Jensen Settlement Agreement (JSA) Frequently Asked Questions

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JENSEN SETTLEMENT AGREEMENT

Q JS1 – What is the *Jensen* lawsuit?

Answer:

The *Jensen* lawsuit is a class-action lawsuit filed in federal court in July 2009 on behalf of persons who had been subjected to seclusion or restraint at the Minnesota Extended Treatment Options (METO) program. The lawsuit was heard by U.S. District Judge Donovan Frank and was based in part on a report by the Office of Ombudsman for Mental Health and Developmental Disabilities. [1]

Q JS2 - What was the outcome of the *Jensen* lawsuit?

Answer:

In December 2011, the state of Minnesota entered into a settlement agreement to conclude the *Jensen* lawsuit. The *Jensen* Settlement resulted in major changes to the way DHS treats people in its programs. Information on the *Jensen* Settlement is found on the DHS web site.

Q JS3 - Who are the *Jensen* Class Members?

Answer:

Jensen Class Members include all persons subjected to the use of any aversive or deprivation procedures, including restraints or seclusion, while a resident at the METO program at any time(s) from July 1, 1997, through May 1, 2011. *Jensen* Class Member does not include any individual who has properly and effectively requested exclusion from the Settlement Class.

Q JS4 - Who is included in the *Jensen* Therapeutic Follow-up group?

Answer:

As part of the Comprehensive Plan of Action developed to implement the *Jensen* Settlement Agreement, DHS has agreed to maintain therapeutic follow-up of Class Members, and clients discharged from METO from May 1, 2011 to June 30, 2011. In addition to *Jensen* Class Members, persons who received treatment at MSHS — Cambridge between July 1, 2011, and August 30, 2014, are included in the Therapeutic Follow-up Group.

Q JS5 – What is the Comprehensive Plan of Action?

Answer:

The Comprehensive Plan of Action is a legal document established in March 2014, which outlines the path the Department of Human Services (DHS) is taking to come into compliance with the terms of the *Jensen* Settlement Agreement. The Comprehensive Plan of Action has three parts:

- Part I addresses the closure and replacement of the Minnesota Specialty Health System (MSHS)-Cambridge facility with community homes and services.

[1] The terminology used to describe people with disabilities has changed over time. The Minnesota Department of Human Services ("Department") supports the use of "People First" language. Although outmoded and offensive terms may be found within this report, the Department does not endorse these term/s

- Part II addresses the modernization of Rule 40 (Positive Supports Rule).
- Part III addresses the development of Minnesota's Olmstead Plan.

Q JS6 – How does the *Jensen* Settlement Agreement and the Comprehensive Plan of Action affect the work of counties and providers?

Answer:
DHS must use its best efforts to make sure counties and providers are following the same best practices in their programs that DHS has adopted in their programs. This may mean changes in rate setting or contracts, or changes in rules and statutes to require that counties and providers update their services. Lead agencies and providers must be involved in implementing the person's plan(s) as written, in compliance with the *Jensen* requirements.

Q JSA7 – Whom should I contact if I have questions concerning the *Jensen* Settlement Agreement, or a *Jensen* Class Member or a member of the Therapeutic Follow-up Cohort?

Answer: Send questions to the DHS *Jensen* Settlement e-mail box at DHS*Jensen*SettlementDHS@state.mn.us

OLMSTEAD

Q O1 – What is the "Olmstead Decision"?

Answer:
In 1999, the US Supreme Court ruled that segregation of people with disabilities is illegal. The "Olmstead Decision" said people with disabilities are best served alongside everyone else, and must be integrated in the community as much as possible, with supports as necessary.

Q O2 - What is an "Olmstead Plan"?

Answer:
An Olmstead Plan is a way for a government entity to document its plans to provide services to individuals with disabilities in the most integrated setting appropriate to the individual if the individual does not object. Information about Minnesota's Olmstead Plan is found on the Minnesota's Olmstead Plan web site.

Q O3 – What does the "most integrated setting" mean?

Answer:
The United States Department of Justice explains that the "most integrated setting" under the Americans with Disability Act (ADA) and Olmstead is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." This means that people with disabilities belong where everyone else is, whether that is jobs, housing, school, doctor's office, or playing golf.

MINNESOTA LIFE BRIDGE

Q MLB1 – What is Minnesota Life Bridge?

Answer:

Minnesota Life Bridge (MLB) is a community-based residential treatment program for individuals with developmental disabilities who exhibit severe behaviors that present a risk to public safety. MLB furthers the provisions and spirit of the *Jensen* Settlement Agreement. MLB has two primary objectives:

1. The first objective of MLB is to try to stop or "divert" people from having to leave their homes, jobs, communities, families and friends for treatment, by providing support where they live.
2. The second objective of MLB is to have treatment options in targeted geographic locations around the state when out-of-home placement for treatment cannot be avoided.

Q MLB2 - How long can people live in a Minnesota Life Bridge treatment home?

Answer:

MLB is not intended to be a long-term residential placement. The goal at MLB is to treat and transition people back to their community. Because MLB is a person-centered treatment program, there is no specified length of stay applied to all people.

Q MLB3 - What is the difference between Community-Based Services (CBS) Crisis Homes and the Minnesota Life Bridge Treatment Program?

Answer:

There are important differences between CBS Crisis Homes and Minnesota Life Bridge. These differences are primarily around eligibility and program structure.

	CBS Crisis Homes	**Minnesota Life Bridge**
Eligibility	A diagnosis of developmental disability, traumatic brain injury or mental illness is required.	1. A diagnosis of developmental disability or related condition/s is required. 2. **Risk to public safety is high (**for example assaults on citizens, felony crimes with criminal court actions)
Mobile Supports	No mobile supports to serve persons in their home and community	Mobile supports to serve persons in their home and community as best possible

Q MLB5 – Are Minnesota Life Bridge services available to children?
Answer:
MLB is not licensed to serve children in its community-based treatment homes or through mobile supports.

Q MLB 6 - How is a referral to Minnesota Life Bridge made?
Answer:
Contact the MLB Transition Coordinator at (763) 689-7326.

Q MLB 7 - Where can I find more information on Minnesota Life Bridge?
Answer:
See the Department of Human Services Community-based Services Manual or Bulletin 14-76-01 (Issued April 29, 2014) Transition of Minnesota Specialty Health System (MSHS) – Cambridge to Minnesota Life Bridge: Admission and Discharge Processes, Transition Planning and Community Mobile Support Services.

SUCCESSFUL LIFE PROJECT

Q SLP 1 – What is the Successful Life Project?
Answer:
The Successful Life Project provides on-going consultation and follow-up for Class Members, and clients discharged from METO from May 1, 2011 to June 30, 2011 and persons who received treatment at MSHS — Cambridge between July 1, 2011, and August 30, 2014.

Q SLP 2 –Where can I find more information on The Successful Life Project?
Answer:
See the Community-based Services Manual or Bulletin # 15-76-01 (Issued January 27, 2015) Successful Life Project Services.

RESTRAINTS

Q R1 –The Minnesota Statutes that define manual restraint usage are somewhat confusing. Can you provide some clarification on the emergency use of manual restraints?

Answer:

Emergency use of manual restraint	**Conditions for emergency use of manual restraint**
Emergency use of manual restraint *is a safety or risk management tool, not a clinical procedure.* [Minn.Stat.§245D.02, Subd. 8a] "Emergency use of manual restraint" means using a manual restraint when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, (without imminent risk of physical harm), verbal aggression, or a person's refusal to receive or participate in treatment or programming on his or her own **does not** constitute an emergency.	[Minn.Stat.§ 245D.061] Emergency use of manual restraint must meet the following conditions: 1. **Immediate intervention** is needed to protect the person or others from imminent risk of physical harm; and *2.* The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety. The manual restraint must end when the threat of harm ends.

Q R2- Can staff use mechanical restraints during a medical procedure?

Answer:

Staff may use mechanical restraints during a medical procedure, if indicated, to provide necessary medical treatment. However, best practice requires that we work toward the least restrictive method used for medical procedures.

Q R3 - Can staff use restraints with *Jensen* Class Members while receiving services at Anoka Metro Regional Treatment Center?

Answer:

The requirements below apply to all *Jensen* Class Members who receive services at Anoka Metro Regional Treatment Center. *Jensen* Class Members:

- Cannot be mechanically restrained, chemically restrained, placed in seclusion or time out, or placed in a prone restraint[2] or prone hold.
- Can only have emergency use of manual restraints to manage an emergency that presents imminent risk of harm to the Class Member or others.

[2] Prone restraint does not include brief physical holding of a person who, during an incident of manual restraint, rolls into a prone or supine position, when staff restore the person to a standing, sitting, or side-lying position as soon as possible.

Q R4 – Can restraints be used with people who have developmental disabilities but are not *Jensen* Class Members while receiving services at Anoka Metro Regional Treatment Center?

Answer:
All people with developmental disabilities should be served according to the terms of the *Jensen* Settlement. These terms use best practices for therapeutic interventions and the least restrictive intervention necessary to achieve safety. These terms will also keep DHS in compliance with guidelines in the Commissioner's DHS Respect and Dignity Practices Statement, the Americans with Disabilities Act and Minnesota's Olmstead Plan.

PERSON-CENTERED PLANNING

Q PCP1 - What is Person-Centered Planning?

Answer:
Person-centered planning (PCP) is a way to assist a person to set real-life goals in alignment with their personal desires and beliefs. A person-centered plan is not about fixing someone or making a person "better"…it is not a treatment plan. There are many approaches to person-centered planning, but all share a common foundation:

- Person-centered planning involves the individual receiving the service and as chosen by the individual, family members, neighbors, employers, community members, friends, and professionals (such as physician/ doctors, psychiatrists, nurses, support workers, care managers, therapists, and social workers), developing a plan on his/her community participation and quality of life. The person-centered plan focuses on the person's preferences, strengths, talents and dreams.
- The plan assists people to define and pursue their own desirable lifestyle and future.
- The plan includes actions to make the vision of their lifestyle and future possible.

Q PCP2 - Does "person-centered" mean just giving a person everything they want?

Answer:
No. Person-centered practice is a way of empowering a person who needs services and supports. It provides a balance of what is important **to** a person with what is important **for** them. Person-centered approaches are rooted in values, goals and outcomes that are important to the person, but also take into account other important factors that affect a person's life. It is not all about giving people whatever they want.

Q PCP3 – Is a PCP circle of support the same as an interdisciplinary support team?

Answer:
No. A PCP group or circle of support that is true to the principles of PCP does not come together because of professional roles or requirements, such as an interdisciplinary support team. A person-centered planning circle is made of people who want to contribute their time and talents because they care about the person and want to work for change in the person's life, and are invited by the person to do so.

Q PCP4 – How is a PCP group formed?

Answer:

The person determines who will be included in his or her PCP group. You can help the person determine who should be in their circle of support by following a few steps:

1. With the person, draw a relationship map.
   - People on the map may include family, friends, community members and support staff.
2. When the map is complete, ask the person who they would like to participate in this planning.
3. When there is a list of possible participants, work together to figure out a good way to invite them to the planning meeting and ways to be creative to have them join the planning meeting for example by electronic means if they are not able to be there in person.

Q PCP5 - Is a person-centered plan only useful for people with intellectual and developmental disabilities?

Answer:

No. The PCP was developed for use in the field of developmental disabilities in the 1980s and is now used with other populations, including older adults, children, people with mental illness, people with chronic illness, etc.

Q PCP6 - What is a Person-Centered Description (PCD) and how is it different from a Person-Centered Plan (PCP)?

Answer:

A Person Centered Description (PCD) provides a snapshot of a person's life based on what is known at the time it was written. A PCD is developed from information provided by the person, and those that know and care about him/her. The PCD is a tool to help others learn about things that are important **to** the person, important **for** the person, and how to provide supports that work well for the person. A PCD does not have action plans. PCPs have action plans.

QPCP7 – Which home and community-based waivers can pay for a person-centered plan and planning services?

Answer:

The Brain Injury (BI), Community Alternative Care (CAC), Community Access for Disability Inclusion (CADI) and Developmental Disabilities (DD) waivers all pay for the cost of a person-centered plan to be completed. A person-centered plan and planning service may be billed under the following waiver services:

1. **BI, CAC, CADI waivers**: Family Training and Counseling or
2. **DD Waiver**: Consumer Training and Education

MINNESOTA STATUTES, CHAPTER 245D

See 245D Home and Community-based Services (HCBS) Frequently Asked Questions