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DEPARTMENT OF HUMAN SERVICES

External Program Review Committee (EPRC): Annual evaluation report

Positive supports, Strategy 2C

January 2021

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https://mn.gov/dhs/partners-and-providers/program-overviews/long-term-services-and-supports/positive-supports

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Introduction

The purpose of this report is to address positive supports strategy 2C listed in the Olmstead Workplan: "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. The review will be completed by External Program Review Committee (EPRC)." Additionally, the committee has opted to include information in this report about work being done to address emergency manual restraint, and clarifying information to help the public learn more about the committee.

Introduction to the EPRC

The EPRC is an advisory committee to the commissioner of the Department of Human Services, which was established through the Minnesota Positive Supports Rule, Minn. Rule 9544. Generally speaking, the committee:

- Reviews requests to use mechanical restraint, provides recommendations to the commissioner to approve or deny requests, and provides ongoing technical assistance and guidance to help Minn. Stat. 245D providers phase out the use of mechanical restraint
- Reviews reports of emergency manual restraint and provides ongoing technical assistance and guidance to DHS-licensed providers who are using manual restraint or other targeted interventions listed in a Positive Support Transition Plan, DHS-6810 (PDF)
- Monitors implementation of Minn. Rule 9544 and provides recommendations to DHS on how to further promote, provide access to and educate people on the use of positive support strategies.

For a detailed list of committee responsibilities, see Minn. Rule 9544.0130.

Contents of this report

The first section of this report will include an update on the use of mechanical restraint among Minn. Stat. 245D service providers.

The second section will be an update on the emergency use of manual restraint among DHS-licensed providers.

The third section will focus on committee recommendations to further reduce the use of all types of restraints and to promote the use of positive support strategies.

The final section will include some additional clarifying information about who is a part of the committee and how they operate.

Acronyms you will see in this document

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

Mechanical restraint

The EPRC is tasked with annually evaluating progress and determining if there are additional measures to be taken to reduce the use of mechanical restraints. Because of the small number of providers using mechanical restraint, the committee is able to monitor progress on an individual level.

Examples of good faith efforts to reduce the use of restraint

Use of mechanical restraint by providers licensed under Minn. Stat. 245D must be reported to DHS, and for most of the 2020 cases, service providers needed approval from the commissioner before using or continuing with the restraint (see more details on the following page). The process for obtaining approval starts with the EPRC. For the EPRC to give the commissioner a recommendation to approve the use of mechanical restraint, service providers must demonstrate that the restraint is necessary to protect the person, as well as demonstrate good faith effort(s) to eliminate the restraint. Complete details about the requirements can be found under Minn. R. 9544.0130. Good faith effort can be demonstrated in many ways and is different for each person, depending on their specific needs. Below are some examples of good faith efforts demonstrated by providers (or partners) who submitted requests for approval in 2020:

- Helped people use augmentative and alternative communication devices
- Improved quality of life, such as supporting relationships with friends and family, supporting people to express their gifts and talents, etc.
- Collected context, antecedent, behavior and consequence data to identify what might trigger or reinforce a behavior
- Assessed the function[1] of behaviors that includes reviewing biological, psychological, environmental and quality of life factors
- Updated person-centered plans that identify things that are important to and for each person
- Consulted with experts on positive supports
- Taught or reinforced safe behaviors that can replace interfering behaviors
- Completed medication reviews and/or attended medical appointments or consultations with specialists
- Worked with occupational therapists to address sensory needs
- Coordinated with Technology for Home to develop new methods for supporting independence and choice
- Met with committee representatives to discuss plans of care, and routinely provided updates
- Increased community inclusion, though opportunities in 2020 were limited due to the Covid-19 pandemic
- Modified or redesigned vehicles or homes
- Routinely updated plans of care to reflect changes and current best practices that are specific to the person
- Purchased items such as interactive toys, sensory items, headphones, tablets, etc.
- Coordinated with schools and other service providers
- Increased or changed staff training.

[1] Behavior is related to many things. It always has a purpose or a function. This does not mean that the behavior is voluntary or used consciously. Examples of purpose and function are getting something, avoiding something undesirable or enjoying something. Some behaviors, like unexplained movements or sounds, can be neurologically based and cannot be changed with behavioral interventions. These behaviors often just "seem to happen." While the person has no control over these behaviors, sometimes the person or staff find that certain stimuli in the environment may trigger their occurrence.

The EPRC's purview on mechanical restraint

This report covers the use of mechanical restraint reviewed and monitored by the committee, then approved or denied by the commissioner of Human Services. It does not include:

- Use of mechanical restraint by service providers licensed under anything besides Minn. Stat. 245D (For example, use of restraint in hospitals or schools is not overseen by the EPRC)
- Use of mechanical restraint by service providers who meet the requirements to do an 11-month phase out via a Positive Support Transition Plan, DHS-6810 (PDF) (Committee review and commissioner approval are not immediately required when providers meet certain requirements under Minn. Stat. 245D.06, subd. 8 and the Positive Support Transition Plan Instructions, DHS-form 6810B (PDF). However, if providers need more than 11 months to safely phase out restraint, they must then contact the committee for a review and seek commissioner approval)
- Uses of mechanical restraint implemented outside the guidelines provided in Minnesota rule or statute (Those reports are handled by either DHS positive supports staff or Licensing).

Data on requests for approval to use mechanical restraint

Overall, the use of mechanical restraint in Minnesota has significantly decreased since the implementation of Minn. R. 9544. The remaining people are closely monitored by the EPRC and have many competent professionals working to find alternatives. The following chart outlines mechanical restraint approvals from the commissioner over the past seven years:

Year	Total approvals granted	New approvals	Renewed Approvals	Approval ended
2014	28	28	(N/A)	0
2015	23	4	19	9
2016	18	5	13	10
2017	13	2	11	4
2018	12	0	12	1
2019	13	3	9	2
2020	9	0	9	2

Assessment of trends in mechanical restraint

Seatbelt harnesses and guards

Over time, members of both the Interim Review Panel (predecessor to the EPRC) and the EPRC noticed teams struggle more with phasing out the seat belt harnesses/guards than phasing out other types of mechanical restraint. 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 December 2020, five of the nine approved requests for prohibited procedures are for seat belt harnesses or guards.

One explanation for the observed difference between seat belt restraints and other restraints is the setting. It is unsafe for staff to unbuckle to assist a person in a moving vehicle. Pulling over can be dangerous or impossible on busy roads. Often staff are unable to sit in the back seats, either because the person has a history of aggressing toward other passengers or because the vehicle does not have backseat space for staff due to adaptive seating. Even when staff do sit next to the person, 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.

Providers have conducted FBAs that have indicated 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. Understanding the safety necessity of wearing a seat belt can be an abstract topic in conversation. Hence it takes many teaching trials with repeated practice. It also requires understanding of long-term and low-likelihood cause-and-effect relationships. Although this is an unusual type of mechanical restraint, providers are still exercising due diligence, considering unsafe vehicular behavior as challenging behavior and completing all necessary documentation to be compliant with best practices and regulation.

The legal constraint of seat belt laws put service providers in a difficult position when the person does not remain buckled. 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. 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.

It is important to highlight that the inability to transport someone safely might contribute to reduced community participation, which is contrary to the Olmstead vision. The EPRC continues to closely monitor this area and provides recommendations as appropriate to each person.

Emergency manual restraint

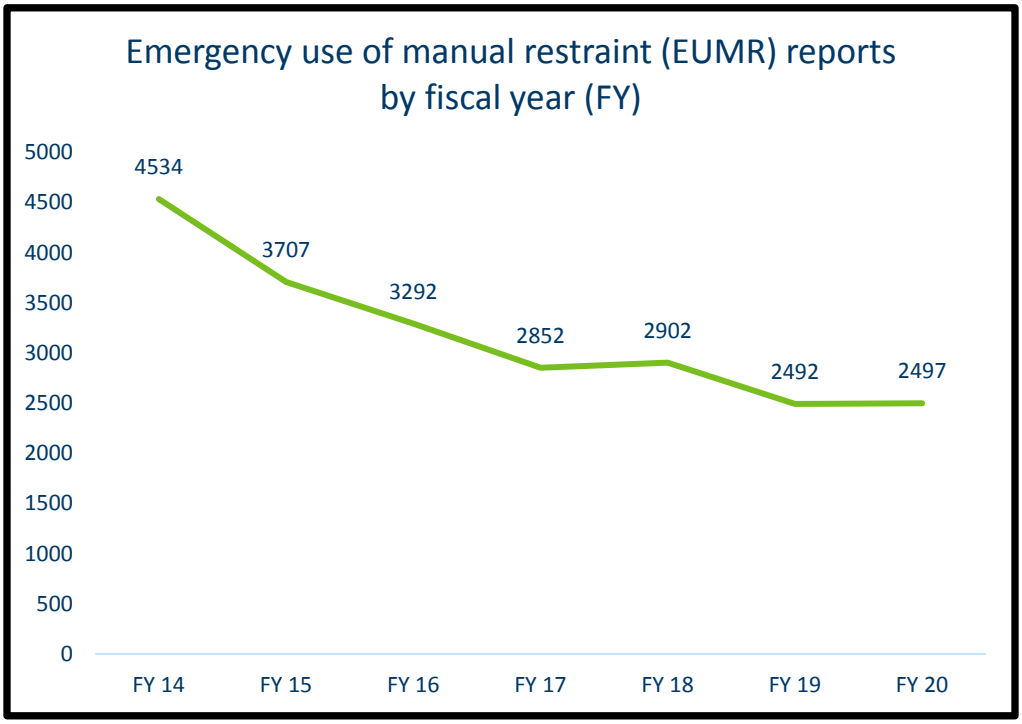
While approximately half of the EPRC focuses on reducing the use of mechanical restraint, the other half primarily focuses on reducing the use of emergency manual restraint, which is the most common type of restrictive procedure used in Minnesota since the implementation of Minn. R. 9544. Emergency uses of manual restraint by DHS license-holders must be reported to DHS via the online BIRF system. On a monthly basis, committee representatives review each report and then provide ongoing technical assistance as needed to help providers develop positive support strategies.

Conditions for using EUMR

The following conditions must be met for a service provider to use EUMR (see Minn. Stat. 245D.061):

- Immediate intervention must be needed to protect the person or others from imminent risk of physical harm
- 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.

Data on trends in EUMR



As shown in the table above, the emergency use of manual restraint has decreased significantly since providers began reporting this use of restraint via the BIRF in July of 2013. While there was a slight increase (+5 reports) in EUMR reports in fiscal year 20, this might be a reflection of incidents related to Covid-19, technical assistance given to providers who had been reporting multiple incidents on a single report form, or other factors. Committee members review each case individually and circumstances vary widely depending on each person's unique needs and available resources.

Technical assistance given to providers for reducing EUMR

When committee members are assigned EUMR BIRF cases, the EPRC takes into consideration the person's history and frequency of restraint use, time length of restraint use, current support from of other DHS representatives, or concerns

such as a violations of people's rights, frequent 911 calls, service terminations, etc. While the number of cases vary from month to month depending on individual needs and circumstances, as of November 2020, 66 people were on the EPRC's monitoring list, which is a significant reduction from prior years. Since the initiation of the committee's EUMR work in 2017, committee members have monitored and/or followed up with support teams on more than 300 people.

Not only do committee representatives read BIRFs, they also read through every PSTP submitted to DHS, as well as related forms such as quarterly reviews, FBAs, data charts and person-centered plans. When a reviewer sees areas for improvement, they contact the provider to follow up, or sometimes they just follow up to let people know the EPRC is available if they have any questions. While sometimes EPRC members give specific suggestions for supporting people, they also strive to spread awareness of additional support options from other service providers. For example, other services providers that might be able to help include positive support service providers, occupational therapists, physical therapists, board certified behavior analysts or counselors. Committee representatives also often talk to teams about their data collection methods. Sometimes for long-standing cases, committee members will help teams out by sorting data collected through BIRFs, to identify trends such as when behaviors are most likely to occur, with who, under what circumstances, etc.

Unique to 2020, some service providers also received technical assistance on how to support people with increased behaviors related to hardships or staffing shortages experienced during the Covid-19 pandemic. For other people, however, a decrease in behaviors were reported, and some teams noted these decreases were likely a result of the person being able to stay home more often, which some people prefer. It was noted by the committee that trends in disability services have been encouraging providers to integrate people into the community as much as possible, but sometimes that is not what the person wants. In the future, it might help to adjust how DHS communicates with providers about the topic of community integration, to ensure the frequency, type and extent of the integration is desired by the person.

Recommendations

2019 recommendations

Below are the four recommendations made by the committee in their 2019 annual evaluation report.

1. Continue the past recommendation to collaborate and build connections with expanded support teams so the subcommittee can continue to assist with the development of effective fading plans on mechanical restraint. Also, continue to help service providers connect with other professionals who can inform supports and services.
2. Update the Positive Supports Rule (Minn. R. 9544) assessment, commonly referred to as the PSR 100 available on TrainLink, to ensure it accurately measures the ability of qualified professionals to conduct functional behavior assessments that inform positive support transition plans. The PSR 100 is currently the commissioner's assessment required under Minn. R. 9544.0020, subp. 47 and Minn. R. 9544.0040, subp. 1.
3. Re-review quality of life measures in positive support transition plan reviews, DHS form 6810A, and evaluate if there are additional tools or methods for creating a more comprehensive picture of each person's life.
4. Continue the past recommendation that DHS and other state agency representatives implement the Olmstead Workplan, which addresses the workforce shortage as recommended by the Direct Care Workforce Shortage Cross Agency Steering Team.

Actions taken in 2020 on the 2019 recommendations

1. Throughout 2020, the EPRC continued supporting teams and providing suggestions on how to move toward eliminating the use of restraint. BIRFs and PSTPs submitted to DHS are reviewed by committee representatives, and recommendations are provided as needed to help teams develop and implement positive support strategies.
2. DHS staff met with committee representatives multiple times in 2020 to work on the Positive Supports Rule assessment. The project has been put on hold temporarily, but the next step was to collect additional data to determine if updating the FBA assessment would result in improved outcomes for people.
3. Two actions were taken related to quality of life measures:
    - The committee developed two optional quality of life indicator tools, one for people who use words to communicate and one for people who do not, for use by people or their support teams to use for starting conversations about how to improve the person's quality of life.
    - The PSTP was updated to put greater emphasis on the quality of life section, to allow more flexibility in how a person defines quality, and to encourage teams to describe how they can support the person in improving their quality of life.
4. Many steps have been taken, and will continue, to address the workforce shortage crisis, such as the development of a staff recruitment and retention guide, continued progress on Olmstead initiatives and other projects being led by DHS staff. See the DHS Workforce Shortage webpage for more information, which will be updated sometime in 2021.

2020 recommendations

- The EPRC recommends continuing the past recommendation to collaborate and build connections with expanded support teams, so committee members can continue to assist with the development of effective fading plans on mechanical restraint, emergency manual restraint and other targeted interventions listed in PSTPs. Also, the committee continues to recommend helping service providers connect with other professionals who can inform supports and services.
- As opportunities for edits arise, it might help to review public communication related to increasing community participation/integration, to better communicate that community activities and interactions with other people should not be forced on a person, and to better communicate that community integration efforts should meet the preferences of the person.
- The EPRC recommends continuing to focus their technical assistance on each person's wellness and quality of life. Improved quality of life has been shown to reduce the occurrence of interfering behaviors.
- When it is safe to do so, given the Covid-19 risk, EPRC members will increase their in-person technical assistance to service providers who are using mechanical restraint.
- The EPRC recommends continuing to offer service providers, beyond the end of the Covid-19 pandemic, the ability to connect with committee members and other support providers or team members electronically, using secure communication tools. These tools have a variety of benefits including access to expertise for people who live in remote areas, quicker response times, and flexibility for team members (such as family members) who might not have easy access to transportation (note: this is not a comprehensive list of all the potential benefits).

Background

Whole committee vs. subcommittee responsibilities and scope

The EPRC is responsible for implementing Minn. R. 9544.0130. While sometimes the committee's role is confused with the role of DHS Licensing, the rule does not direct the committee to enforce statute, rule or policy. The committee's role is to provide guidance, assistance and resources to providers, and to provide recommendations to DHS and the commissioner.

In 2017, in order to reduce caseloads so committee members could focus more closely on specific people, the committee decided to split their work into three tasks, and to hold separate monthly meetings for each task:

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, such as mechanical restraint (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)

By reducing caseloads for each committee member, this structure has allowed committee representatives more time to thoroughly review people's individual circumstances and needs, more time to meet with people, and more opportunities to build better, more effective working relationships with service providers.

Committee representatives

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 utilizing 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 Minn. Stat. 245.462) or licensed health professionals (as defined in Minn. Stat. 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.

Laura Daire has a bachelor of science in biology and psychology. With over 10 years of experience in the field, she has worked as a direct support professional in residential and day treatment programs for people with intellectual disabilities. She currently serves as an assistant executive director for a residential provider. In this role, she has had the opportunity to teach those she serves positive support strategies that have given them the tools to go from a life with minimal community integration to spending time with their families and friends, maintaining gainful employment and minimizing challenging behaviors.

Dr. Danielle Bishop is a clinical pharmacist with board certification in the area of psychiatric pharmacy. As a member of the EPRC, she works to identify opportunities where medication optimization might lead to positive outcomes. Danielle has provided pharmaceutical care for 15+ years 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.

Susie Haben is a unit supervisor in the Health Regulation Division at the Minnesota Department of Health. She has worked in a variety of settings throughout her career, such as long-term care, community emergency services and home and community-based services aimed specifically at serving people with developmental disabilities as well as people living with mental illness or traumatic brain injuries.

Liz Harri, BCBA is a board certified behavior analyst (BCBA) with 11 years of experience in the field. She works for the Minnesota Department of Human Services on the Community Capacity and Positive Supports team as a person-centered and positive supports specialist. As a member of the EPRC, Liz assists with BIRF and PSTP data analysis, as well as supporting teams with PSTP implementation. Liz is also a member of the Minnesota Northland Association for Behavior Analysis (MNABA) board.

Tatiana Kerestesh is a licensed public health nurse and nurse educator with 13 years of experience. Tatiana has worked in social services for over 15 years, from a direct care staff to a supervisory and director position prior to becoming a nurse. Her most recent experience includes public health nurse at Ramsey County and nursing faculty at St. Paul College Practical Nursing Program.

Dan Baker, Ph.D., NADD-CC, CCEP, is with the Minnesota Department of Human Services, where he serves as the positive supports specialist and successful life project clinical supervisor with Quality Assurance and Disability Compliance Services (though throughout most of 2020 his title had been the positive support compliance specialist and internal reviewer). Dr. Baker is involved with the design, development and monitoring of treatment programs to align with the positive supports and person-centered culture. Dr. Baker's clinical focus is on positive behavior support, models of community and educational support, transition services and mental health services for people with disabilities. Dr. Baker is a certified compliance and ethics professional.

Stacy Danov, Ph.D., LP, has experience working as a psychologist implementing person-centered practices and positive behavior supports in Minnesota. She completed her doctorate in educational psychology from the University of Minnesota. Dr. Danov also has a certificate in autism spectrum disorders from the University of Minnesota. She currently works for DHS on the Community Capacity and Positive Supports Team as the clinical coordinator. Her work includes providing clinical direction and leadership in the design, development and monitoring of improved supports and services that are consistent with evidence-based practices. Dr. Danov is a certificated person-centered thinking and person centered planning picture of a life trainer. She presents locally and nationally on her work in positive behavior supports and person-centered practices including presentations for the Home and Community Positive Behavior Support Network of APBS. She is a founding member of the Minnesota Positive Behavior Support Network and is an active member of the Learning Community for Person Centered Practices.

Melanie Eidsmoe has a bachelor of arts in sociology and social work and is a licensed social worker. With more than 14 years of experience in the field, she has worked as a direct support professional and supervisor in residential programs for people with intellectual disabilities. She currently serves as an assistant director for a residential provider. In her roles, she has had the opportunity to implement and teach positive support strategies. She has successfully provided people with the tools they need to go from a life with minimal community integration to spending time with their families and friends doing things that are important to them.

Kim Frost M.S., BCBA, is a board certified behavior analyst with 23 years of experience in the field of intellectual disabilities, mental health disorders and traumatic brain injury. Her experiences range from working in psychiatric and traumatic brain injury hospitals, to providing behavior analytic early intervention to children on the autism spectrum. Through her professional experiences, the importance of choice and person-centered planning became the heart of her work and published research. Since 2006, Kim has acted as the behavior analyst and services coordinator for a day training & habilitation program for adults in the Twin Cities, where she continues her work in positive behavior supports with an emphasis on person-centered choice.

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.

Michael Boston has a B.A.S. in psychology with more than 13 years of experience working primarily with adults with varying developmental disabilities as well mental health disorders. He has held many roles and many positions in adult foster care to include 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, positive behavior support plan 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.

Lindsay L. Nash holds an M.S.Ed in psychological professions with a B.A. 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. Currently, 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 service recipients to ultimately 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 individuals 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.

Stacie Enders is a positive supports policy analyst for DHS under the Community Capacity and Positive Supports team. She is not a committee member but works as a coordinator for the committee and participates in committee activities. She holds an undergraduate degree in middle school education and a graduate degree in public administration. She has more than a decade of experience promoting the use of positive support strategies 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.

Linda Wolford currently serves as the interagency coordinator for the Community Capacity and Positive Supports team of the Disability Services Division and is a backup for Stacie Enders on staffing this committee. She has an undergraduate degree in criminal justice studies and master's in counseling psychology with a rehabilitation emphasis. She coordinates employment, workforce shortage and other Olmstead initiatives across DHS and other state agencies. In addition, she currently is the co-chair of the Employees with Disabilities Employee Resource Group for DHS. She formerly worked at DHS doing home care policy, working on employment initiatives and consumer directed personal care assistance services under several federal grants. Linda has completed two years of training in person-centered coaching. In her 30+-year career, Linda has worked in the fields of disability and diversity in higher education, for the state and for several nonprofits. She has also provided training and consultation on disability at both the local and national levels.