



Minnesota Department of **Human Services**

Rule 40 Advisory Committee Meeting Summary: 7.9.12

Attending:

Committee members: Steven Anderson, Kay Hendrikson, Anne Henry, Barbara Kleist, Pat Kuehn, Traci Lisowski, Annie Mullin, Leanne Negley, Andrew Pietsch, Kelly Ruiz, Bonnie Jean Smith, Gloria Steinbring, and Colleen Wieck

DHS Staff: Rick Amado, Alex Bartolic, Jane Brink, Donovan Chandler, Lori Dablow, Stacy Danov, Gail Dekker, Glenace Edwall, Katherine Finlayson, Dan Hohmann, Jill Johnson,, Jennifer Kirchen, Bob Klukas, Carol LaBine, Natalie Marr, Sandra Newbauer, Maureen O’Connell, Dean Ritzman, Lauren Siegel, Michael Tessneer, Suzanne Todnem, Munna Yasiri, Charles Young

Other State Staff: Michelle Ness (Minnesota Department of Health)

Other Organizations and guests: Brad Hansen (The Arc Greater Twin Cities), Sue McGuigan (Brain Injury Advisory Council), Bonnie Markham, Beth Fondell (University of Minnesota, Institute on Community Integration)

Committee Charge The Rule 40 Advisory Committee was formed as part of a settlement agreement. The committee will study, review and advise the Department of Human Services on how to modernize Rule 40 to reflect current best practices. This was the sixth meeting of the Rule 40 Advisory Committee, which met from 9:00 a.m. to 3:30 p.m.

Presentations The Committee heard brief talks from Mike Tessneer and Alex Bartolic about the settlement agreement context and purpose and scope, respectively. Chemical and Mental Health Services Administration Assistant Commissioner Maureen O’Connell spoke about the collaboration and coordination going on between Chemical and Mental Health Administration and Disability Services Division. The committee also heard a presentation from Dr. Natalie Marr, licensed psychologist and clinical director for Minnesota Specialty Health Systems programs, about Cambridge’s staff training requirements and practices.

Mike Tessneer: Reminded the committee about the context and expectations stated in the settlement agreement. The settlement agreement requires the committee review Arizona’s policy about managing inappropriate behavior.

Alex Bartolic: The purpose of this process is to establish standards for person-centered positive approaches, explicitly prohibit seclusion and restraint, and outline what to do in emergency situations when intervention is necessary to prevent harm. It also needs to address what to do if something happens that requires emergency intervention. This is in the context of person-centered principles and the outcomes that the Disability Services Division has adopted to promote, CHOICE:

Community membership

Health, wellness and safety

Own place to live

Important long-term relationships

Control over supports

Employment earnings and stable income

We have been talking about scope and coordinating with other standards from the beginning of this process. Policies are starting to take shape and we have learned as a group about other regulations, some within DHS and some in other state agencies (e.g., Minnesota Department of Education). As we have been examining how to apply the provisions being developed by this committee, we have been reminded that the current rulemaking authority for this effort is limited to licensed settings and services that serve individuals with developmental disabilities. However, we want to apply the principles and practices that are being fleshed out by this committee, including prohibitions, definition of an emergency and what to do in those situations, training, technical assistance, oversight, and monitoring, in the waiver provider standards statute and our federally approved waiver plans for all home and community based services. If, after embedding these provisions in statute and our waiver plans, there is a need for a rule that is applicable across all home and community based services, we will request legislative authority this next session to expand the scope of the rule. As previously explained, this rule fits in a broader framework of other policy initiatives and requirements. For example, requirements around the use of chemical restraints will come from recommendations of the waiver provider standards, as legislative language is developed for Minnesota Statutes chapter 245D, the home and community-based services provider standards licensing authority. Additionally, DHS has made a commitment to evaluate standards in other regulations that are in place against the provisions recommended by this committee to determine what changes are needed to ensure the principles of person-centered positive approaches to interventions are consistently applied and there is adequate oversight, data collection, training and technical assistance across all of our services.

Maureen O'Connell: There is tension in the disability world and within the mental health field because there is a fear that the strong standards currently in the mental health field will not be as strong if applied across all disability populations. But the department is committed to best practices for all people with disabilities to reach the highest standards we can. O'Connell and Glenace Edwall, who is Director for DHS' Children's Mental Health Division, are both committed to ensuring that Minnesota has the highest standards across services. O'Connell recognizes that many people who seek services have multiple diagnoses so the department must look at all disabilities and set high

standards for all providers. The department will take the work of this committee and evaluate other regulations and determine which policies need to be updated and which policies will apply to all disabilities. The Chemical and Mental Health Administration will work with the Rule 40 Advisory Committee on this important work. O'Connell heard that members of the Advisory Committee were happy to hear about some of the work the Chemical and Mental Health Services Administration is doing and taking this work across divisions. The Chemical and Mental Health Services Administration plans to convene a separate mental health stakeholders group to discuss the work of the Rule 40 Advisory Committee.

Concern was voiced that some mental health providers do not have readily at hand the information requested in the provider survey initiated by the Advisory Committee. One Advisory Committee member expressed concern that such data is not available and that people with the same diagnosis are treated differently by the same provider. There was agreement from O'Connell that there should be a foundation of person-centered planning, dignity and self-determination for all disability programs.

Alex Bartolic: Provided an update on the Advisory Committee timeline. DSD will host additional work group sessions with Advisory Committee members and state staff to get the in-depth policy work done. The work group meetings are open to interested parties. Information and recommendations regarding the topics will go back to the committee for final recommendation.

Rule Name: The committee members discussed a new rule name. Many suggestions were made and noted. Comments included dissatisfaction with the word "disruptive" as being negative and the word "positive" should be in the title. Katherine Finlayson from the Licensing Division of DHS recommended that the rule not include adjectives because they are subject to interpretation but rather focus on what is being regulated. The rule name will be revisited at the August meeting.

Members could vote for up to three choices. Votes are in Parentheses next to the proposed rule name. There was no clear consensus on a single name but there were three proposals that each received four or five votes.

1. (1) Behavior Supports Rule
2. (1) Positive Behavior Supports
3. (1) Disruptive Behavior Management
4. (0) Addressing Challenging Behaviors
5. (1) Behavior Intervention Strategies
6. **(5) Quality Outcomes Standards and Safeguards for Behavior Supports**
7. (0) What to Do in Case of Emergencies
8. **(5) Emergency Intervention Strategies (Rule Safeguards)**
9. **(4) Regulated Intervention Standards**
10. (2) Regulations and Safeguards for Behavior Supports
11. (2) Behavioral Intervention Practices and Procedural Safeguards
12. (0) Controlled Behavior Standards

Natalie Marr: Doctor Marr provided various handouts on the training and curriculum used to train Minnesota Specialty Health Systems (MSHS) programs staff. All staff at the Cambridge facility went through the training required in the settlement agreement. The specific materials will be made available by State Operated Services staff but many of the trainings are hands-on and do not have accompanying handouts. Doctor Marr stated that MSHS purchased an online training program through the College of Direct Supports for the staff in MSHS. The state does not have a master contract for those services because MSHS purchased training based on the number of staff they employ. Alex Bartolic explained that some parts of the College of Direct Supports training have been purchased by the Department of Human Services for families' use. Information about how to view the training material will be on the Rule 40 Advisory Committee web site.

Discussion

Positive techniques (Input for Work Groups)

Committee members received a draft of possible rule language for discussion purposes only. The committee members previously expressed a desire to make person-centered planning a rule requirement. Some of the positive practices, such as person-centered planning, might best belong in Minnesota Statutes chapter 245D because we want the standard to apply to all providers of care and treatment services and not limit the standard to providers who serve persons with developmental disabilities in licensed facilities. Some policy requirements should go in rule and others in a provider manual which may be the best option to keep enforced practices current. There was concern that the specific enforced practices need to be updated in a timely fashion to remain current.

Prohibited techniques (Review of Prior Work)

The committee members again looked at the rule draft. One recommendation was to ensure the prohibited techniques are consistent with permitted actions. For example, pinching was prohibited as a form of corporal punishment but then pinching a person's nose was permitted to release a person's bite. The committee considered the role of personal safety devices and whether they are mechanical restraints that should be prohibited or made a separate category and permitted with teaching requirements. There was concern that if any type of mechanical restraint is allowed, even as a safety device, it might be a slippery slope to inappropriate use of mechanical restraint because providers might stop or have limited teaching so the person does not progress away from the safety device.

Sometimes a provider will take away, restrict usable access to or modify proper use of a person's medical equipment or devices such as an electric wheelchair if the person is causing harm with it. When a provider restricts use of medical equipment or devices, it should be considered an emergency technique that triggers reporting.

The committee must also balance protecting persons served in programs and giving providers effective tools. One example discussed is response cost. Response cost is an aversive procedure but it might be an effective tool for providers to use. Does the committee want to recommend prohibiting response cost in all its forms or permit the technique and if so, with what kinds of controls should be imposed on the use of response cost? Also how do “level” programs fit in here? Committee members raised concern over prohibiting response cost systems because of concern about provider reaction to such a prohibition that might limit the number of providers who accept persons with challenging or disruptive behaviors. Response cost is the loss either of a previously earned reinforce or of an opportunity to obtain reinforcement oftentimes used with token economy programs. Response cost programs become punitive when the person does not earn the token or has one taken away.

Committee members and other attendees had a lively discussion about specific techniques and whether they should be prohibited or not. One suggestion was to add a “catch-all” clause that prohibits anything that is used as a punishment or to hurt someone.

Training (Input for Work Group)

The committee discussed suggestions such as:

1. College of Direct Supports – allows staff to do online training as they are available and has competency testing
2. Setting the minimum training requirement for adequately trained staff including what is acceptable training; standardize training; possibly require approval by commissioner
3. Coordinating training requirements with other existing training requirements (such as in statute)
4. Providing targeted support
5. Providing affordable emergency/crisis support and access to expertise when necessary
6. Specific training on the inappropriateness of punishment procedures
7. Code of ethics – see National Alliance for Direct Support Professionals’ code

Monitoring/reporting/oversight/metrics (Input for Work Group)

Monitoring and Reporting The reporting that Cambridge does was described as a luxury that will be more challenging to implement in the community. For example, being able to call a consultant during the restraint and having enough mental health professionals to call was considered unrealistic. Another recommendation was to look at Arizona’s monitoring and reporting requirements. One option is to differentiate reporting requirements for different types of restraints such as a few seconds of redirection versus hands-on restraint. The committee should also be mindful of other reporting requirements so as to not duplicate existing statutes and rules and instead figure out where gaps exist. Some current reporting standards should be maintained, such as reporting incidents to guardians.

Reporting requirements must be clear as well as what process is triggered by each report, including who is involved in the restraint, who is responsible to take action and when. Most importantly, an oversight process must be triggered when incidents are reported so that the information does not simply get filed without review and consideration.

Currently, all reporting to the Licensing Division is done manually and is not electronic. Software exists that the state could utilize at no cost to the state and a nominal fee charged to providers.

Oversight and Metrics DHS oversight of:

- Training
- Problem areas – geographic, etc. and resources for providers
- Accountability and penalties
- (Trends)

How does a provider provide care and treatment oversight? What information is relevant for care and oversight? If a provider has fifteen restraints in a four-bed house in one month, what does this mean? What action does the provider and oversight agency take?

Emergency restraint techniques (Input for Work Group)

A challenge is that not all staff are under clinical supervision so how do we apply this rule to all providers? Designate the QDDP to review all emergency restraint use?

The rule must be clear not only in what is an emergency technique but also what is not. There was concern that staff will not do physical escort even if the client does not resist because of concern it might be a physical restraint and entail the reporting requirements.

We discussed whether any mechanical restraints would be permitted such as Velcro softcuffs and fabric ankle straps. Some people opined that all mechanical restraints should be prohibited while others felt it was worth a discussion. If restraint is permitted, we were recommended that wrist and ankle restraint should not be permitted to be joined to each other.

The role of the crisis plan or risk management was suggested to address many of the concerns being raised. For example, the question was raised about emergency deprivation – e.g., suicidal client who has shoelaces, lights bulbs, etc. removed – and unexpected dangerous behavior. One concern is that the providers do not always have all the information they need because there is not always full disclosure during the intake process.

August meeting

1. We will review these three work group reports: Person-centered planning, positive support strategies and emergency use of restraint
2. Committee moves toward final recommendation on the three topics.

To improve meetings Materials should continue to be sent out no later than the Wednesday before the Monday meeting or one week before the meeting if possible. Good pace maintained at the meeting.

Reminder The August meeting is scheduled the FIRST Monday of the month on August 6, 2012, and will be held in room 3148 at the Lafayette building located at 444 Lafayette Road, St. Paul, MN 55155.

Questions or comments As always, if committee members or observers have questions, please email them to the Rule 40 email box at DHS.rule40@state.mn.us

Visit our website at

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelecti onMethod=LatestReleased&dDocName=dhs16_166534