

About the subcommittee that reviews and responds to reports of emergency use of manual restraint

The purpose of this report is to share with the public who is on the External Program Review Committee's subcommittee, what they do and how work is conducted. Questions about their work should be directed to PositiveSupports@state.mn.us.

Background information

Acronyms you will see in this document

- BIRF: DHS form 5148: Behavioral Intervention Report Form
- DHS: Minnesota Department of Human Services
- DSD: Disability Services Division
- EPRC: External Program Review Committee
- EUMR: Emergency use of manual restraint
- FBA: Functional behavior assessment
- PBSP: Positive behavior support plan
- PSTP: DHS form 6810: Positive Support Transition Plan

Qualifications for joining the committee

To qualify for the committee, members must be experts in positive support strategies, defined as people who have comprehensive and authoritative knowledge of or skill in using positive support strategies as alternatives to the use of restrictive interventions. In addition to being experts in positive supports, some members are also mental health professionals (as defined in Minnesota Statutes, section [245.462](#)) or licensed health professionals (as defined in Minnesota Statutes, section [245D.02](#)). Members work for a variety of employers in Minnesota, which gives the committee the ability to see many different perspectives and improves insight.

Subcommittee member backgrounds

Stephanie M. Schaefer, MS, has been working in the field for almost 40 years, with 22 of them spent as an advocate through an employment agency in Waite Park, MN. She is a positive supports professional, providing training to support professionals on positive behavior supports, completing functional behavior assessments and designing positive behavior goals for people who receive employment services. She is a member of the Association for Positive Supports Minnesota, an instructor in how to avoid holds through the Crisis Prevention Institute, and qualified to write person-centered plans for people. Finally, she owns a business where she supports foster care providers in meeting licensing standards.

Dr. Danielle Bishop is a clinical pharmacist with board certification in the area of psychiatric pharmacy. She has more than 15 years of experience providing pharmaceutical care in both community-based and inpatient mental health

settings. Team-based, person-centered care and evidence-based psychopharmacology have been focuses throughout her career to ensure safe and effective use of medications. As a member of the EPRC, she works to identify opportunities where medication optimization may lead to positive outcomes.

Lindsay L. Nash holds an MEd in psychological professions with a BA in sociology/criminology. She has 22 years of experience working in human development and behavior and increasing quality of life by creating cultures of positive supports. She has a history of using the features of positive behavior supports as well as applied behavior analysis, in addition to person-centered thinking and planning. In her role as a designated manager for an adult foster care program as well as a member of the EPRC, she provides research, education, coaching, assessing and support for staff, providers and people who receive services to promote and increase self-determination, skill building, knowledge and competency in creating inclusive quality environments. This is done through relationships, personal choices and community involvement, thereby reducing aversive and prohibited procedures.

Jodi Greenstein, MSW, LICSW, CBIS, has been working with people with cognitive and physical challenges since 1988 as a social worker. She has been supervisor of Community Behavioral Services at Courage Center/Courage Kenny Rehabilitation Institute since 2005, overseeing the work of positive support analysts and professionals. She has served as chair of the DHS TBI Advisory Committee (2011) and is a certified instructor with the Crisis Prevention Institute.

Michael Boston has a BAS in psychology with more than 13 years of experience working primarily with adults with varying developmental disabilities as well as mental health disorders. He has a range of experience in adult foster care, including direct support professional, plan writing/implementation, managing houses, activity planning, human resources, team building, policy and procedure, training of staff, PSTP and FBA writing, EUMR monitoring, positive supports collaboration, PBSP writing and person-centered training. Most recently he has been involved as a designated coordinator for a supported living service environment, helping to promote person-centeredness through training and plan writing. His expertise is working with people who engage in interfering behaviors, as well as supporting people who are non-verbal.

Dr. Mary Piggott has a Ph.D. in special education, developmental disabilities. She has worked for DHS since 2014 as a person-centered positive support specialist. She is a certified person-centered thinking trainer and person-centered planning/picture of a life trainer. Before entering her current role, she supervised psychology staff in the Brainerd and Willmar Adolescent Psychology program, and she was the lead clinician for the development of person and family-centered community-based specialized foster care for adolescents with borderline personality disorders and conduct disorders in the metro area. She has been working in the field of disability services for more than 40 years and started her career as a direct support professional.

Stacie Enders is not a committee member but supports the committee as coordinator through the Community Capacity and Positive Supports team at DHS. She holds an undergraduate degree in middle school education and a graduate degree in public administration. She has more than a decade of experience supervising services and providing positive supports to people with developmental disabilities as a school teacher, home and community-based service provider and Minnesota DHS employee. Her work was recognized by the Arc of Denton County, Texas, as the 2014 Community Support Person of the Year.

Whole committee versus subcommittee responsibilities and scope

The External Program Review Committee is responsible for implementing [Minn. R. 9544.0130](#). In 2017, in order to reduce caseloads so committee members could focus more closely on specific people, the committee decided to split its work into three tasks:

1. Review EUMR BIRFs and provide guidance to service providers who use EUMR (managed by the EUMR subcommittee)
2. Review and monitor requests for the use of prohibited procedures (managed by the requests for approval subcommittee)
3. Monitor implementation of [Minn. R. 9544](#) and make recommendations to the commissioner about policy changes related to the rule (managed by the whole committee)

The EUMR subcommittee's duties are defined under Minn. R. 9544.0130 Subpart D:

“Review each reported emergency use of manual restraint and the license holder's response to the emergency use for the person. The commissioner must identify criteria that the external program review committee will use to evaluate the license holder's response. If the committee determines that a change is needed to reduce the frequency or duration of future emergency uses by the license holder, the external program review committee must provide guidance to the license holder about its response.”

While sometimes the committee's role is confused with the role of Licensing, the rule does not direct the committee to enforce statute, rule or policy. The subcommittee's role is to “provide guidance,” assistance and resources to providers.

Conditions for using EUMR

While there are many types of incident reports, this subcommittee's main job is to review and respond to reports of EUMR that are submitted through the BIRF. The following conditions must be met to use EUMR (see [Minn. Stat. 245D.061](#)):

1. Immediate intervention must be 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.

Reviewing reports of EUMR

How information is gathered, sorted, assigned and responded to

Every month, subcommittee members are assigned to people who receive services who might need some type of additional support. These people include those who need a PSTP because of repeated EUMR (according to [Minn. R. 9544.0070, Subpart 3](#)), people who were restrained recently for more than 30 minutes, and other people the committee or the DHS positive supports team believes might need changes to their care plans.

1. The process starts with the BIRF, which is completed by service providers and submitted to DHS. Those reports are then organized, reviewed and shared with the subcommittee by DHS staff who assign work based on providers and regions, with an effort to assign subcommittee members to people in their area and to assign all people served by one provider to the same subcommittee member. Work is also sometimes assigned by caseload size to ensure subcommittee members have enough time to investigate what is happening with each person thoroughly.
2. The next step in the process is for subcommittee members to read the EUMR BIRFs and any supporting documentation available (such as PSTPs or FBAs). While the subcommittee members are not required to do an in-depth case review on everyone who has ever had an EUMR BIRF and can use their professional judgment to

prioritize work, they do no fewer than 20 case reviews every month. Subcommittee members essentially look for two things in the documentation:

- That service providers are following Minnesota statute, rule and policy
 - That the documentation reflects professional standards of practice outlined in [Minn. R. 9544.0030, subp. 4](#)
3. If the subcommittee member has a concern or a recommendation to reduce the use of restraint, he or she contacts the provider to offer guidance. Also, subcommittee members often contact providers even when they don't have recommendations just to offer their support and to let service providers know they are available for consultation as needed.
 4. For people who have been on the subcommittee's assignment list for several months and who are not experiencing a downward trend in the use of restraint, subcommittee members and DHS staff offer site visits. After each visit, a list of recommendations is provided and then the subcommittee member continues to monitor and offer additional support as needed. However, the committee prioritizes helping service providers find local support because the committee does not have the capacity to support everyone in the state who engages in interfering behavior.
 5. Monthly, the entire subcommittee meets to review progress on their cases, to coordinate as a team and to brainstorm next steps for any challenging cases.

Examples of work completed

Some common examples of recommendations committee members have made are:

- Update or request an FBA to pinpoint why the person is engaging in interfering behavior
- Complete a person-centered plan to find out what is important to the person and what might be effective reinforcement strategies
- Ask the case manager to set up services with an occupational therapist, physical therapist, counselor or positive support professional
- Schedule a medical or dental exam to explore if a physical ailment might be contributing to the behavior
- Add additional information to the PSTP, such as explaining more in detail how the team will teach the person a new skill
- Collect information on what happens before the behavior occurs (typically called context and antecedent data)

The following are some case examples for real people (names changed to protect identity):

[These stories will be omitted from public posting until the subcommittee can be sure that the stories do not violate any regulations about sharing private health information]

