

## EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT



Minnesota Department of **Human Services**

### **Rule 40 Advisory Committee Meeting Handout Table of Contents October 22, 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 October 22, 2012 Agenda**

- I. Opening (9:00-9:15) Gail
  - Dekker
  - A. Introductions
  - B. Agenda review and handouts
  - C. November meeting
  
- II. Update and questions (9:15-9:30) Alex
  - Bartolic
  
- III. Review Monitoring work group work recommendation (Handouts 2-10) Committee Kay Hendrikson, Anne
  - A. Work group representatives report to committee  
Henry
  
- IV. BREAK (10:30-10:45)
  
- V. Review Monitoring work group work recommendation (Handouts 2-10) Committee
  - A. Committee discusses to move to final recommendation
  
- VI. Review draft standards and language Committee
  - A. Purpose and non-purpose of today's review (Handout 11)
  - B. Review draft silently (Handout 12)
  - C. Discuss concerns, improvements, edits
  
- VII. LUNCH (12:00-12:45)
  
- VIII. Continue discussion of draft standards and language Committee
  
- IX. BREAK (1:45-2:00)
  
- X. Continue discussion of draft standards and language Committee

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XI. Closing (no later than 3:50-4:00)

Gail

Dekker

- A. Meeting evaluation: What worked well for this meeting?
- B. Any questions?
- C. Tentative meeting: November 15, 9:00-3:30, Hiway Federal Credit Union, conference room, 840 Westminster Road, St. Paul 55130

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### **Monitoring, Reporting, Oversight Work Group August 16, 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. Reminders of initial input from advisory committee members
  - A. Calling an external consultant during an emergency restraint is not feasible for all providers; concern there are not enough mental health professionals to call
  - B. Differentiate reporting requirements for different types of restraints
  - C. Look at 245B, 245D and other reporting requirements and fill in gaps
  - D. Electronic reporting
    1. Therap software as described by Leeanne Negley
    2. Health department has electronic reporting
  - E. Incident reporting within 24 hours
  - F. Monitoring during an incident; reporting, review, oversight, etc. after the incident
  - G. Statewide report to identify problem areas – a management report
  - H. DHS oversight – how do we do this and what data is useful, etc.
  - I. How to bring in CSS
  - J. Revive regional review committees
  - K. Reinforce penalty for noncompliance; provider accountability
    1. Balance penalty with concern that provider may discharge the person as too difficult for provider to serve.
    2. Consider providing help instead of punishment – robust training and expertise.
- IV. Questions for the Work Group
  - A. In one or two sentences, say what a successful monitoring, reporting and oversight process looks like. Example: “Providers participate in an “after-action” review with consultant after each emergency use of restraints to learn what could be done better.”
  - B. What are the main components of monitoring, reporting and oversight?
  - C. What needs to happen to monitor the person during use of restraints?

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- D. What notification needs to happen following use of restraints? What documentation should be included? Who should receive notification? When?
- E. What review, if any, should follow use of restraints? What is purpose of the review? Who should be involved? If there are recommendations to the provider following a review, are they optional or required?
- F. DHS oversight: What is the purpose of such oversight? What data should DHS gather, i.e., what should be measured? How should DHS use the data? What should be communicated about the data to whom?

### V. Closing

- A. Suggestions for the next meeting
- B. Next meeting:
  - 1. Friday, August 31, 10:00-12:00 noon in Lafayette 3146
  - 2. If needed, a third meeting has been scheduled for Wednesday, September 12, 1:00-3:00 in Lafayette 6146.
- C. Final questions?

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### Monitoring Work Group Meeting Notes August 16, 2012

#### Attending

**Rick Amado**, DHS-SOS; **Steve Anderson**, Advisory Committee Member and Mt. Olivet & ARRM Rep; **Erwin Concepcion**, DHS-SOS; **Alicia Donahue**, Ombudsman for MH/DD; **Katherine Finlayson**, DHS-Licensing; **Kay Hendrikson**, Advisory Committee Member & Ombudsman for MH/DD; **Anne Henry**, Advisory Committee Member and Disability Law Center; **Renee Jenson**, Barbara Schneider Foundation; **Barb Kleist**, Advisory Committee Member, ARC; **Tim Moore**, Advisory Committee Member, U of M; **Michelle Ness**, MDH; **Sandee Newbauer**, LTC Ombudsman; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz**-Advisory Committee Member and Dakota County; **Lauren Siegel**, DHS-DSD; **Mike Tessneer**, DHS-Compliance; **Gail Dekker**, DHS-DSD, facilitator

#### Purpose

Develop content for monitoring, documentation, reporting, and oversight of 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 a successful monitoring, reporting and oversight system?*

#### Comments

1. People have meaningful targets that they regularly achieve and goals are updated to bring them closer to achieving their dreams and vision for their lives.
2. System flows smoothly, there is low use of emergency restraints. There is a new norm, learning and achieving.
3. Respect; make people's lives better across settings and populations.
4. Minnesota is once more a national leader
5. Providers receive help in becoming learning organizations
6. Inclusive, hospitable, welcoming communities.
7. Results in more qualified providers who are willing to serve people, not fewer.
8. It is not enough to do our best with a system that doesn't work. We should extinguish the use of restraints—that should be the goal.

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9. Environment is safe for persons and providers.

B. *In one or two sentences, say what a successful monitoring, reporting and oversight process looks like. Example: "Providers participate in an 'after-action' review with consultant after each emergency use of restraints to learn what could be done better."*

### Comments

1. Data on website shows what is happening. There are regular updates. Information is provided by provider (but protects the person) and also provided in aggregate format.
2. Everyone knows what to do, what to report and when.
3. Every incident of emergency use is reported contemporaneously to the program's leaders (whether the license holder, program director, etc.) within 30 minutes of initiation.
4. After-action review with a consultant needs to happen quickly. Avoid bureaucratic process. Triage incidents for immediate support.
5. System is accountable, driven by evidence-based practices with continuous learning and support.
6. Use of restraints declines over time.
7. DHS oversight includes statewide quarterly reporting, published quarterly, data is reliable, valid and timely.
8. Provider and the person being served both participate in the after-action review.
9. There is a standardized process with balanced contextualized approach. Consider the person, the provider and the situation.
10. Distinguish between putting out fires and fire prevention. Focus on growth of person.
11. Use of restraints, effective early monitoring of effectiveness of services and supports.
12. Integrate data collection with other systems such as MnCHOICES.
13. User-friendly, realistic, clear roles. People know what to do when.
14. Proactive, intuitive, responsive, thorough, and effective.
15. Continuity of care for a person across providers; data shows this is happening.
16. Statewide review board to review strategies, manuals, resources, lessons learned.
17. Immediate resource—a hotline—for any question.
18. State is a driver for excellence, beyond any minimum entry/Licensing criteria.
19. There are more behavior analyst jobs and competent people are actually employed in them.

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20. Roles are professionalized at all levels, from direct care staff on up.
21. Monitoring of positive supports at state level with data on use of positive supports.
22. Persons using the system love their lives (both persons receiving supports and persons working in the system)
23. Replacing aversive and deprivation techniques—providers must report on this

### *C. What are the main components of a monitoring, reporting and oversight system?*

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

1. Prohibited techniques
  - a. Reporting, monitoring and oversight must include deprivation, restrictive practices, use of punishment, violation of persons' rights.
2. Adequate funding
  - a. There is adequate funding of monitoring, reporting and oversight
3. Differentiation between types of restraints
  - a. System differentiates between brief, minor restraints and lengthy, intensive restraints.
4. Plans attain goals
  - a. PCP and plans reach benchmarks and attain goals
5. Early response systems
  - a. Proactive early monitoring and intervention that assures effective, successful PCP and PBS positive supports.
  - b. Tools that make it easier to identify problems and correct them early on.
  - c. Timely triage from an expert following incidents.
6. Incentives for zero use of restraints
  - a. Provide incentives for zero use of restraints
  - b. Built-in triggers for remediation and renewals



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- c. Track monetary/business benefits of stopping use of restraints and seclusion, such as lower turnover, less sick time, less use of workers' compensation, higher worker satisfaction, higher client satisfaction, lower liability costs, lower recovery time, less trauma, and a safer environment.
  - d. Data include tracking hospital usage, 911 calls; monitor trends.
7. Reporting and data system goals
- a. Data are used to drive improvements
  - b. Data provide incentives for community connections
  - c. System goals are identifiable and measurable. Collect data that are functional, useful to measure progress toward system goals and outcomes. Drop any data that don't meet that criteria.
8. Reporting and data system characteristics
- a. Transparent, clear reporting requirement.
  - b. Transparent and accessible to everyone.
9. Reporting and data system uses
- a. Measures indices of PBS training programs, restraints and restricted procedures.
  - b. Comprehensive statewide data gathering system is useful for analysis
  - c. Computerized system that can be accessed by the community to report instances of restraint use, restricted procedures, that allows for data input (person, date, time, antecedent) to allow for tracking, trending, that triggers review of the specific incident and analysis of the specific facility/client to result in providing additional training and implementing positive supports to eliminate the use of restraints when the same situation arises in the future.
  - d. Monitor and reporting and oversight provide feedback loop to those participating.
10. Data system is integrated
- a. Online reporting tools are integrated with existing/developing system to streamline reporting and analysis functions.
  - b. Computer-based and integrated with other software and database systems.
  - c. System can be accessed by DHS and MDH and summarize data for the public

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### 11. Reporting Process

- a. Provider makes verbal report to DHS upon becoming aware of incident.
- b. Provider makes written report to DHS within 24 hours.
- c. Provider makes written summary to DHS of its investigation and action within 14 days.
- d. Provider sends aggregate reports to DHS quarterly.
- e. DHS must review, analyze information to identify trends, provide feedback individually [to provider?]

### 12. Support providers and their staff in a non-punitive way

- a. Create and foster support for staff in a non-punitive way.
- b. Once a service is licensed, it is held accountable for doing better each year than the year before with an individualized organization development plan.
- c. No blaming or shaming.
- d. System is usable by all providers and measures de-escalation interventions.

### 13. DHS leadership buys-in

- a. Total buy-in from DHS top leadership.
- b. At all levels people who work in human services, both public-sector providers and private-sector providers and staff, direct support up through the DHS commissioner, must know what is possible

### 14. Establish regional committees

- a. Positive supports, outcomes oversight monitoring; regional committees with experts in all relevant disciplines: organization processes, organization goals, individual person-centered goals, and positive behavior support goals.

### 15. Provider training and technical assistance

- a. TA and training contractors for all evidence-based positive supports. Set criteria to call in and build capacity.
- b. Training for all involved regarding their roles and responsibilities (providers, case managers, etc.)

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- c. Use CCS or CSS-type consultation as needed.

### 16. Have services move around people

- a. Services move in and out around people; people do not have to change where they live, where they work, recreate to get supports that work for them.
- b. People who exhibit challenging behaviors are not kicked out of their homes (involuntary eviction)

### 17. Each provider must have an internal rights review committee.

## D. *Process: What needs to happen during the emergency use of restraints?*

### Comments

1. If a provider cannot follow all the procedures as outlined in the settlement agreement, the provider should not be able to use restraints.
2. Yes, but this is an institutional response with multiple people available. But much use of restraint is brief, manual restraint only long enough to permit de-escalation and change in the immediate environment.
3. Yes, but how do you draw the line about what kind of restraint is dangerous or lethal? A brief restraint can be dangerous.
4. Providers need to learn to let go (stop the restraint) before the person is fully calm.
5. We need to be able to monitor the psychological impact of using restraints. When does the use of restraints exacerbate psychological distress or challenging behaviors?
6. We need to write standards clearly, so that we all see the same thing when we look at what is happening in a situation.
7. The provider must monitor the process during use of restraints, not just monitor the person.
8. The employee must have great self-awareness during the use of restraints and this needs monitoring, too.
9. The restraint process must be monitored by someone who is not doing the restraint.
10. What was done to prevent the use of restraints so that it was a last measure, not a first measure?
11. Consider graduated intervention, like length of time, harm to self or others. If environment is secure, provider should back off use of restraint.
12. Staff training is important as is authority to respond to prevent harm in known situations.
13. It's important to minimize trauma, no punishment for the person or the staff.

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14. One required criterion before using restraints is that no lesser option will achieve safety. It's best practice to have another staff person observe the application of restraints. Do a short intervention, then assess the situation. Has it changed? Respond appropriately.
15. Question the assumption that the person cannot be released until calm.
16. If an injury occurs to the person, it's a restraint violation.
17. I am concerned about not having staff for monitoring the person who applies the restraints. In many situations, there is only one staff person around, whether in a small four-bed residence or when taking residents out into the community.
18. Standards for very brief interventions, very brief use of manual restraints, must be different (Two people made comments to support this.)
19. No, if we know something can happen because of prior experience, we must plan for it.
20. No, we should not have different standards for different types of restraints, whether categorized by duration of restraint or any other way (Four people made comments to support this.) It's not in the provider's interest; they will lose therapeutic capital with any use of restraints.
21. With the right training, no restraints will ever be needed. (Two people made comments to support this.)
22. Yet, a no hands-on policy may result in outcomes no one wants, such as resorting to 911 calls.
23. But even a small hands-on incident can be an instance of abuse. More training is needed.
24. We should not prohibit all touch. Some touch can be comforting, affirming, and not always a restraint.
25. It is not a failure if you have to put your hands on someone to restrain them. You can't plan for every contingency and you must be able to keep people safe. (Two people made comments to support this.)
26. The monitoring of emergency use of restraints could be proportional to the use of the restraint. If the restraint is light, perhaps the monitoring and reporting is light.
27. It's important to return to positive therapeutic approach as soon as possible. This is the new paradigm and emergency use of restraints is only a small part of that. (Two people made comments to support this.)
28. We need consistent standards, flexibility for providers now, while we move forward. The providers should tell us about that in their organization plans, including the persons' risk management plans.
  - A. Providers will need better training to do this.
29. We need a strong link between monitoring and training. The purpose of oversight is to trigger the training to build provider competence and capacity.

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### **Next meeting**

Friday, August 31, 10:00-12:00 noon in Lafayette 3146.

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### **Monitoring, Reporting, Oversight Work Group August 31, 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)
  - G. Review August 16 work group meeting notes
  
- VIII. Reminders of initial input from advisory committee members and previous work group meeting (See page 2)
  
- IX. Questions for the Work Group
  - G. What notification needs to happen following use of restraints? What documentation should be included? Who should receive notification? When?
  - H. What review, if any, should follow use of restraints? What is purpose of the review? Who should be involved? If there are recommendations to the provider following a review, are they optional or required?
  - I. Positive Indicators: What data about positive techniques should be reported? Why? What will be done with the data? To whom and by whom should the data be reported?
  - J. DHS oversight: What is the purpose of such oversight? What data should DHS gather, i.e., what should be measured and why? How should DHS use the data? What should be communicated about the data to whom?
  - K. At the last meeting, there was not a convergence of opinion among the people present about whether all emergency uses of restraints required the same response. We would like to ask you to discuss this further to see if more agreement is possible.
    - 1. Example: A person starts to walk or run into traffic. The staff person reaches out to grab the person's arm to prevent the forward movement. Staff person holds the person's arm for 10 seconds. Is this an emergency use of restraint? Must it be documented? Reported? If yes, what will this report trigger? Internal review only? External review as well?
    - 2. If the above example does not trigger full reporting and review, how can we prevent misuse or backsliding?
    - 3. Other examples?

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- L. Feasibility check: Recognizing that we have thousands of large and small providers who provide residential, day and hourly services; that Minnesota covers a large geographic area; and that the political and financial climate are not expansive, what do you recommend to make monitoring, reporting and oversight more feasible? Prompts:
  - 1. Are these best practices/standards?
  - 2. Financial reality
  - 3. Different provider size, resources, locations, and service types
  - 4. Effectiveness – will this accomplish what we want?
  - 5. Efficiency – does this accomplish what we want in the most efficient, practical way?
- M. Initial advisory committee meeting input on page 2: Did we address the concerns and suggestions raised?
- X. Closing
  - D. If needed, next monitoring work group meeting is Wednesday, September 10, 1:00-3:00 in Lafayette 6146.
  - E. Need 1-2 representative(s) to report on work group recommendations to advisory committee at meeting on Monday, October 22. We supply a summary of recommendations for your use.
  - F. Next Advisory Committee meeting is Friday, September 7, 9:00-4:00 in Lafayette 3148.
  - G. Final questions?

### **Reminders of initial input from advisory committee members and previous work group meeting**

- L. Calling an external consultant during an emergency restraint is not feasible for all providers; concern there are not enough mental health professionals to call
- M. Differentiate reporting requirements for different types of restraints
- N. Look at 245B, 245D and other reporting requirements and fill in gaps
- O. Electronic reporting
  - 3. Therap software as described by Leeanne Negley
  - 4. Health department has electronic reporting
- P. Incident reporting within 24 hours
- Q. Monitoring during an incident; reporting, review, oversight, etc. after the incident
- R. Statewide report to identify problem areas – a management report
- S. DHS oversight – how do we do this and what data is useful, etc.
- T. How to bring in CSS
- U. Revive regional review committees
- V. Reinforce penalty for noncompliance; provider accountability
  - 3. Balance penalty with concern that provider may discharge the person as too difficult for provider to serve.
  - 4. Consider providing help instead of punishment – robust training and expertise.
- W. See August 16 work group meeting notes

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### Monitoring Work Group Meeting Notes (REVISED) August 31, 2012

#### Attending

**Rick Amado**, DHS-SOS; **Mark Anderson**, Barbara Schneider Foundation; **Stacy Danov**, DHS-SOS; **Katherine Finlayson**, DHS-Licensing; **Brad Hansen**, ARC; **Kay Hendrikson**, Advisory Committee member and Ombudsman for MH/DD; **Anne Henry**, Advisory Committee member and Disability Law Center; **Dan Hohmann**, DHS-SOS; **Renee Jenson**, Barbara Schneider Foundation; **Barb Kleist**, Advisory Committee member (by phone); **Bob Klukas**, DHS-Appeals & Regulations; **Pat Kuehn**, Advisory Committee member and Ramsey County; **Jim Leibert**, DHS-DSD; **Tim Moore**, Advisory Committee member and University of Minnesota; **Michelle Ness**, MDE-Office of Health Facility Complaints; **Kelly Ruiz**, Advisory Committee member and Dakota County; **Dean Ritzman**, DHS-DSD; **Suzanne Todnem**, DHS-DSD and project lead; **Gail Dekker**, DHS-DSD, facilitator

#### Meeting

This is the second meeting of this work group. Refer to meeting notes from the August 16 meeting. A third meeting will be held in September; date, time and location to be determined.

#### Purpose

Develop content for monitoring, documentation, reporting, review and oversight of 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.

#### Context

The recommendation and discussions of the monitoring work group take place within the context of the other recommendations of the advisory committee thus far including:

1. The Rule 40 advisory committee has clearly stated their recommendation that only manual restraints will be permitted and only in emergencies. That recommendation has not changed with these notes.
2. The work group discussed what review process will take place to assure the new standards already recommended by the advisory committee are met.
3. The idea of requiring a certification to utilize a manual restraint in the event of an emergency was mentioned as a possible licensing mechanism to enforce the new standards recommended by the advisory committee.
4. Certification would restrict the use of restraints even further than the tighter standards as only providers with the certification could utilize manual restraints in emergencies.



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5. The certification would fit within the framework of the new standards the advisory committee recommends.

### Resources

1. "Monitoring, Reporting and Training on 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 notification needs to happen following the use of restraints? What documentation should be included? Who should receive notification? By when?*

### Comments

1. Following the emergency use of restraints, the provider should notify the following people:
    - a. The administration of the organization, whether this is the owner, manager
    - b. The designated internal reviewer within the organization
    - c. The person's family or guardian
    - d. The person's case manager
    - e. The external reviewer
  2. Notification method:
    - a. The person's family or guardian and the person's case manager should receive initial notification by phone call on the same day.
    - b. The provider staff person should fill out a standard form that describes the incident.
      - i. The METO form is a model, but could be easier to fill out, should apply to more types of providers, should be available electronically.
      - ii. This form should be completed and submitted within one business day and submitted by fax or email.
- B. *What review, if any should follow the use of restraints? What is the purpose of the review? Who should be involved? If there is a recommendations to the provider following a review, is the provider required to follow the recommendation or is this optional?*
    1. Question: What data are available on incidents? Response: The Licensing Division is developing a compliance monitoring tool that will be able to report citation data and will be able to aggregate citation data for trend analysis.

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2. In addition, Licensing is considering a certification process to use restraints in emergencies. Certification will require license holders to have additional qualifications and training. A license holder cannot use any restraints, even in emergencies, without the certification.

### **3. Internal review**

- a. Purpose: The provider conducts an internal review of the emergency use of restraints with involved staff to determine what happened and what can be learned from the situation, including context and antecedents, whether the person's plan(s) should be reviewed and revised to prevent recurrence of the use of restraints.
- b. The review must be led by a named individual. Multiple staff, including all those involved in the use of restraints, should participate. This should be either: the owner, a QDDP, the clinical lead.
- c. This staff person who leads the review must be trained to conduct such a review and must have guidelines for the review available in a manual.
- d. Staff need training in how to conduct an incident (internal) review and what action should be taken as a result of the internal review, such as to revise the person's positive support plan to reduce the likelihood of a recurrence of the situation that led to the use of restraints.
  - i. If there is a QDDP, that person would be trained to lead the review.
  - ii. Response from Licensing: The providers that Licensing Division works with do not usually have a QDDP. For people with developmental disabilities, these providers do not provide treatment; they provide residential and habilitation services. If the provider is a family foster care provider, there are often no staff except the home owner/foster parent(s).
- e. Licensing Division staff need to be trained on internal reviews so they know what to monitor for.
  - i. Response from Licensing: We can monitor whether something has been documented or done, but we never substitute our judgment for clinical judgment because it's not our area of authority or expertise.
- f. The internal review should take place during or at the end of the shift when the incident occurred before the staff leave.

### **4. Debriefing**

- a. Apart from the internal review, there should be a debriefing of all staff involved in an incident, as well as the person subject to restraints. This is for benefit of all to process what happened and to address any trauma, feelings, or immediate emotional needs of persons involved. We don't want staff to take an unprocessed event home to family. This should be done before the end of the staff persons' shift.

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### **5. Consultation**

- a. There is a need for a 24-hour hotline or crisis resource that can provide consultation by phone quickly to help a provider de-escalate in the moment and determine what steps to take immediately following the crisis.
- b. In addition, a provider should be able to call this resource for follow-up support within a week. (Concern expressed that a formal external review would come weeks or months after the incident, due to backlogs.) This consultant could be CSS or MCCP with appropriate direction and training and resources. They would visit the site, assess the situation, review or create a crisis plan in the context of the person's person-centered plan.
- c. Response: Clinical staff said they would be reluctant to provide advice over the phone during an emergency because they would not know enough about the person and the situation and this could create a liability for them or their organization.
- d. Response: Concern about this approach not getting to the root cause of volatile situations.

### **6. Data**

- a. Related to tracking incidents, DHS should track all 911 calls.
- b. Concern that the term "monitoring" is punitive, and we need to act more positively. Instead of saying monitoring, can we use another term?
- c. One suggestion: incident tracking?
- d. Note that serious injuries or death must already be reported to ombudsman's office. This is a helpful model for incident reporting.

### **7. External Review**

- a. Purpose of an external review (in addition to an internal review): To provide clinical technical assistance (TA) to improve services at a higher level and to offer an outside, objective viewpoint beyond what is available inside the organization.
- b. Description of the external review:
  - i. This external review would be consultative, not punitive.
  - ii. The reviewers would be a panel of persons who have clinical expertise.
  - iii. There would be a dialogue with the provider and provider's staff to identify issues, trends, systems.
  - iv. The review would include a review of the person-centered plan, the positive support strategies, the work environment, etc.

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- v. The external review would evaluate the “goodness of the fit” between the provider’s capacity to provide the services that this person wants and needs.
  - vi. The review would take place in-person, not just a paper or document review.
  - vii. The external review is separate from technical assistance or support.
- c. Would provider be required to follow external reviewers’ recommendation?
- i. If yes, providers must have appeal rights.
  - ii. External review panel needs standards of operation.
- d. What triggers an external review?
- i. It could be reactive, triggered by the emergency use of restraints.
  - ii. It could be proactive, a regular review of person-centered plan and positive support strategies for persons receiving services from providers licensed by DHS.
- e. Who receives copy of external review panel’s recommendation?
- i. Provider
  - ii. Person, their family or guardian
  - iii. Ombudsman’s office
  - iv. Licensing Division.
  - v. Response from Licensing: If you want the external review to be consultative, then do not send the recommendation to Licensing.
  - vi. Note: Communication of external review panel’s recommendation must meet data privacy requirements.

### **Next Meeting**

Confirmed 9/10/12: Next meeting of the Monitoring, etc. Work Group will be Wednesday, September 12, 1:00-3:00 p.m., Lafayette Room 6146.

## EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT



Minnesota Department of **Human Services**

### **Monitoring, Reporting, Oversight Work Group September 12, 2012 AGENDA**

#### **XI. Welcome, introductions, housekeeping, agenda review**

#### **XII. Starters**

- H. Meeting purpose and product
- I. Givens
  - 5. We will recommend standards that will apply to people with disabilities
  - 6. Standards will be expressed in statute, rule and manual
- J. 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)
- K. Review August 16 and August 31 work group meeting notes

#### **XIII. Reminders of initial input from advisory committee members (See page 2.)**

#### **XIV. Questions for the Work Group**

- A. DHS oversight: What is the purpose of DHS oversight? What data should DHS gather, i.e., what should be measured and why? How should DHS use the data? What should be communicated about the data to whom?
- B. Positive Indicators: What data about positive techniques should be reported? What will be done with the data? To whom and by whom should the data be reported?
- C. External Review: Last time we described an internal review process following the emergency use of restraints conducted by the provider's staff, and we began to discuss an external review process. (See 8/31 meeting notes, pages 2-4)
  - 1. What is the purpose of external review? If you have an internal review, what value does an external review add? What triggers an external review? Is there an external review for every emergency use of restraints? Who should be involved in this review? What information and action are within and outside the scope of an external review? If there are recommendations to the provider following a review, is it optional or required to follow them?
- D. At the first meeting of this work group, there was not a convergence of opinion among the people present about whether all emergency use of restraints required the same response. We would like to ask you to discuss this further to see if more agreement is possible.

## EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT

- E. Feasibility check: Recognizing that we have thousands of large and small providers who provide residential, day and hourly services; that Minnesota covers a large geographic area; and that the political and financial climate are not expansive, what do you recommend to make monitoring, reporting and oversight more feasible? Prompts:
  - 6. Are these best practices/standards?
  - 7. Financial reality
  - 8. Different provider size, resources, locations, and service types
  - 9. Effectiveness – will this accomplish what we want?
  - 10. Efficiency – does this accomplish what we want in the most efficient, practical way?
- F. Initial advisory committee meeting input on page 2: Did we address the concerns and suggestions raised?

### XV. Closing

- H. Next Advisory Committee meeting is Monday, October 22, 9:00-4:00 in Lafayette 3148.
- I. Request one or two presenters, preferably Advisory Committee members, to report on this group's work at the October 22 meeting. We will supply a summary.
- J. Final questions?

### Reminders of initial input from advisory committee members and previous work group meeting

- X. Calling an external consultant during an emergency restraint is not feasible for all providers; concern there are not enough mental health professionals to call
- Y. Differentiate reporting requirements for different types of restraints
- Z. Look at 245B, 245D and other reporting requirements and fill in gaps
- AA. Electronic reporting
  - 5. Therap software as described by Leeanne Negley
  - 6. Health department has electronic reporting
- BB. Incident reporting within 24 hours
- CC. Monitoring during an incident; reporting, review, oversight, etc. after the incident
- DD. Statewide report to identify problem areas – a management report
- EE. DHS oversight – how do we do this and what data is useful, etc.
- FF. How to bring in CSS
- GG. Revive regional review committees
- HH. Reinforce penalty for noncompliance; provider accountability
  - 5. Balance penalty with concern that provider may discharge the person as too difficult for provider to serve.
  - 6. Consider providing help instead of punishment – robust training and expertise.

## EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT

### Monitoring Work Group Meeting Notes September 12, 2012

#### Attending

**Mark Anderson**, Barbara Schneider Foundation; **Rick Cardenas**, ACT; **Katherine Finlayson**, DHS-Licensing; **Brad Hansen**, Arc; **Kay Hendrikson**, Advisory Committee member and Ombudsman-MH/DD; **Anne Henry**, Advisory Committee member and Disability Law Center; **Dan Hohmann**, DHS-SOS; **Renee Jenson**, Barbara Schneider Foundation; **Jill Johnson**, DHS – CMH; **Bob Klukas**, DHS-Rules; **Pat Kuehn**, Advisory Committee member and Ramsey County; **Jim Leibert**, DHS-DSD; **Gail Lorenz**, Barbara Schneider Foundation; **Tim Moore**, Advisory Committee member and U of M; **Michelle Ness**, MDH-Office of Health Facility Complaints; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz**, Advisory Committee members and Dakota County; **Charles Young**, DHS-DSD; **Suzanne Todnem**, DHS-DSD, project lead; **Gail Dekker**, DHS-DSD, facilitator

#### Meeting

This is the third meeting of this work group. A fourth meeting will be held in October, date and time to be determined.

#### Purpose

Develop content for monitoring, documentation, reporting, review, and oversight of new standards.

#### Product

Recommendations to be presented to the Rule 40 Advisory Committee for their consideration at the October 22 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 on the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas" (August Advisory Committee meeting handout #5)
2. Work group meeting notes from August 16 and August 31

#### About Proposed 245D legislation

Katherine Finlayson gave the group information on language that DHS is drafting on strengthening provider standards for home and community-based services, which will be inserted in Minn. Stat. 245D, if passed by the legislature in 2013.

## **EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT**

In the statute, there is already a distinction between emergency and incident:

- An emergency happens to a program, such as a tornado.
- An incident is something that happens to a person.

This will have implications for Advisory Committee terminology, such as its definition of emergency, techniques that can be used in an emergency, and so on.

In existing statute, Minn. Stat. 245A and 245B, when there is an incident, the licensed provider must make a record of the incident and report it within 24 hours to the person's case manager and the person's legal representative. In addition, if the incident results in a death or serious injury to a person, the report must be sent in addition to the Ombudsman for Mental Health and Developmental Disabilities and to the Licensing Division of DHS. If the provider has a dual license by DHS and the Department of Health, the report must be sent to MDH as well.

Katherine expressed concern about this group recommending a reporting process that greatly increased the volume of incident reports because the Licensing Division does not have enough staff to address the increased volume.

Following up on the discussion of internal and external review at the August 31 meeting, Katherine cautioned the work group that if the purpose of those reviews is not compliance, no report should be sent to Licensing, because by law they cannot ignore a report of anything that is a licensing violation. A participant asked whether reports could be sent to CSS. Katherine said it might be a partial solution, however, the work group should be aware that CSS is a mandated reporter for the Vulnerable Adult Act (VAA) and the Maltreatment of Minors Act (MOMA).

### **About Measurement**

Jim Leibert, a research scientist and statistician in the Disabilities Services Division, gave the work group a few guidelines as they think about what data should be gathered related to monitoring, reporting, review and oversight under the new rule/statute. Gail Lorenz added several comments.

1. Clarify what you want to measure.
2. Measure only what you are willing to change your mind about or change your practices. If new data will not lead to a change of practice, it is a waste of time to collect it.
3. The work group should consider how data can be stratified and aggregated.
4. Make sure data can be analyzed and manipulated.
5. Remember that other agencies are involved, such as MDH.

### **Questions for the Work Group**

- A. *DHS oversight: What is the purpose of DHS oversight?*



## **EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT**

### Comments about the Purpose of DHS Oversight

1. To ensure that people are safe
2. To measure the reduction of the use of restraints
3. To measure the increased use of positive support strategies
4. To ensure that funds are being used wisely
5. To measure trend analysis and to identify what needs to be changed.
  
6. To support persons' recovery or growth or skill development. To see if people are doing better. Are their lives better?
7. To ensure the rule/statute is accomplishing what we want it to do.

### Comments about Oversight and Statistics

8. It's important to separate regulatory oversight from data oversight.
  - a. Regulatory oversight is to measure compliance with statute and rule.
  - b. Data oversight is to be used for evaluation, trend analysis, and gap analysis and can feed into program direction decisions.
  - c. Data can be used to compare Minnesota with other states.
  - d. Data can be used by consumers to make decisions about providers.
  
9. It's important to distinguish clinical significance for an individual and statistical significant for the service system.

- B. *What data should DHS gather, i.e., what should be measured and why? How should DHS use the data? What should be communicated about the data to whom?*

### Comments on What Should be Measured

Measure:

1. The use of prohibited techniques, where there will hopefully be a reduction.
2. Possible abuse
3. The number of restraints used, by type: manual restraint, prone restraint, mechanical restraint, chemical restraint, punishment, over-correction, deprivation, punishment, corporal punishment, time outs, seclusion, sensory deprivation, denial of access, requirement to assume a position or posture
4. The number of incidents of use of restraints and number of people restrained, by provider.
5. The type of restraints used.
6. Staff involved in use of restraints by name (as permitted by privacy laws).
7. Outcome of use of restraint:
  - a. Was medical attention needed and if yes, what type and for whom, such as person, staff person, another client?
  - b. Was medical attention diagnostic (to see if person is okay) or was treatment needed?

## **EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT**

8. De-escalation techniques tried before use of restraints
9. Frequency and intensity of behavior by the person during each incident
10. Number of other clients and impact on other clients because of an incident
11. Whether there was a crisis plan and whether staff followed it.
12. When data is sent to an ombudsman, the demographics of person in an incident: date of birth, case manager and guardian (recognizing the person's privacy rights)
13. The number of persons with person-centered plans in place
14. The number of person-centered plan goals that have been met
15. The number of persons with positive support strategies plans in place
16. The number of positive support strategies plan goals met.
17. Client satisfaction
18. Worker outcomes, such as worker satisfaction, worker turnover rate, worker absenteeism rate
19. Staff training levels and correlate to client satisfaction and outcomes.
20. Track discharges and loss of placements, and where person went following discharge or loss of placement
21. The context or antecedents of the use of a restraint.
22. Number of evidence-based improvements to positive support plans. Purpose:
  - a. Push people in system to continuously improve
  - b. Push people to make evidence-based decisions
23. Calls to law enforcement:
  - a. Number of calls
  - b. Number of times when taser is presented (a threat to use the taser)
  - c. Number of times when taser is used on person
  - d. Number of times handcuffs are used
  - e. Number of times force is used
  - f. Number of transport holds (i.e., person is taken against their will to hospital or jail)
  - g. Where person is taken: hospital, jail, and for how long
24. Where data has been sent, such as ombudsman, Licensing, Health, etc) and result. Was there follow-up on the referral?

### Other Comments about Measurement

25. Clarify in definition of restraint that any re-application of a restraint, however quickly or however briefly, is a new incident of restraint.
26. Note that a change in service offered by a person or a provider may affect the data, which may lead to the ascription of the reason for the change to the wrong cause.
27. Timing: Say what must be done immediately.
28. What is the baseline? Need it to measure improvements. Measure at individual level.
29. Recognize that much of the data work group wants may already be collected by requirements of current Rule 40.
30. How do keep data collection improving to reflect evolving best practices?
31. DHS should measure its data collection processes periodically to ensure they remain up-to-

## **EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT**

date. Someone should monitor DHS's performance.

32. Remember there are SAMHSA grant funds to support reduction in the use of restraints and seclusion.
  33. There is value in requiring that all staff who put hands on a person be reported because it communicates a change in approach.
  34. What reports should be seen by regulators, such as Licensing, and why? What do you want to accomplish?
  35. DHS should design its reporting system so that reports are automatically weighted and automatically referred as needed for review by clinicians or review panels.
  36. System reports should be shared on a public web page.
  37. DHS should make annual reports on the data to the legislature and made available to the public.
    - a. Note that DHS Licensing reports maltreatment already.
- C. *Positive Indicators: What data about positive techniques should be reported? What will be done with the data? To whom and by whom should the data be reported?*

### Comments

#### Measure:

1. Changes made, results, and tell success stories.
2. Changes in use of restraints due to use of positive supports.
3. During the transition, the use of positive supports.

#### Other Comments about Positive Indicators

4. It is difficult to document when things are going well. It takes staff time to document this, which means they are not working with the person while they're doing this documentation.
5. Yet, as people do the right things more often, there will be more time to document the positive things.
6. Note that most providers are small providers who do not have access to a computer.
7. Note that the current Rule 40 requires the description of adaptive behavior to replace challenging behavior. Continue to use this.

# EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT



Minnesota Department of **Human Services**

## Monitoring, Reporting, Oversight Work Group October 15, 2012 AGENDA

(1:00-1:10)

### **XVI. Welcome, introductions, housekeeping, agenda review**

### **XVII. Starters**

- L. Meeting purpose and product
- M. Givens
  - 7. We will recommend standards that will apply to people with disabilities
  - 8. Standards will be expressed in statute, rule and manual
- N. 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)
- O. Review August 16, August 31 and September 12 work group meeting notes

### **XVIII. Reminders of initial input from advisory committee members (See page 3)**

### **XIX. Questions for the Work Group**

(1:10-1:45)

- G. External Review: Last time we described an internal review process following the emergency use of restraints conducted by the provider's staff, and we began to discuss an external review process. (See 8/31 meeting notes, pages 2-4)
  - 2. What is the purpose of an external review?
    - a. *On 8/31 the work group said:*
      - i. *The purpose of the external review is to provide clinical technical assistance (TA) to improve services at a higher level and to offer an outside, objective viewpoint beyond what is available inside the organization.*
      - ii. *The external review would be consultative, not punitive.*
      - iii. *The reviewers would be a panel of people who have clinical expertise*
      - iv. *The process would be a dialogue with the provider and provider's staff to identify issues, trends, systems.*
      - v. *The external review would evaluate the "goodness of the fit" between the provider's capacity to provide the services that the person wants and needs.*
      - vi. *The external review would take place in person, not just a document review.*
    - 3. What triggers an internal review?
      - a. *On 8/31 the work group said the internal review follows the emergency use of restraints and that it should take place during or at the end of the shift when the incident occurred, before the involved staff leave their shift.*

## EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT

4. How is an external review different from the internal review previously discussed?
5. What triggers an external review?
6. Who performs the external review? What are the qualifications of reviewers? What is the role of provider/license holder?
7. What information and action are within and outside the scope of an external review? What are the standards of operation?
8. If there are recommendations to the provider following a review, is it optional or required to follow them?
  - a. *On 8/31, Katherine Finlayson pointed out that if providers are required to follow external review recommendations, the provider must have appeal rights. On 9/12, she said that if you mean the purpose of the review to be consultative, not punitive, you should not report recommendations of the external review to Licensing because Licensing cannot ignore violations. Beyond that, the work group did not make a recommendation.*

(1:45-2:00)

- H. At the first meeting of this work group, there was not a convergence of opinion among the people present about whether all emergency use of restraints required the same response. We would like to ask you to discuss this further to see if more agreement is possible. See 8/16 minutes, page 5, especially Comments 17-26.

(2:00-2:30)

- I. Feasibility check: Recognizing that we have thousands of large and small providers who provide residential, day and hourly services; that Minnesota covers a large geographic area; and that the political and financial climate are not expansive, what do you recommend to make monitoring, reporting and oversight more feasible? Prompts:
  11. Are these best practices/standards?
  12. Financial reality
  13. Administrative waste and duplication, administrative burden on providers, reviewers, etc.
  14. Different provider size, resources, locations, and service types
  15. Effectiveness – will this accomplish what we want?
  16. Efficiency – does this accomplish what we want in the most efficient, practical way?

(2:45-2:55)

- J. Initial advisory committee meeting input on page 2: Did we address the concerns and suggestions raised?

## XX. Closing

(2:55-3:00)

- K. Next Advisory Committee meeting is Monday, October 22, 9:00-4:00 in Lafayette 3148.
- L. Request one or two presenters, preferably Advisory Committee members, to report on this group's work at the October 22 meeting. We will supply a summary.
- M. Final questions?

**Reminders of initial input from advisory committee members and previous work group meeting**

10/19/2012 Draft language 29

## **EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT**

- II. Calling an external consultant during an emergency restraint is not feasible for all providers; concern there are not enough mental health professionals to call
- JJ. Differentiate reporting requirements for different types of restraints
- KK. Look at 245B, 245D and other reporting requirements and fill in gaps
- LL. Electronic reporting
  - 7. Therap software as described by Leeanne Negley
  - 8. Health department has electronic reporting
- MM. Incident reporting within 24 hours
- NN. Monitoring during an incident; reporting, review, oversight, etc. after the incident
- OO. Statewide report to identify problem areas – a management report
- PP. DHS oversight – how do we do this and what data is useful, etc.
- QQ. How to bring in CSS
- RR. Revive regional review committees
- SS. Reinforce penalty for noncompliance; provider accountability
  - 7. Balance penalty with concern that provider may discharge the person as too difficult for provider to serve.
  - 8. Consider providing help instead of punishment – robust training and expertise.

## EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT

### Monitoring Work Group

#### Meeting Notes

October 15, 2012

#### Attending

**Rick Amado**, DHS-SOS; **Steve Anderson**, Advisory Committee member, Mt. Olivet Rolling Acres and ARRM; **Erwin Concepcion**, DHS-SOS; **Stacy Danov**, DHS-SOS; **Katherine Finlayson**, DHS-Licensing; **Brad Hansen**, ARC; **Kay Hendrickson**, Advisory Committee member and MH/DD Ombudsman; **Anne Henry**, Advisory Committee member and Disability Law Center; **Renee Jenson**, Barbara Schneider Foundation; **Pat Kuehn**, Advisory Committee member and Ramsey County; **Bob Klukas**, DHS-Rules; **Gail Lorenz**, Barbara Schneider Foundation; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz**, Advisory Committee member and Dakota County; **Charles Young**, DHS-DSD; **Suzanne Todnem**, DHS-DSD and project lead; **Gail Dekker**, DHS-DSD, facilitator

#### Meeting

This is the fourth and final meeting of this work group.

#### Purpose

Develop content for monitoring, documentation, reporting, review, and oversight of new standards.

#### Product

Recommendations to be presented to the Rule 40 Advisory Committee for their consideration at the October 22 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" (Handout #5 from the August Advisory Committee Meeting)
2. Work group meeting notes from August 16 and 31 and September 12.

#### Questions

- A. *Based on prior meeting notes, compare and further flesh out the distinctions between the internal reviews of an emergency use of restraints vs. the external reviews of an emergency use of restraints.*

#### Internal Review Comments

1. On August 31 meeting notes, page 2, Internal Review, change QDDP reference to qualified professional, definitions to be determined, in order to reflect the scope of the new standards.
2. The internal review occurs before an external review and the internal review can inform the external review.
3. The provider should take solid action from every incident of restraint.
4. The internal review document gets reported to the person's case manager.
5. The internal review document gets reported to the state: DHS Licensing, Disability Services policy person for oversight, Ombudsman for MH and DD.

## **EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT**

### External Review Comments

1. Clinical expertise in external review implies greater expertise than is generally found in programs.
2. The external review panel and process needs to be established before any external review is done. In other words, there is not an ad hoc external review panel pulled together every time an external review is needed.
3. The value of the external review is that it clarifies the importance of not using restraints. It interrupts the cycle and increases accountability.
4. Culture change requires major efforts, and the external review is an example of that because it will require reporting every incident.
5. Concern: The external review panel may look at the “goodness of fit” of that setting or service for the person, but they need to be mindful of the lack of services or placements for these challenging persons.
6. The external review recommendation gets reported to the person, their family or guardian, provider, the case manager, DHS-Licensing, Ombudsman for MH/DD.
7. If the external review function was housed at the MH/DD ombudsman’s office, it would draw on the review expertise that already exists in that office, which reviews deaths and incidents of serious injury. This office is also focused on quality of life and systemic qualitative change. And this office has credibility.
8. The Health Department’s Office of Health Facility Complaints also has this expertise.
9. The external review is not simply a document review. They have the authority to go to the site.
10. Concern about placing the external review panel in the Ombudsman’s office—that if they continue their pattern of meeting monthly, they will not be set up to provide speedy response when needed. This panel does not need to move as fast as a crisis responder, but it needs to move faster than monthly meetings.
11. The Licensing Division can review whether the provider followed the external review panel’s recommendations. It can act to penalize the provider if the provider did not follow through to implement the external review panel’s recommendation if another bad incident (use of restraints) happens. If, however, the provider did follow the external review panel’s recommendation and another bad incident happens, Licensing would not penalize; the incident is reviewed internally and just gets reported again to all the normal report recipients. The external review panel would then decide what to recommend this time. This is a learning experience for all parties.
12. If the external review panel’s recommendation included training, DHS should describe the qualifications of an acceptable trainer, but the choice of trainer is up to the provider. However, the provider must follow through on the recommendation.

### Comparison of Internal Review and External Review Comments

1. The internal review is focused on the incident, the person and the staff person(s) involved. The external review is focused on the incident, the person and the staff person(s) involved in the broader context of the organization, its systems, patterns, trends, and capacity to serve the person, i.e., “goodness of fit.”
2. Both internal review and external review need to keep the focus on outcomes to prevent the use of restraints.
3. Both the internal review and the external review are for quality improvement.
4. Both internal review data and external review data can highlight what is being done well and can be used to reward providers.

### General Comments/Discussion

1. Include the use of restraints as a type of incident. A report goes to Licensing and to the ombudsman.



## **EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT**

2. Can a report to Licensing not be punitive? Can it instead lead to a referral to external review?  
Response: Licensing is the regulator. Licensing looks at documentation, the fact and quality of reporting.
3. External review should be triggered by every emergency use of restraints because every use of restraints is a failure.
4. Concern about staff resources. Can the response be flexible, individual vs whole external panel, quick vs. full-bore review. Can the external panel response be flexible and proportional?
5. What if staff change? Every single incident cannot be reviewed externally. Great concern about the number of reviews that would be required.
6. The state will have to provide resources and oversight.
7. It's important to differentiate the roles of crisis providers, CSS, MCCP, and MH crisis providers from the external review panel.
8. Unfortunately, providers can refuse to work with crisis providers. They would not have the opportunity to refuse the external review panel.
9. The case manager is the first responder. The case manager offers CSS or other emergency support. The provider should not be able to decline that service.

### Decisions

1. While every incident of the emergency use of restraints must be reported to the external review panel, the review panel has the flexibility to decide how it will respond.
  2. Over time, the external review panel could move to a maintenance schedule of reviews—perhaps quarterly—to ensure the provider is making the needed internal changes to prevent further incidents of the emergency use of restraints.
  3. The review panel has the right to review and intervene that is not dependent on the provider's request for support or consultation.
  4. Place the external review responsibility in the MH/DD Ombudsman's office.
  5. The review panel would include a variety of people but it would have a clinical focus and expertise.
  6. The MH/DD Ombudsman's office would need to be funded to carry out this responsibility.
  7. Data must be collected consistently, online, and must be able to be aggregated from the individual level, the organization level, by provider type, up to the state level.
  8. DHS should create a process flowchart for providers, case managers and others about what needs to happen with an incident of the emergency use of restraints.
  9. DHS oversight includes publishing data about the use of restraints.
- B. *Feasibility Check: Recognizing that Minnesota has thousands of large and small providers who provide residential, day, and hourly services; that the state has a large geographic area, and that the political and fiscal climate are not expansive, what do you recommend to increase the feasibility of your recommendations?*

### Comments

1. Be clear on the costs of the use of restraints, including financial costs and that people are being hurt by the use of restraints. Take a leadership stand.
2. Offer providers, case managers and others process templates and use online technology to standardize and streamline documentation.
3. Build on existing infrastructure, such as using the Ombudsman's office for the external review panel, instead of developing a parallel infrastructure from scratch.
4. Similarly, use existing crisis providers as part of the existing infrastructure and clearly differentiate the role of crisis providers from that of the external review panel.

## **EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT**

5. Don't raise the bar/standards so high that a provider cannot do an internal review. The internal review process for small providers is easy and affordable to do. One suggestion: don't set a bar on formal requirements of who can do internal review.
6. Make things quantifiable. Embed this in MnCHOICES so the assessment looks at incidents of restraint.
7. Have the reporting system capture the complete behavior of the person.
8. Make the reporting system compatible from the individual level up to summary reports. Data is captured the same way all the way through, from individual to provider to types of provider to parts of the state to statewide.
9. Stakeholders need to continue to be involved through implementation.
10. If the external review panel is housed at the ombudsman's office, it will need to be resourced.
11. Concern about tinkering and weakening of standards and approach before implementation.

## EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT



Minnesota Department of **Human Services**

### Rule 40: Monitoring, Reporting, Oversight Work Group Summary

#### Attended some or all work group meetings:

**Rick Amado**, DHS-SOS; **Mark Anderson**, Barbara Schneider Foundation; **Steve Anderson**, Rule 40 Advisory Committee Member, Mt. Olivet; **Rick Cardenas**, ACT; **Don Chandler**, DHS-SOS; **Erwin Concepcion**, DHS-SOS; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, OMHDD; **Katherine Finlayson**, DHS – Licensing; **Brad Hansen**, Arc Greater Twin Cities; **Anne Henry**, Rule 40 Advisory Committee Member, Minnesota Disability Law Center; **Kay Hendrikson**, Rule 40 Advisory Committee Member, OMHDD; **Dan Hohmann**, DHS – MSOCS; **Renee Jenson**, Barbara Schneider Foundation; **Jill Johnson**, DHS-CMH; **Barb Kleist**, Rule 40 Advisory Committee Member, Arc; **Bob Klukas**, DHS-rules; **Pat Kuehn**, Rule 40 Advisory Committee Member, Ramsey County; **Jim Leibert**, DHS-DSD; Dr. **Gail Lorenz**, Barbara Schneider Foundation; **Chris Michel**, OMHDD; **Tim Moore**, Rule 40 Advisory Committee Member, U of M; **Michelle Ness**, MDH/OHFC; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz**, Rule 40 Advisory Committee Member, Dakota County; **Lauren Siegel**, DHS-DSD; **Mike Tessneer**, DHS-Compliance; **Charles Young**, DHS-DSD; **Suzanne Todnem**, DHS-DSD, project lead; **Gail Dekker**, DHS-DSD, facilitator

This summary is intended to reflect the work group’s recommendation to the advisory committee in regard to monitoring, reporting and oversight. Not all specific ideas discussed are included; please refer to each work group meeting date notes for greater detail. Rather, multiple suggestions are represented here with broader concepts statements.

#### I. Context and reminders

##### A. Givens

1. The charge of the work group was to recommend standards that will apply to persons with disabilities
2. The standards will be expressed in statute, rule, and manual

B. Resource: “Monitoring, Reporting and Training on the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas” (August Advisory Committee meeting handout #5)

##### C. Purpose

1. Develop content for monitoring, documentation, reporting, review, and oversight of new standards.

##### D. Product

1. Recommendations to be presented to the Rule 40 Advisory Committee for their consideration at the October 22 meeting.

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- II. Goals of successful monitoring, reporting and oversight
  - A. Ensure persons progress/improve/grow
    - 1. Provide resources, non-punitive support to providers
  - B. Improve person's lives across settings and populations
  - C. Improve the safety of all persons
  - D. Reduce the use of emergency restraints
- III. Successful process has:
  - A. Data reported and available on a website that is properly maintained and updated
    - 1. Of each provider, and
    - 2. Aggregate data
  - B. Clear and transparent standards and process
  - C. Timely
  - D. Efficient yet recognized each person
  - E. Meaningful
  - F. User-friendly
  - G. Satisfied persons
  - H. High-quality services
- IV. Values
  - A. Improvement; not punishment
    - 1. Re: services
    - 2. Re: standards
    - 3. Re: resources
    - 4. Incentivizes desired outcomes
  - B. Growth of
    - 1. Provider (competency)
    - 2. Persons (e.g., skill building, satisfaction)
  - C. Individualization, person-centered services

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- D. Resources
- E. Responsive
- V. Comprehensive monitoring
  - A. High-level for trends, patterns
  - B. Including positive indicators
  - C. Outcomes
  - D. And comprehensive triggers
    - 1. E.g., various reviews, training, early intervention/support to provider, access to timely triage after a restraint incident, etc.
- VI. Restraint monitoring
  - A. Of person and process during a restraint
  - B. Of techniques used by provider
- VII. Reporting and notifications
  - A. Of use of restraint in an emergency (a.k.a. “incident”; incident reporting – process already in place, we can model after or piggyback on existing process such as to ombudsman office)
    - 1. Process
      - a. Online, computer-based
      - b. Notifications to:
        - a. Administration of the organization (owner, manager, etc.)
        - b. Designated internal reviewer within the organization
        - c. Person’s family or guardian
        - d. Person’s case manager
        - e. External reviewer
        - f. DHS
      - c. Verbal reports
      - d. Written reports
      - e. Aggregate reports
      - f. Reviews (see below)

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- g. Debrief of all staff involved in an incident and the person before staff leave at the end of the shift; debrief is intended to address any trauma, feelings or immediate emotional needs of person and staff involved.

### B. Of other options used

1. Hospital usage
2. 911 calls

### C. Of other techniques used by providers

1. E.g., Permissible token programs that do not take back tokens

### D. What is reported:

1. All people involved (staff, person, etc.)
2. Start and end time of restraint
3. What measures were taken to avoid restraint (what, when, how long)
4. What was learned
5. Any injury to staff or person
6. Etc.

## VIII. Reviews

### A. Internal review (see 8.31.12 notes)

1. Purpose: to determine what happened and what can be learned from the situation; focus on the incident context and antecedent circumstances
2. Trigger for internal review: every emergency use of restraint
3. Who: designated staff member will lead; review will include all staff involved with the restraint or on their shift when the restraint occurred, the person when possible
4. When: during the staff's shift, and no later than when staff leave at the end of the shift

### B. Debrief (see 8.31.12 notes, page 3)

1. Different from the internal review
2. Purpose: to address any trauma, feelings or immediate emotional needs of persons and staff involved in the restraint

### C. External review

1. Purpose:

## **EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT**

- a. to provide outside, non-punitive clinical technical assistance for quality improvement
  - b. to look at the provider's system/program level of issues, trends, processes and competencies that may feed into the emergency use of restraints
  - c. to determine if person/provider is a good fit
2. Trigger for external review: every emergency use of restraint
  3. Who: Ombudsman for MHDD would house the external review panel or clinical experts
    - a. Would need funding for this responsibility.
  4. When: TBD – but more than a monthly meeting of the review panel
  5. What: flexible – every use of restraint would be reported to the review panel; the review panel decides how it will respond – review would be proportionate with situation reported.
  6. Recommendation issued, copy sent to:
    - a. License holder
    - b. Person, family/guardian (HIPAA compliant)
    - c. Ombudsman's office
    - d. DHS – policy area (possibly licensing but triggers regulation of recommendation)
    - e. Counties/case managers

### **D. Processes policies**

1. DHS will create a process flowchart for providers, case managers, and others to know what needs to happen when restraint occurs.

## **IX. DHS Oversight**

### **A. Regulatory (licensing)**

1. Use of prohibited techniques
2. Restraint use
  - a. Type
  - b. Duration
  - c. Number of incidents
  - d. Person and staff involved
  - e. Context (e.g., alternatives/de-escalation tried, person-centered plan, etc.)

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f. Etc.

### B. Data

1. Demographic information of persons restrained (aggregate, anonymous)
2. Data collection has consistent standards from individual, provider, provider type, to statewide so data can be aggregated consistently at all levels
3. Provider statistics:
  - a. Number of restraints
  - b. Number of person-centered plans (ratio with number of persons)
  - c. Number of person-centered plan goals met (ratio?)
  - d. Client satisfaction (a rating system?)
  - e. Staff satisfaction (rating system?)
  - f. Calls to law enforcement, hospital use, etc.

C. Interdisciplinary teams / regional committees

D. Statewide review board

E. Outcomes

X. Feasibility – recommendations to create wide applicability (see 10.15.12 notes, pg. 3-4)

- A. provide templates, standardize processes and documentation; use technology (e.g., online reports)
- B. build on existing infrastructure
- C. make things quantifiable, transparent, clear



## EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT

**Rule 40 Advisory Committee**  
**Draft Review**  
**October 22, 2012**

### **Purpose of Today's Review**

We are showing you draft text of your recommendations. Our purpose today is to ask you:

1. As you read these recommendations, have we heard you accurately?
2. What is missing as a recommendation?

Secondarily, if you notice:

3. Terms used inaccurately
4. Typos

### **Non-Purpose of Today's Review**

We don't want you to focus on:

1. Format or order of document
2. Level of detail
3. Wordsmithing
4. Whether these recommendations fit as statute, rule or manual contents

### **Next Step**

At the November 15 Advisory Committee meeting, we will share:

1. First draft text of your recommendations on monitoring, reporting, review, and oversight
2. Second draft of October 22 text based on your comments today

## EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT

1 **Disclaimer:** This proposed draft is not a final statute, rule or manual nor is it department policy.  
2 This draft is intended to reflect the department's understanding and interpretation of the Rule 40  
3 advisory committee's current (incomplete) recommendations to the department on behavioral  
4 safeguards. The content will go into statute, rule or manual. The main focus is looking at the  
5 standards expressed by the advisory committee.

### 6 **245A.70 EMERGENCY USE OF RESTRICTIVE PROCEDURES; PURPOSE AND** 7 **APPLICABILITY**

8 Subdivision 1. **Policy statement.** (a) Sections 245A.70 to 245A.73 govern the emergency use of  
9 restrictive procedures with persons receiving services from a program subject to licensure according to  
10 this chapter. Emergency use of restrictive procedures may only be used in compliance with sections  
11 245A.70 to 245A.73.

12 (b) Sections 245A.70 to 245A.73, establish the following:

13 (1) limitations on the manner in which restrictive procedures are implemented and prohibitions on  
14 the use of certain procedures and techniques as specified in section 245A.XX, subdivision X;

15 (2) conditions for emergency use of restrictive procedures as specified in section 245A.XX,  
16 subdivision X;

17 (3) criteria and procedures for licensed programs regarding the emergency use of restrictive  
18 procedures with persons served by the program as specified in section 245A.XX, subdivision X;

19 (5) standards and conditions for the emergency use of restrictive procedures, including de-escalation  
20 attempts, reporting, reviewing, and assessing each emergency use as specified in section 245A.XX,  
21 subdivision X;

22 (6) requirements for external administrative review, evaluation and program improvement related to  
23 the use of restrictive procedures across the program as specified in section 245A.XX, subdivision X.

24 (c) These requirements do not encourage or require the emergency use of restrictive procedures.  
25 License holders are required to use positive support strategies and alternatives to restrictive procedures  
26 and to document that positive strategies have been tried and have been unsuccessful as a condition to  
27 implementing an emergency use of a restrictive procedure.

28 (d) Prevention of behaviors targeted for reduction is predicated on identification of what is important  
29 to a person in addition to needed support, planning to meet those needs, and the use of specific positive  
30 support strategies and de-escalation techniques in the person's support plan.

31 (e) The commissioner shall adopt rules governing the use of restrictive emergency procedures in  
32 accordance with section 245A.09 consistent with the provisions of sections 245A.70 to 245A.73.

## EMERGENCY USE OF RESTRICTIVE PROCEDURES - DRAFT

1 Subd. 2. **Applicability and scope.** Programs licensed by the commissioner according to this chapter  
2 are subject to the requirements in sections 245A.70 to 245A.73, except for the following programs and  
3 services:

4 (1) X; and

5 (2) X.

6 Subd. 3. **Definitions.** For the purposes of this section, the terms in this subdivision have the  
7 meanings given them.

8 (a) "Aversive stimulus" means an object, event, or situation that decreases the rate or probability of  
9 a behavior when presented as a consequence or increases the rate or probability of a behavior when  
10 removed as a consequence.

11 (b) "Deprivation" means that the individual has gone without access to a particular reinforcer for a  
12 period of time.

13 (c) "Deprivation technique" means the process of limiting an individual's access to a particular  
14 reinforcer in order to increase the reinforcer's potency.

15 (d) "Emergency use of a restrictive procedure" means using a restrictive procedure listed in Minn.  
16 Stat. 245A.70, subd. 6, when a person's conduct poses an imminent risk of physical harm to self or others  
17 and less restrictive strategies would not achieve safety. Property damage on its own, verbal aggression, or  
18 a person's refusal to receive or participate in treatment or programming do not constitute an emergency.

19 (e) "Functional assessment" has the meaning in Minn. Stat. 245.462 and 245.4871.

20 (f) "Functional behavior assessment" (FBA) means an analysis of the relationships between a  
21 behavior and the conditions under which the behavior occurs.

22 (g) "Licensed health professional" means a person licensed in Minnesota to practice those  
23 professions described in section 214.01, subdivision 2.

24 (h) "Manual restraint" means physical intervention intended to hold a person immobile or limit a  
25 person's voluntary movement by using body contact as the only source of physical restraint, including the  
26 use of physical escort, physical holding, or physical contact to redirect behavior. This term does not  
27 apply to the use of physical contact to facilitate a person's completion of a task or response when directed  
28 at increasing adaptive behavior when the person does not resist or the person's resistance is minimal in  
29 intensity and duration.

30 (i) "Mechanical restraint" means the use of devices, materials, or equipment attached or adjacent to  
31 the person's body or implementation of certain practices which restricts freedom of movement, normal  
32 access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as  
33 an intervention precipitated by a person's behavior, in a manner that prevents the person from being able  
34 to independently and voluntarily remove the restraint or direct someone else to remove it.

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1 (j) Mechanical restraint devices, materials, or equipment include, but are not limited to, helmets,  
2 face masks, leg restraints, arm restraints, hand mitts, soft ties, belts, or vests, and wheelchair safety bars.

3 (2) Mechanical restraint practices include, but are not limited to, the use of bed rails or similar  
4 devices on a bed that restrict freedom of movement or prevent the person from getting out of bed, chairs  
5 that prevent a person from rising, or placing a resident in a wheelchair so close to a wall that the wall  
6 prevents the person from rising.

7 (3) Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is  
8 leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be  
9 considered restraints.

10 (4) The term does not apply to mechanical restraints used in the manner identified in section  
11 245A.XX, subdivision X. The term does apply to mechanical restraint used to prevent injury with persons  
12 who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue  
13 damage, that have caused or could cause medical problems resulting from the self-injury.

14 (k) "Program" means a residential or non-residential program licensed according to this chapter and  
15 as defined in 245A.02, subdivisions 10 and 14.

16 (l) "Reinforcer" or "reinforcement" means

17 (i) "Positive reinforcer" or "Positive reinforcement" means increasing the rate, likelihood or future  
18 probability of a behavior by the contingent presentation of a stimulus following the behavior.

19 (ii) negative reinforce or reinforcement

20 (m) "Restrictive procedures" means application of an action, force, or condition that controls,  
21 constrains, or suppresses the action, behavior, intention, bodily placement, or bodily location of a person  
22 in a manner that is involuntary, unintended by that person, and depriving or aversive to that person.

23 (n) "Restrictive procedures manual" means the training and technical assistance manual authorized  
24 by the commissioner to govern the use of restrictive techniques and procedures. The commissioner may  
25 revise or update the restrictive procedures manual to comply with legal requirements or to meet  
26 professional standards, guidelines, and evidence-based practices related to the use of restricted procedures  
27 in the area of home and community-based services to persons with disabilities or persons age 65 or older.

28 (o) "Restraint" means the use of manual, mechanical, prone, or chemical restraint.

29 (p) "Support team" has the following meaning:

30 (1) for programs licensed to provides home and community based services to persons with  
31 disabilities or age 65 and older it has the meaning given in section 245D.02, subdivision 33;

32 (2) for programs licensed to provides X it has the meaning given in X; and

33 (3) for programs licensed to provide X it has the meaning given in X.

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1 (q) “Target behavior” means a response that is identified as the object of assessment.

2 (r) “Token economy program” means a program in which a person earns generalized conditioned  
3 reinforcers such as tokens, chips, or points, as an immediate consequence for specific behavior; a person  
4 accumulates tokens and exchanges them for items or activities from a menu of back-up reinforcers. Token  
5 economy programs do not remove tokens.

6 (s) “Trauma-informed care” means an approach to care and treatment that is based upon a thorough  
7 understanding of the neurological, biological, psychological, and social effects of trauma on humans and  
8 the prevalence of these experiences in persons who receive mental health, substance use, vocational  
9 support, or daily living support services.

10 Subd. 4. **Permitted techniques and procedures.** (a) Use of the instructional techniques and  
11 intervention procedures listed in this subdivision are permitted and are not subject to the requirements  
12 established by sections 245A.71 to 245A.73. Use of these techniques and procedures must be addressed  
13 in each person’s service or treatment plan in compliance with the applicable licensing requirements for  
14 the services provided.

15 (b) The following techniques and procedures are intended to allow license holders the opportunity to  
16 deal effectively and naturally with instruction and treatment interventions and must not be used to  
17 circumvent the requirements of this section:

18 (1) corrective verbal feedback or verbal prompt to assist a person in performing a task or exhibiting  
19 a response;

20 (2) use of token economy programs that do not remove tokens for behavior that is not desired.  
21 Removal of tokens for select target behavior would be a response cost procedure or negative punishment  
22 as identified and prohibited under subdivision 5;

23 (3) physical contact, with no resistance from the person, to calm or comfort a person in distress;

24 (4) physical contact, such as hand-over-hand contact, to facilitate a person's completion of a task or  
25 response that is directed at increasing adaptive behavior, or learning a skill when the person does not  
26 resist or the person's resistance is minimal in intensity and duration, as determined by the support team.

27 (5) Physical guidance means moving a person’s body part(s) when there is no force used against the  
28 person’s resistance. It may be used as a prompt technique in skill-building activities. During physical  
29 guidance, the instructor who is guiding the learner is making continuous assessments of the learner’s  
30 progress and difficulties. Physical guidance never relies on greater force than the learner’s present level of  
31 resistance;

32 (6) minimal physical contact or physical prompt necessary to redirect a person 's behavior when:

33 (i) the behavior does not pose a serious threat to the person or others and the behavior is effectively  
34 redirected with less than 60 seconds of physical contact by staff;

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1 (ii) the physical contact is used to escort or carry a person; or

2 (iii) the physical contact used to conduct a necessary medical examination or treatment by a licensed  
3 health professional.;

4 (7) manual restraint or mechanical restraint a necessary for a licensed health professional to conduct  
5 a medical examination or for the administration of a medical treatment if the following conditions are met  
6 before treatment is administered:

7 (i) the license holder received written informed consent from the person or their legal representative  
8 for the use of the manual or mechanical restraint under the circumstances of this clause; or

9 (ii) the treatment is court-ordered;

10 (8) mechanical restraint used to:

11 (i) protect a person known to be at risk of injury resulting from lack of coordination or frequent loss  
12 of consciousness as a result of a diagnosed medical condition;

13 (ii) assist in safe and correct positioning of a person with physical disabilities in a manner specified  
14 in the person's individual plan; or

15 (iii) to assist a person in turning or to help the person get out of bed, such as bed rails.

16 (9) response blocking is permitted and means physically intervening as soon as the person begins to  
17 emit the selected target behavior to prevent or "block" the completion of the target behavior.

18 (c) Use of manual or mechanical restraint as identified paragraph (b), clauses (5) and (6), may only  
19 be used when ordered by a licensed health professional and the use of the manual or mechanical restraint  
20 is implemented only as ordered.

21 Subd. 5. **Limitations.** (a) The following limitations apply when implementing a restrictive  
22 procedure:

23 (1) restrictive procedures may not be implemented with a child in a manner that constitutes sexual  
24 abuse, neglect, physical abuse, or mental injury, as defined under section 626.556, subdivision 2;

25 (2) restrictive procedures may not be implemented with an adult in a manner that constitutes abuse  
26 or neglect as defined in section 626.557, subdivisions 2 and 17;

27 (3) restrictive procedures may not be implemented in manner that violates a person's rights related  
28 protections required by state licensing standards and federal regulations governing the program;

29 (4) restrictive procedures may not restrict a person's normal access to a nutritious diet, drinking  
30 water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping  
31 conditions, necessary clothing, or to any protection required by state licensing standards and federal  
32 regulations governing the program;

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1 (5) restrictive procedures may not deny the person visitation or ordinary contact with legal counsel,  
2 legal representative, or next of kin; or

3 (6) restrictive procedures may not be used as a substitute for adequate staffing, for the convenience  
4 of staff, as punishment, or as a consequence if person refuses to participate in the treatment or services  
5 provided by the program.

6 Subd. 6. **Prohibited procedures.** The following actions or procedures are prohibited as  
7 identified or defined herein:

8 (1) using corporal punishment such as hitting, pinching, or slapping;

9 (2) speaking to a person in a manner that ridicules, demeans, threatens, or is abusive;

10 (3) requiring a person to assume and maintain a specified physical position or posture as a restrictive  
11 procedure, for example, requiring a person to stand with the hands over the person's head for long periods  
12 of time or to remain in a fixed position;

13 (4) use of prone restraints. "Prone restraints" means, use of manual or mechanical restraint that  
14 places a person in a face-down position. This does not include brief physical holding of a person who,  
15 during an incident of physical restraint, rolls into a prone, or supine or face-up position, and the person is  
16 restored to a standing, sitting, or side-lying position as quickly as possible. Applying back or chest  
17 pressure while a person is in the prone or supine position is prohibited.

18 (5) placing a person in seclusion. "Seclusion" means confining of a person alone in a room from  
19 which egress is beyond the person's control or prohibited by staff members or a mechanism such as a lock  
20 or by a device or object positioned to hold the door closed or otherwise prevent the person from leaving  
21 the room in order to isolate a person from others to interrupt and intervene with symptoms or target  
22 behavior that places the individual or others at risk of harm;

23 (6) use of timeout. "Timeout" means removing a person from positive reinforcement, the contingent  
24 withdrawal or removal of the opportunity to earn positive reinforcement or the loss of access to positive  
25 reinforcers for a specified period of time. / "Time out" means removing a person from an activity to a  
26 location where the person cannot participate in or observe the activity and includes moving or ordering a  
27 person to an unlocked room. Timeout includes:

28 (i) use of exclusionary timeout. "Exclusionary time out" means creating a time out from positive  
29 reinforcement by placing a person in an isolated area away from available reinforcers; and

30 (ii) use of contingent observation. "Contingent observation means a person is temporarily  
31 removed from their immediate environmental situation and positioned a distance away from the  
32 environmental setting that they were participating in for a specific period of time due to their exhibiting of  
33 disruptive behavior. The person is required to observe, but not allowed to participate in, ongoing  
34 reinforcing activity. This procedure utilizes a form of exclusionary time-out in conjunction with modeling  
35 and reinforcement of others for exhibiting desired behavior.

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1 (7) use of chemical restraint; “Chemical restraint” means the administration of a drug or medication  
2 when it is used to control the person’s behavior or restrict the person’s freedom of movement and is not a  
3 standard treatment of dosage for the person’s medical or psychological condition.

4 (8) totally or partially restricting a person's senses;

5 (9) using a noxious smell, taste, substance, or spray, including water mist, as an aversive stimulus;

6 (10) denying or restricting a person's access to equipment and devices such as walkers, wheelchairs,  
7 hearing aids, and communication boards that facilitate the person's functioning. When the temporary  
8 removal of the equipment or a device is necessary to prevent injury to the person or others or serious  
9 damage to the equipment or device, the equipment or device must be returned to the person as soon as  
10 possible;

11 (11) use of positive punishment. “Positive punishment” means an action or technique used to  
12 decrease the rate, likelihood or future probability of a behavior by the contingent presentation of a  
13 stimulus. Positive punishment includes overcorrection. “Overcorrection” means an action or technique  
14 based on positive punishment in which, contingent on the selected target behavior, the person is required  
15 to engage in effortful behavior directly or logically related to fixing the damage caused by the selected  
16 target behavior. Overcorrection includes:

17 (i) restitutorial overcorrection to reduce target behaviors the behavior reduction, in which contingent  
18 on the selected target behavior, the person is required to clean, repair or correct the damage or return the  
19 environment to the original state and then engage in additional behavior to bring the environment to a  
20 condition vastly better than it was prior to the selected target behavior. restitutorial overcorrection,  
21 meaning a procedure that requires a person to clean, repair, or correct an area or situation damaged or  
22 disrupted as a result of the person's behavior to a point where the area or situation is not only restored to  
23 but exceeds its original condition; or

24 (ii) positive practice overcorrection, positive practice overcorrection, meaning a procedure that  
25 requires a person to demonstrate or practice a behavior at a rate or for a length of time that exceeds the  
26 typical frequency or duration of that behavior. The behaviors identified for positive practice are typically  
27 appropriate adaptive behaviors or are incompatible with a behavior identified for reduction or elimination  
28 in a person's individual plan;

29 (12) use of negative punishment. “Negative punishment” means an action or technique used to  
30 decrease the rate, likelihood or future probability of a behavior by the contingent removal or termination  
31 of a stimulus following the behavior. Negative punishment includes:

32 (i) the use of token economies that include the removal of tokens for select target behavior; and

33 (ii) response cost that relies on the removal of a specific amount of reinforce.



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1 (13) use of level system programs, step programs or response cost programs. “Level system  
2 program,” “step programs” or “response cost programs” means programs which remove something from a  
3 person that the person already earned;

4 (14) faradic shock;

5 (15) any aversive techniques; and

6 (16) any nonemergency use of any restrictive procedure identified in section 245A.71, subdivision  
7

X.

8 Subd. 7. **Emergency use of restrictive procedures.** (a) Emergency use of restrictive procedures  
9 listed in clauses (1) and (2) is permitted when the procedures are implemented in compliance with the  
10 requirements of section 245A.72, on an emergency basis for persons served in the program. All license  
11 holders must have a policy and procedure in place that meets the standards in 245A.70 to 245A.73.

12 (1) manual restraint; and

13 (2) temporary removal of an object

14 (b) Manual Restraint means physical intervention intended to hold a person immobile or limit a  
15 person’s movement by using body contact as the only source of physical restraint. It is any manual  
16 method that restricts freedom of movement or normal access to one’s body, but it does not include  
17 conduct necessary to perform medical examination or treatment. The definition of mechanical restraint  
18 also does not apply “to devices used to treat a person’s medical needs”

19 (c) Temporary removal of an object means the withdrawal or withholding of goods or adaptive  
20 devices or equipment, to which a person would otherwise have access, as a protective consequence of the  
21 person's inappropriate use of the item when that use would likely result in harm to the person or others or  
22 could result in adaptive devices or equipment being damaged. Temporary withdrawal or withholding is  
23 meant to be a brief period lasting no more than several minutes until the person's behavior is redirected  
24 and normal activities can be resumed.

### 25 **245A.71 EMERGENCY USE OF RESTRICTIVE PROCEDURES; PROGRAM STANDARDS**

26 Subdivision 1. **Emergency use of restrictive procedures plan.** (a) The license holder must have a  
27 plan for the emergency use of restrictive procedures permitted under section 245A.7X, subdivision X. The  
28 plan must include the following elements:

29 (1) A definition of which permitted restrictive procedures the license holder will allow to be used on  
30 an emergency basis and a description of the specific techniques that will be used to implement those  
31 procedures, including the types of physical holds or manual restraint techniques to be used.

32 (2) A requirement that the license holder complete an assessment of each person upon service  
33 initiation to determine the likelihood that the person may engage in behaviors that may require immediate  
34 intervention to protect the person or others from imminent risk of physical harm when less restrictive

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1 strategies do not achieve safety. The goal of the assessment is to obtain information about the person that  
2 could help minimize the use of a restrictive procedure by identifying the following:

3 (i) non-restrictive techniques that would help the individual control his or her behavior;

4 (ii) the person's need for methods or tools to manage his or her behavior;

5 (iii) a physician's statement regarding any pre-existing medical conditions or physical disabilities  
6 and limitations that would place the individual at greater risk during the use of a restrictive procedure or  
7 which would make implementation of any restrictive procedure medically contraindicated. A requirement  
8 that alternatives to or means under which a restrictive procedure might be used when there is a medical  
9 contraindication must be written as a treatment order by the person's physician;

10 (iv) any history of sexual or physical abuse or other trauma that would place the person at greater  
11 psychological risk during the use of a restrictive procedure; and

12 (v) techniques identified by the person or his or her family that would help minimize the use of a  
13 restrictive procedure .

14 (3) the internal procedures that must be followed for implementing an emergency use of a restrictive  
15 procedure, that includes the requirements identified in section 245A.7X, subdivision x;

16 (4) a description of the training a staff member must have completed before being permitted by the  
17 license holder to implement a restrictive procedure under emergency conditions, that includes the  
18 requirements identified in section 245A.7X, subdivision x;

19 (5) a requirement that each emergency use of restrictive procedures is reported and notification  
20 provided as identified in section 245A.7X, subdivision x; and

21 (x) incident reporting and internal review/staff debrief following each emergency use of restrictive  
22 procedures as identified in section 245A.7X, subdivision x, that reviews the context and antecedents of  
23 the restrictive procedures.

24 (6) that the license holder conduct an administrative review and assessment of each emergency use  
25 of restrictive procedures as identified in section 245A.7X, subdivision x, that includes a review of the  
26 person's individual plan to address the need for positive behavior supports and modification of the plan  
27 when determined necessary by the qualified professional; and

28 (7) a requirement that the license holder must prepare a written quarterly review of trends or patterns  
29 in the use of restrictive procedures in the program as identified in section 245A.7X, subdivision x.

30 (b) The license holder must submit the completed plan to the commissioner for review. The plan  
31 will be evaluated to determine whether the requirements are met and if so the program will be licensed.  
32 The plan cannot be implemented before the commissioner issues the approval.

33 (c) The license holder must ensure that the plan is accessible to staff persons responsible for  
34 supervising, implementing and monitoring the use of the plan.

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1 (d) The license holder must provide an orientation to the program's restrictive procedures plan to  
2 persons within five working days of service initiation. The license holder must provide an explanation of  
3 the plan to the person or the person's legal representative. Upon request, the license holder must provide  
4 the person or the person's legal representative a copy of the plan. Reasonable accommodations must be  
5 made by the license holder to provide this information in other formats as needed to facilitate  
6 understanding of the plan by the person or the person's legal representative. The license holder must  
7 obtain dated signatures from the person or the person's legal representative on the date the explanation is  
8 provided to document receipt of the explanation of the plan.

### 9 **245A.72 EMERGENCY USE OF RESTRICTIVE PROCEDURES; STAFF QUALIFICATIONS** 10 **AND TRAINING.**

11 Subdivision 1. **Staff qualifications.** The license holder must ensure that each staff person  
12 responsible for supervising, monitoring, or implementing a restrictive procedure is competent to do so  
13 safely and according to the license holders written emergency use of restrictive procedures plan, through  
14 training, experience, and education. The license holder must ensure that staff has sufficient training,  
15 experience, and education to meet each person's individual needs as identified in each person's service or  
16 treatment plan. Competence must be evaluated based on knowledge testing and observed skill assessment.

17 Subd. 2. **Staff training.** (a) Staff must complete knowledge and skills training before unsupervised  
18 contact with a person served by the program. The training must cover the following areas:

19 (1) the needs and behaviors of persons served by the program, including population specific training,  
20 and person-centered planning;

21 (2) relationship-building and cultural competency;

22 (3) alternatives to restrictive procedures, including techniques to identify events and environmental  
23 factors that may trigger behavioral escalation;

24 (4) de-escalation methods, positive strategies;

25 (5) avoiding power struggles;

26 (6) documentation standards for the use of restrictive procedures and how to document;

27 (7) how to obtain emergency medical assistance;

28 (8) time limits for restrictive procedures;

29 (9) Trauma informed care;

30 (10) the proper use of the restrictive procedures approved for the program, including simulated  
31 experiences of administering and receiving manual and mechanical restraint if allowed as restrictive  
32 procedures in the program's plan;

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1 (11) recognizing symptoms of and interventions with potential to cause positional asphyxia if  
2 manual restraint is allowed as restrictive procedures in the program's plan;

3 (12) thresholds for employing and ceasing restrictive procedures;

4 (13) when to utilize crisis resources including 911

5 (14) how to monitor and respond to the person's physical signs of distress; and

6 (15) the physiological and psychological impact on the person and the staff when restrictive  
7 procedures are used;

8 (16) incident reporting requirements, how to collect data and complete a report,

9 (17) any other training obtained under another requirement, if the same or similar as above, satisfies  
10 the requirements here.

11 (b) The license holder must ensure that a staff person trained in first aid and cardiopulmonary  
12 resuscitation is available at the facility.

13 (c) Training under this subdivision must be repeated annually.

14 (d) The license holder must ensure the training was provided by a qualified source, and must  
15 document the date the training was completed and total number of hours of training provided, the name  
16 and qualifications of the instructor providing the training, and the training curriculum used.

17 (e) License holders must permit family members or other persons who provide support to the person  
18 to participate in scheduled training sessions upon the request of the person or the person's legal  
19 representative.

20 Subd. 3. **Graduated training requirements.** (a) All staff, license holder executives, managers,  
21 supervisors must receive the training in subdivision 2(a) of this section. In addition to that training, the  
22 following graduated training requirements apply.

23 (b) **Direct care staff who implement positive support plans training requirements.** Direct care  
24 staff who implement positive support plans must have the following additional training:

25 (1) additional de-escalation training;

26 (2) additional positive support strategies training, subject to practical competency demonstration;

27 (3) relationship between behavior and a person's environment;

28 (4) person-specific knowledge and competence;

29 (5) staff self-care;

30 (6) supervisory skills, including collegial care and knowing how and when to communicate with  
31 the person's family, monitoring and training staff documentation and reporting;

32 (7) diagnoses and medications; and

33 (8) when to utilize crisis resources including 911.

34 (c) **Staff who develops positive support plans training requirements.** Staff who develop positive  
35 support plans must have the following additional training:

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- 1 (1) additional theory training;
- 2 (2) additional demonstrations of practical competency ;
- 3 (3) experience and demonstrated competence in developing actual behavior plans under supervision;
- 4 (4) research and resources;
- 5 (5) supervision, including how to train, coach and evaluate staff and communicate effectively; and
- 6 (6) Continuing Education requirements relevant to their field.

7 (d) **Staff who oversee positive support plans training requirements.** Staff who oversee positive  
8 support plan development staff must have the following additional training:

- 9 (1) Functional behavior assessment training;
- 10 (2) Person-centered planning application;
- 11 (3) Biology and behavior;
- 12 (4) Plan development while integrating disciplines;
- 13 (5) Data system use and design in care settings;
- 14 (6) Local human services system, procedures and resources;
- 15 (7) Supervisory and leadership; and
- 16 (8) Organization leadership and building capacity.

17 (e) **License holder's executives, manager and owners training requirements.** License holder  
18 executives, managers and owners must the following additional training:

- 19 (1) Outcome measurement;
- 20 (2) Local resources;
- 21 (3) Disability services management best practices;
- 22 (4) Person-centered thinking for organizations and implementation; and
- 23 (5) Continuing education.

### 24 **245A.73 EMERGENCY USE OF RESTRICTIVE PROCEDURES; STANDARDS AND** 25 **CONDITIONS BEFORE USE**

26 Subdivision 1. **Positive strategies.** (a) Prevention of behaviors targeted for reduction is predicated  
27 on identification of individual person's supports, planning to meet those needs, and the use of specific  
28 positive support strategies and de-escalation techniques in the person's support plan.

29 (b) License holder is responsible to acknowledge and address the person's need to properly  
30 reintegrate into services after an emergency use of a restrictive procedure. License holder is responsible to  
31 acknowledge and address the staff's need to properly reintegrate into providing services after the  
32 emergency use of a restricted procedure.

33 Subdivision 2. **Framework.** The license holder must provide a framework that demonstrates the  
34 following values and principles:

- 35 (1) the person is at the center of positive strategies;
- 36 (2) the license holder shall assess the preferences, dreams, values and how to address the needs of  
37 the person in light of those preferences. This includes the person's medical, social and skill-building  
38 needs;

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1 (3) the license holder shall design plans that focus on the person building skills to more fully  
2 participate in the community;

3 (4) the license holder shall provide data and reporting required under section 245A.7X, subdivision  
4 x;

5 (5) the license holder shall seek necessary resources to continually improve its delivery of services  
6 to persons served;

7 (6) the license holder will comply with all credentialing requirements and minimum competency  
8 requirements;

9 (7) the license holder shall ensure the emergency use of restrictive procedures manual is accessible  
10 to all staff.

11 Subdivision 3. **Trauma-informed care.** In accounting for the effects trauma has on individuals and in  
12 caring for individuals, license holders must consider that persons most likely have experienced trauma  
13 even if there is not a known trauma history. The license holder must use trauma-informed care  
14 approaches. The trauma-informed care approach seeks to moderate the possibility of worsening these  
15 neurological, biological, psychological, and social effects of trauma with treatment interventions.

16 Subdivision 4. **Positive strategies.** “Positive strategies” means evidence-based treatment strategies  
17 combined with biomedical science with person-centered values and systems change to increase quality of  
18 life and decrease selected behaviors and psychiatric symptoms.

19 Subdivision 5. **Therapeutic interventions.** “Therapeutic interventions” means a form of intervention  
20 which consists of early identification of potential emergencies; prevention of emergencies through verbal,  
21 non-verbal, and non-physical methods; diversion by providing choices to persons or alternate activities,  
22 environments or personal contacts.

### 23 **245A.74 EMERGENCY USE OF RESTRICTIVE PROCEDURES; CONDITIONS AND** 24 **PROCEDURES DURING USE**

25 Subdivision 1. **Monitoring of person during emergency use of a restrictive procedure.** (a) While a  
26 person is subjected to an emergency use of a restrictive procedure, staff must monitor the person for  
27 physical signs of distress such as difficulty breathing, \_\_\_\_

28 Subdivision 2. **Standards and conditions for emergency use of restrictive procedures.** (a) Emergency  
29 use of a restrictive procedure must meet the conditions of clauses (1) to (12));

- 30 (1) Immediate intervention is necessary to protect a person or others from imminent risk of physical  
31 harm;
- 32 (2) Property damage on its own, verbal aggression or a person’s refusal to receive or participate in  
33 treatment or programming do not constitute an emergency;
- 34 (3) The restrictive procedure represents the lowest level of intrusiveness required to achieve safety;
- 35 (4) The restrictive procedure is implemented only when the assessment and physician’s order have  
36 been obtained as required in subdivision 8, paragraph (a), clause (2);

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- 1 (5) Before staff uses a restrictive procedure, staff must complete the training required in subdivision
- 2 13 regarding the use of restrictive procedures in the program;
- 3 (6) The person must be constantly and directly observed by staff during the use of the restrictive
- 4 procedure;
- 5 (7) Staff must contact and notify the program director or other designated professional about the use
- 6 of the restrictive procedure to ask for permission to use the restrictive procedure as soon as it may
- 7 safely be done but no later than 30 minutes after initiating the use of the restrictive procedure;
- 8 (8) As soon as safely possible after implementation, staff will communicate with the person and
- 9 ascertain whether staff can safely cease the emergency restrictive procedure. Staff will continue
- 10 the procedure if safety of the person or others remains. Staff must document each attempt to
- 11 cease.
- 12 (9) Use of the restrictive procedure must not be applied longer than is necessary to achieve safety for
- 13 the person and others;
- 14 (10) Use of the emergency restrictive procedure must end when the threat of harm ends;
- 15 (11) When the use of the restrictive procedure ends, the person and staff must debrief and
- 16 safely return to the ongoing activities as soon as possible.
- 17 (12) Staff must treat the person respectfully throughout the procedure; and
- 18 (13) Medical assessment and treatment must be obtained if the person has been injured from
- 19 use of a restrictive procedure.
- 20 (b) Use of manual restraint must meet the conditions identified in paragraph (a) and the following
- 21 conditions:
- 22 (1) Efforts to lessen or discontinue the manual restraint must be made at least every 15 minutes
- 23 unless contraindicated; and
- 24 (2) The time each effort to lessen or discontinue or to provide an opportunity for release from the
- 25 manual restraint and the person’s response to the effort must be noted in the person’s permanent
- 26 record and required reporting documentation in section X.
- 27 (c) Internal review. [place holder]
- 28 (d) External review. [place holder]
- 29 (e) Functional behavior assessment. A functional behavior assessment should include a clear and
- 30 specific description of the behavior of interest and reveal the context in which the behavior occurs, the
- 31 antecedents or triggers that signal the availability of reinforcement for the behavior of interest and the
- 32 consequence that maintains the behavior of interest. A functional behavior assessment allows the
- 33 practitioner to predict when the behavior of interest is likely to occur.

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1 245D:

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3 **245D.XXX Access to person-centered planning services.** (a) License holders must inform the person  
4 and the legal representative, if applicable, that person-centered planning services are available to the  
5 person and explain what the services are, that the state requires these services be offered to the person and  
6 how to initiate the services. The license holder must give the person, or the person's legal representative,  
7 this information when the person enters the program and at least annually thereafter. The person may  
8 choose to or not to utilize the person-centered planning services and create a Person-centered Plan.  
9 Persons with a legal representative will receive person-centered planning services unless the person  
10 expressly requests otherwise. Persons who are minors shall have as much control of the person-centered  
11 plan as appropriate considering the person's condition.

12 Subdivision 1. **Person-centered planning values and principles.** (a) Person-centered planning is a  
13 highly individualized process designed to respond to the expressed needs and desires of the person. The  
14 license holder must ensure that:

- 15 (1) Every person is presumed competent to direct the planning process, achieve his or her goals and  
16 outcomes and build a meaningful life in the community;
- 17 (2) Every person has strengths, can express preferences and can make choices;
- 18 (3) The person's choices and preferences are honored and considered, if not always implemented;
- 19 (4) Every person contributes to the person's community and has the ability to choose how supports  
20 and services enable him or her to meaningfully participate and contribute;
- 21 (5) The person-centered planning process maximizes the person's independence, creates community  
22 connections and works towards achieving the person's chosen outcomes; and
- 23 (6) A person's cultural background is recognized and valued in the person-centered process.

24 Subdivision 2. **Development of a person-centered plan.** When a person chooses to create a person-  
25 centered plan, the license holder shall refer the person to the person's **case manager** for a list of person-  
26 centered planning facilitators.

27 Subdivision 3. **The person-centered planning process.** (a) The person chooses who to include in the  
28 person-centered planning process. If a person has a legal representative, the person may choose to or not  
29 to include the legal representative in the person-centered planning process. If the legal representative is  
30 included in the planning process, the legal representative's role is to advocate on behalf of the person,  
31 their preferences and strengths through the planning process. If there is a difference of opinion between  
32 the legal representative and the person as to preference or the plan, the person's preference shall take  
33 precedence.

34 (b) The person chooses with whom to and not to disclose the person-centered plan. If the person chooses  
35 not to disclose the contents of the person-centered plan with the license holder, the license holder is  
36 required to create legally required plans for the person that address the person's individual needs.

37 (c) An individual chosen or required by the person may be excluded from participating in the person-  
38 centered planning process only if inclusion of that individual would constitute a substantial risk of  
39 physical or emotional harm to the person or substantial disruption of the planning process. Justification  
40 for an individual's exclusion shall be documented in the case record.



1        Subdivision 4. **Using the person-centered plan.** (a) If a person utilizes person-centered planning  
services  
2        and discloses the plan to the license holder in whole or in part, the license holder shall use the  
person-  
3        centered plan to develop a service plan, crisis prevention plan and any other plans license holder is  
legally  
4        required to develop for the person.

5        (b) Person-centered planning services will be used anytime the person's goals, desires,  
circumstances,  
6        preferences or needs change or as the person requests but not less than annually. The provider shall  
7        inform the person of their right to update the person-centered plan at least annually.

8        (c) If a person is not satisfied with his or her person-centered plan, the person or legal representative  
may  
9        make a request for review the person-centered plan to the person-centered planning facilitator. The  
review  
10       shall be completed within 30 days of the request.

11       Subdivision 16. **Person-centered planning.** "Person-centered planning" means a process that  
creates a  
12       plan intended to support the person which recognizes the person's capacity to engage in activities  
that  
13       promote community life including the person's preferences, choices and abilities.