  - c. Know how to apply person-centered planning principles
  - d. How biology affects behavior
  - e. More theory of other disciplines, such as biology, neurology
  - f. How to integrate disciplines to develop plans
  - g. How to design and use data system to measure effectiveness of care
  - h. Understand resources of human services system, its procedures, and people in your local system.
  - i. Know how to build capacity of employee and of organization (“Lead and teach”)
  - j. Know how to and conducts periodic supervision/consultation/mentoring of behavior professionals.
5. *What training for provider executives, managers, owners (non-clinical persons)?*

Comments

- a. Outcomes that they and their staff are responsible to achieve.
  - b. What they can hold clinical people accountable for.
  - c. Know how to include your staff in organizational decisions. The concern is that as owner or manager of business makes administrative, organizational, or financial decisions, this will have an impact on the people you serve, so you must consult with your staff to understand what those impacts will be and take them into account.
  - d. Know where you can get help.
  - e. Management best practices
  - f. Continuing education
  - g. Competency in person-centered thinking at the organizational level and the ability to address this in their organization.
  - h. Ability to create a person-centered environment for their staff.
6. *What training for case managers?*

Comments

- a. Case managers do not need to know how to do an FBA.
- b. CEUs to keep current on innovations and evolving knowledge.
- c. Know what is possible: resources about the system because they are pivot point for accountability, they sign off on plans, etc.
- d. Training in their monitoring and oversight roles and responsibilities, as well as these responsibilities for other parties they work with, such as providers, Licensing, etc.
- e. More in-depth knowledge of person-centered planning, ability to talk teams through it. Knowledge of four primary approaches of PCP.

7. *What training for professional guardians (paid for their services)?*

### Comments

- a. Training for everyone (All items in A.1)
  - b. Training for direct care staff (All items in A.2)
  - c. Case manager training (All items in A.6)
8. *What training for Families (recommended, not required; not subject to this rule)?*

### Comments

- a. Know what is possible (similar to case managers)
  - b. Know about voluntary informed consent, difference between substitute decision making vs. making a decision in person's best interests.
  - c. Person-centered planning
  - d. Positive support strategies
  - e. De-escalation strategies
  - f. If person is on consumer-directed community support (CDCS), person and/or their family should receive info on consumer support grants (CSG), fiscal support entities (FSEs)
9. *What training for persons in consumer-directed community services option (CDCS)? Recommended, not required; not subject to this rule.*

### Comments

- a. What they can expect from providers
  - b. What they can hold providers accountable for
  - c. Appeals, grievance rights and procedures
  - d. Training for everyone (All items in A.1)
  - e. How to self-advocate
  - f. Consumer support grants, fiscal support entities.
10. *What training for persons receiving services? (Recommended, not required; not subject to this rule.)*

### Comments

- a. Training for everyone (All items in A.1) as the person can understand
- b. Information on their rights
- c. Information on person-centered planning.

11. *What training for DHS policy staff?*

### Comments

- a. Training for everyone (All items in A.1)
- b. Case manager training (All items in A.6)
- c. In-depth training on:
  - i. Person-centered planning for individuals and organizations
  - ii. Annual training in evolution and innovations and best practices in their field, whether DD, Aging, Mental Health, etc.
- d. Field trips, field work, spend time in counties, service settings.
- e. Training on how to evaluate success and effectiveness of state policies.

B. *If we need to stage training (due, for example, to a limited number of qualified trainers), what are your training priorities? Who should be trained first? In what topics?*

### Comments

1. Set standards, let providers include required training in their orientation and continuing training.
  2. Determine what is needed annually by employee role and add in to requirements.
  3. Train trainers who can train others. Options recommended:
    - a. Start with master's level and go down.
    - b. Start with direct care staff because they have so much contact with persons being served.
    - c. Start by region or by system and train all levels simultaneously so everyone in an area or system are getting the same messages and aligning the same way.
  4. Train DHS policy staff early.
  5. Train case managers early.
  6. Train crisis providers. Be clear about what we expect of them.
- C. *What are acceptable training delivery methods? What methods are less effective and for what types of training?*

### Comments

1. All training must have a product that the trainee must produce whether it is to pass a competency test or to demonstrate a skill.
  2. Guideline: If you touch a person, you must demonstrate skills. If you don't touch a person, you can rely on monitoring or online training.
  3. Mentoring should be available for owners, managers, executives.
- D. *What do you recommend to make training feasible across all provider types?*

### Comments

1. Use online subscription
2. Minimize travel for providers.
3. DHS should have a training group that can travel and offer regional workshops.
  - a. Use provider associations, such as ARRM, and other conferences for cost-effectiveness.
4. Marketing is needed to emphasize reasons to buy in, such as effectiveness, improved safety, prospect to save money.
5. Discuss with colleges and licensing boards ways to revise curriculum to bring along next generation of professionals.
6. Purchase copyrights of existing training and make widely available.





Minnesota Department of **Human Services**

## Rule 40: Training Work Group Summary

### Attended one or both work group meetings:

**Rick Amado**, DHS-SOS; **Mark Anderson**, Barbara Schneider Foundation; **Dan Chandler**, DHS-SOS; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, OMHDD; **Dan Hohmann**, DHS-SOS; **Bob Klukas**, DHS-Rules; **Pat Kuehn**, Rule 40 Advisory Committee Member; **Sue McGuigan**, TBI Advisory Committee; **Chris Michel**, OMHDD; **Tim Moore**, Rule 40 Advisory Committee Member; **Genie Potosky**, DHS-Performance Measurement & Quality Assurance (PMQI) Division; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz**, Advisory Committee Member; **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. Recommended components of a successful training system

- a. Training organizing principles are:
  - i. Framework: Introduction to the changes, rationale for changes, evidence for changes, main concepts. Method of training can be online (for greater flexibility, access anytime, and lower cost). Proof of learning can be a knowledge test.
  - ii. Strategies and Tactics: Includes functional behavior assessment, person-centered planning, positive support strategies, de-escalation strategies, etc. Method of training is in-person and proof of learning requires a skills demonstration by trainee.
  - iii. Policy: Includes the requirements of statutes, rules, Vulnerable Adult Act (VAA), Maltreatment of Minors Act (MOMA), protection of rights. Method of training can be online. Proof of learning can be a knowledge test.
- b. These organizing principles provide a basis for all elements of the training system. For example, training topics would fit into one of the three organizing principles. Whatever role a person plays, they will receive training in all three principles but with differing emphasis based on their role. For example:
  - i. Direct service staff might receive more training on strategies and tactics than provider executives.
  - ii. DHS staff and provider executives might receive more training in policies than the direct service staff.
- c. Underlying goals of the training include:
  - i. Quality assurance
  - ii. Culturally competent and responsive services
  - iii. Demonstrated learned competencies
  - iv. Training results in certification and professionalization of participants.

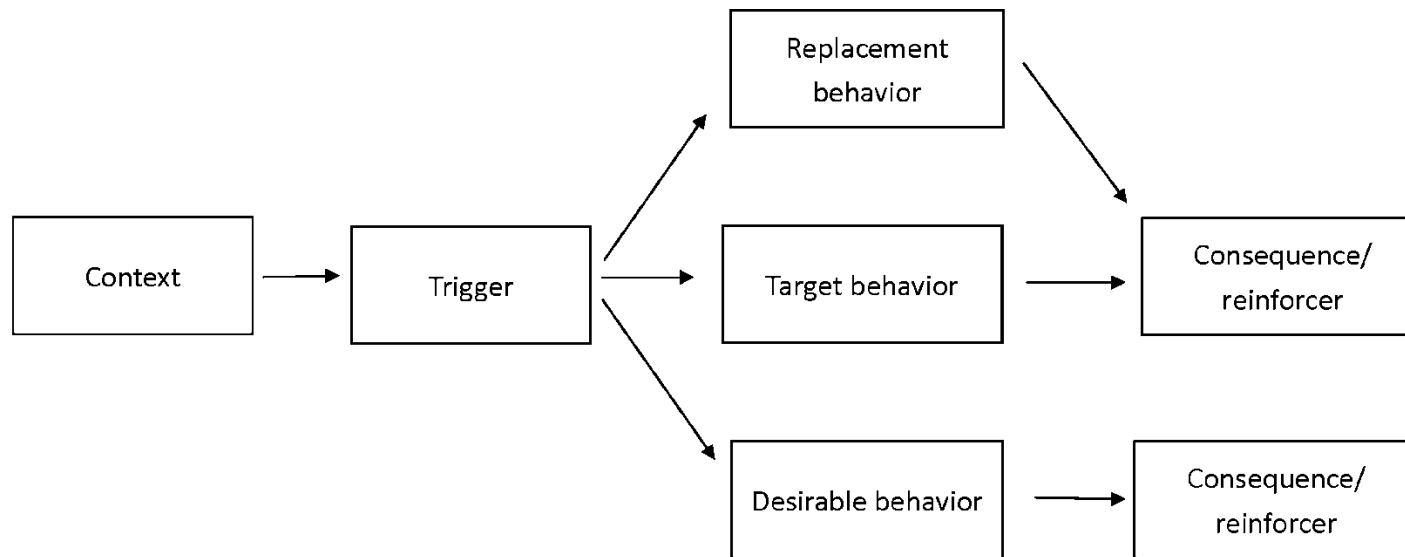
- d. **Training Development:** Who will develop the training? What training already exists? For example, the Kansas Positive Behavior Supports System is already being used by State Operated Services and is administered by the Institute on Community Integration of the U of M. There is a need to evaluate the costs, subject matter and logistics of the proposed trainings (See training work group meeting notes from 8/17 on Pages 4-6 to see possible training resources.)
- e. **Delivery:** Training should encompass:
  - i. Multiple formats
  - ii. Asynchronous delivery, that is, online training available 24/7
  - iii. Core and advanced tracks
  - iv. Specific time requirements
  - v. Reference material
  - vi. All training must require proof of competency. For some topics, proof of competency can be demonstrated by a knowledge test. For other topics, such as skills and strategies, competency cannot be demonstrated by passing a knowledge test; instead the staff person must practice the skills during training and show the skills in a demonstration.
- f. **Mentoring:** This should be available for direct care staff, owners, managers and executives. There should be:
  - i. Regional hubs for development and support
  - ii. Time to practice the learned techniques (including some supervised time)
  - iii. 24-hour consultation.
- g. **Accessibility:** Initial training on PCP and PBS should be available to all caregivers.
  - i. All of the required or desired trainings must be affordable and available.
  - ii. Because these trainings will need to be accessible to providers throughout the state, minimize travel for providers with online training. Create a DHS training group that can travel and offer workshops.
- h. **Specific training topics include:**
  - i. Crisis management and de-escalation techniques
  - ii. Review of prohibited techniques and why punishment/aversive procedures are not effective or safe for person or staff
  - iii. The legal and safer ways to use restraints in an emergency
  - iv. Creating buy-in for the theoretical/cultural changes inherent in these changes
  - v. Rights of the person
  - vi. Basics of behavior change
  - vii. Trauma-informed care
  - viii. Relevant policies such as VAA and MOMA
  - ix. Cultural competency, that is increasing one's ability to work effectively with people from diverse racial and ethnic backgrounds, as well as developing awareness of the culture of the service delivery system, the work culture of the provider organization, and one's own cultural assumptions.

### III. Additional Recommendations on Training

- a. **Measuring outputs and outcomes:** While the measuring of inputs (such as the number of hours of training offered) and outputs (such as number of competency tests passed) is relatively easy, measuring outcomes is more difficult, but more important because improved service outcomes is the reason for the training. Providers should have a system that supports success and highlights strengths but also accurately ensures the required knowledge and skills are being accumulated.
- b. **Mandated, but differentiated, training for providers and provider staff, county and state agency staff, and others, depending on their roles**



# Competing Behavior Model



# Competing Behavior Model

An example

