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DEPARTMENT OF HUMAN SERVICES

External Program Review Committee: Annual evaluation report

Positive supports: Strategy 2C

Jan. 1, 2019

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Olmstead Plan Positive Supports, Strategy 2C

Annually evaluate progress and determine if there are additional measures to be taken to reduce the use of mechanical restraints to prevent imminent risk of serious injury due to self-injurious behaviors.

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About the External Program Review Committee

Purpose

The External Program Review Committee monitors the implementation of Minn. R. 9544, assesses the competency of qualified professional applicants to develop and implement positive support transition plans, reviews reports of emergency use of manual restraint and provides guidance to license-holders about their response to the emergency use of manual restraint. The committee also makes recommendations to the commissioner about:

- Policies related to Minn. R. 9544.0130 requirements
- Requests for emergency use of procedures in accordance with Minn. Stat. §245.8251, subd. 4.

Background

Over the past several decades, models of care for people with disabilities have shifted from focusing on institutional-like settings toward integrated, community-based home care. At the same time, providers have shifted away from the use of punitive practices and restrictive interventions to manage challenging behavior. Modern best practice focuses on using positive supports to encourage full participation in a life the person desires and values. The trend toward positive supports and person-centered approaches is occurring all over the country. People with disabilities have expectations for meaningful jobs, connections with others, community participation and independent living. Service providers are getting better at understanding how to support choice, control and direction.

The state of Minnesota recognized previous protections for people with disabilities were inadequate. The state made changes to reflect best practices. In 2009, residents of the Minnesota Extended Treatment Options program filed a class action lawsuit against the Minnesota Department of Human Services (DHS) alleging that they had been unlawfully and unconstitutionally restrained. Under a settlement agreement — known as the Jensen Settlement Agreement — Minnesota agreed to modernize its requirements for the use of restrictive interventions and positive supports.

In 2012, the Minnesota Legislature passed Minn. Stat. Chapter 245D, which outlines required standards, including positive support protections. These actions, however, did not cover all people with a developmental disability or related condition served by a DHS-licensed provider. To fulfill the state's agreement to implement the recommendations of the Rule 40 Advisory Committee, the department sought an administrative rule to govern the use of positive supports in all DHS-licensed facilities serving a person with a developmental disability or related condition. The result of this work is the Positive Supports Rule, Minn. R. 9544.

The Positive Supports Rule incorporates best practices for serving people with disabilities in the most integrated setting as identified by the Rule 40 Advisory Committee, the Jensen Settlement, national trends, lessons learned from the past and the Americans with Disabilities Act. The Positive Supports Rule ensures all DHS-licensed services and facilities that serve people with developmental disabilities or related conditions follow the prohibitions and limits in Chapter 245D. As a result, no DHS-licensed service or facility is permitted to use

clinically contraindicated practices on people who receive services governed by either 245D or the Positive Supports Rule.

The state recognizes providers face challenges while learning to support people with only positive support strategies after being allowed to use restrictions and restraints. Therefore, 245D and the Positive Supports Rule outline some situations in which a provider may use a prohibited procedure for a limited time to phase out the procedure.

One situation in which a provider might use a prohibited procedure is when the provider begins services for a person whose previous caregiver used prohibited procedures. If the person and his/her care team determines immediately ending the use of the procedure might cause serious harm to the person or others, the team may use the procedure for up to 11 months. The care team must incorporate the use of this procedure into a Positive Support Transition Plan (PSTP), DHS-6810 (PDF) and regularly report its use to DHS via the Behavior Intervention Reporting Form (BIRF), DHS-5148. The care team has 30 days after the start of services to develop the plan and 11 months after the plan's implementation date to phase out the use of the prohibited procedure.

A second situation in which a provider might use a prohibited procedure is when a person continues to engage in interfering behavior beyond the 11-month phase-out period. If the person displays self-injurious behavior that could cause serious harm and the care team determines a prohibited procedure is necessary to safeguard the person and others, the commissioner may grant approval for a limited time while the care team develops effective positive support strategies to phase out the procedure. For these situations, the commissioner established a temporary Interim Review Panel to review and grant approval for the emergency use of procedures (procedures are defined in Minn. Stat. 245D.06, subd. 5), while the External Program Review Committee was being assembled. The Interim Review Panel started reviewing and denying or approving requests in late 2014.

In February 2017, the Interim Review Panel transitioned to the External Program Review Committee. The functions of the External Program Review Committee continue to include those provided through the Interim Review Panel process. Additionally, the committee has the option to make recommendations to the commissioner about policy changes related to the requirements of Minn. R. 9544, reviews behavior intervention reporting forms for the emergency use of manual restraints, evaluates provider responses after the emergency use of manual restraints and assesses the competency of qualified professionals who develop and implement positive support transition plans.

Current task and observations

The External Program Review Committee evaluates progress and determines whether providers need to do more to reduce the use of mechanical restraints. Mechanical restraints are only allowed beyond the 11-month phase-out period as an emergency procedure for those who have submitted a Request for the Authorization of the Emergency Use of Procedures, DHS-6810 (PDF) form and have received approval from the committee and the commissioner. The commissioner grants approval for emergency use of procedures on a case-by-case basis. The length of approval ranges from 60 days to one year.

Table 1: Requests and approvals

New and renewed approvals and phased-out requests for mechanical restraints

Year	Total approvals granted	New approvals	Renewed approvals	Phased-out
2014	28	28	0	0
2015	23	4	19	9
2016	18	5	13	10
2017	13	2	11	4
2018	12	0	12	1

Over time, members of both the Interim Review Panel and External Program Review Committee noticed teams struggle more with phasing out the seat belt harnesses/guards than phasing out mitts, arm splints or helmets. For example, of the seven people who had approval for a seat belt harness/guard in 2014, four still had approval in 2018. In comparison, of the 21 people who had approval for other types of mechanical restraint in 2014, only two still had approval in 2018. As of Aug. 31, 2018, seven of the 13 approved requests for prohibited procedures are for seat belt harnesses or guards.

One explanation for this observed difference is the contrast between the type of self-injurious behavior that requires a seat belt harness/guard vs. the type of self-injurious behavior that requires the use of mitts, arm splints or helmets. Specifically, seat belt harnesses/guards typically address self-endangerment behaviors (behaviors that increase the potential for harm) whereas mitts, arm splints and helmets address self-injurious behaviors (behaviors that result in immediate harm).

Another difference between seatbelt restraints and other restraints is the setting. It is unsafe for staff to unbuckle to assist the person and most of the requests for the emergency use of procedures were for people who do not tolerate others sitting near them. For those who will allow staff to sit by them, it can still be challenging to both support the person and remain buckled. Pulling over can be dangerous or impossible on busy roads. Also, there are fewer environmental resources available in a vehicle: Some favored items outside of the vehicle include swings, mats/wedges, pianos, free space to move around, etc. Another consideration is that the emergency use of manual restraint is often not an option because staff cannot adequately position themselves to implement a hold safely. Unbuckling and other challenging behaviors can be distracting to the driver, which puts passengers, other vehicles and pedestrians at risk. Functional behavior assessments indicate some of the difficulties around driving for some people include not knowing where the vehicle is going, finding the motion disruptive, not wanting to leave where the person had just been, noises and motion sickness.

The legal constraint of seat belt laws put service providers in a difficult position when the person does not remain buckled. Understanding the safety necessity of wearing a seat belt is abstract and not simple to teach. It also requires understanding of long-term and low-likelihood cause-and-effect relationships. Further, Minnesota's seat belt law is a primary offense, meaning drivers and passengers in all seating positions — including in the backseat — must be buckled or in the correct child restraint. Law enforcement will stop and ticket unbelted drivers or passengers. A seat belt ticket is $25 but can cost more than $100 with fees (see Office of Traffic Safety). Service providers also are legally liable for the health and safety of the people served. Minn. Stat. 245D.06, subd. 2 requires that service providers:

- Follow procedures to ensure safe transportation, handling and transfers of the person and any equipment used by the person, when the license-holder is responsible for transportation of a person or a person's equipment
- Be prepared for emergencies and follow emergency-response procedures to ensure the person's safety in an emergency

Evaluation of progress

Providers with approval for emergency use of procedures must submit summation data to DHS on the use of mechanical restraints every seven days through the Behavior Intervention Reporting Form (BIRF), DHS-5148. Regardless of the frequency of mechanical restraint usage, each provider who has approval must submit one behavior intervention reporting form per week, per person. For example, a provider who uses mechanical restraint once a week with a person and a provider who uses mechanical restraint 100 times a week with a person both must submit only one behavior intervention reporting form for that person. Therefore, to determine if a team is making progress toward reducing the use of restraints, it is necessary to review the person's individual reports, which might include the behavior intervention reporting forms, positive support transition plans, quarterly positive support transition plan reviews or other data that care teams submit to DHS or the External Program Review Committee. The committee weighs and considers information required by Minn. R. 9544.0130 within the context of the person's quality of life.

Successes

While success looks different for each person, the committee has received reports of positive outcomes for every person under review. Some of the positives include:

- Increased community participation (to the extent desired by the person)
- Acquisition of new skills
- More time interacting with caregivers (storytelling, massages, games, etc.)
- New technology that allows the person to communicate needs and wishes
- Increased tolerance of previous precursors to target behaviors
- Environmental and home modifications

The External Program Review Committee has achieved success in increasing capacity of the state system and creating a culture of positive supports. Specifically, the committee regularly provides technical assistance to care teams in areas where teams have self- or committee-identified needs. For example, the External Program Review Committee:

- Meets with teams to review functional behavior assessments, data patterns and positive support transition plans
- Provides recommendations for consideration (e.g. examine whether staff are following and interpreting the plan in the same way)
- Maintains a webpage to provide resources for positive supports and an outline of information typically gathered during the phase-out period
- Informs providers and guardians about available services they might not have been aware of (e.g. Technology for Home or behavioral support services)
- Helps teams connect with other specialists (e.g., external positive support behavior specialists, deafblind communication experts, pharmacologists, etc.)
- Connects teams with DHS staff when they need technical assistance in other areas (e.g. rate exceptions).

Past recommendations

In January 2018, the committee assigned itself the following task: The committee will track data for seatbelt harnesses/guards separately from other types of mechanical restraints (e.g., mitts, arm splints, helmets). The committee will review this data in fall 2018 to identify similarities and differences between the two groups.

Data

The committee collected the following data and reviewed it in October 2018. Tthe results:

Base group

In 2018 providers had approval to use seatbelt restraints for six people, other (not related to seatbelts) types of mechanical restraint for five people and both a seatbelt restraint and one other type of mechanical restraint for one person.

Is there a different trajectory for each category?

The trajectory cannot be assessed because providers typically use seatbelt restraints proactively, whereas they apply other types of mechanical restraints after the person starts to attempt self-injury.

Ages

- The average age of the seatbelt group is 23.5 years old with a range of 15-32 years.
- The average age of the other group is 30 years old with a range of 22-36 years.

Staff ratios

There were no significant differences between the two groups for staffing ratios. All but two people (one in the seatbelt group and one in the other group) have at least 1:1 staffing.

Scores using the FBA and PSTP quality checklists

This task is likely not feasible because:

- It is possible the data might not be valid because it would be impossible to hide identities and reviewers might score higher for teams they have a rapport with vs. teams they have never met.
- This would not take into account supporting documents or other aspects of the person's care, such as person-centered planning or staff longevity.
- It would require a sophisticated scoring system and multiple reviewers to be valid, so it might not be feasible because of time constraints. The influence of factors outside of the two documents could prevent us from ensuring the scoring system is measuring what we intend it to measure.

Staff turnover

This information is not being recorded, though at least seven providers have reported problems with staffing to committee representatives. One person's services were terminated because of staffing shortages.

Licensed setting

There is no significant difference between the two groups for licensed settings. For the seatbelt group, two live with their parents and the rest live in corporate foster care homes. For the other group, one is served by family foster care and the rest live in corporate foster care homes.

Staff training (type and length)

There is no numerical data for this category, but committee representatives have met with every team in person. All of them appeared competent, capable and caring toward the people with whom they work. Their documentation also suggests high-quality care.

Policies and procedures

Each person has a plan that outlines the procedures staff should use to support the person. The committee has reviewed all plans. At one of the summer subcommittee meetings a member noted that the plans have been much higher quality than previous years. The committee did not have further recommendations for the majority of plans reviewed within the past six months.

Future recommendations

Given the work of the Interim Review Panel and External Program Review Committee, we have learned much about what strategies work best. The committee will continue to expand on effective strategies. For issues that need to be addressed, the committee has the following recommendations to guide future work:

- The committee will continue to provide technical assistance to teams for cases that have had little movement toward phasing out mechanical restraints. The committee encourages evidence-based practices and places an emphasis on quality-of-life measures that align with the person's values.
    - One type of assistance we have and will continue to offer is help with finding more highly trained positive support behavior professionals who can support the current service provider.
- The committee will continue conversations with teams and help them improve their data-collection and analysis methods.
- The committee recommends DHS and other state representatives implement the Recommendations to Expand, Diversify and Improve Minnesota's Direct Care and Support Workforce to continue to address the direct support staff workforce shortage.