Minnesota Department of Human Services

STATEMENT OF NEED AND REASONABLENESS

Proposed New Permanent Rules Governing Positive Supports, and Prohibitions and Limits on Restrictive Interventions

Minnesota Rules, Proposed Parts 9544.0005 to 9544.0140;
Repeal of Minnesota Rules, Parts 9525.2700 to 9525.2810

INTRODUCTION

Current best practices in behavior guidance have advanced to embrace person-centered planning, full integration in community life, and positive support strategies. This is true for persons with disabilities, and it is true more generally for others as well. Consistent with these advancements, in 2011 the Minnesota Department of Human Services (the Department) agreed in a landmark settlement agreement to ensure that all of its licensed services incorporate positive support strategies. Shortly thereafter, the Minnesota State Legislature formalized this promise in a statute directing the Department to require positive support strategies in its licensed services. This important step assures the widespread use of positive supports throughout Minnesota for persons with disabilities and persons age 65 and over.

Along with advances in behavior support strategies, states are also moving away in large numbers from outdated and no longer acceptable interventions for managing the most serious and challenging behaviors – those that are self-injurious or threaten the safety of others. Interventions used in the past, including physical restraints or seclusion, could be dangerous, punitive, or inappropriate in a community setting. The Minnesota Legislature is now joining other states in requiring that use of restrictive interventions be phased out, and replaced with person-centered planning and a positive support model of care.[1]

This rulemaking is largely driven by the above-noted settlement of a class-action lawsuit commonly known as the *Jensen* case. [2] The lawsuit alleged the unlawful restraint of persons with developmental disabilities in a Department-run residence for persons with disabilities. As part of the settlement, the Department agreed to pursue a number of broad initiatives.[3] One of those initiatives was to "modernize" the rules that previously governed restraint and seclusion, which is commonly known as "Rule 40."[4] This rulemaking is the execution of that obligation.

For purposes of this rulemaking, Department-licensed services are grouped into two categories: home and community-based services, which is a set of services defined under federal Medicaid law[5]; and all other services. There are important differences between the two categories: first, the different sources of law that govern the services; and second, the different primary target populations and persons governed under these laws.

In 2012, the legislature adopted Minnesota Statutes, chapter 245D, replacing law that previously governed home and community-based services, the first type of Department-licensed services. In pertinent part, chapter 245D did two things: first, it established prohibitions and limits on the use of aversive and deprivation procedures, seclusion, and the like; and second, it required

the use of positive support strategies. As explained on page 4 of this SONAR in the *Statutory Authority* section, the 2013 legislature directed the Department to adopt rules governing these matters.[6]

Home and community-based services generally serve persons with all types of disabilities, and persons age 65 and over. This target population includes persons with disabilities who have especially high needs. If a person's needs are so high that the provider used restrictive interventions to guide behavior, one could typically expect to find that person being served in a home and community-based services setting, albeit with some exceptions.

As noted, chapter 245D requires home and community-based services to use positive support strategies and to discontinue use of restrictive interventions. Chapter 245D does not govern the second type of Department-licensed services, namely, all services other than home and community-based services. Rather, in 2014, the Minnesota Legislature, in connection with the terms of the Jensen Settlement Agreement, directed the Department to adopt rules that would govern positive support strategies and would ensure the applicability of the prohibitions and limits in chapter 245D to all of its licensed services and settings when serving a person with a developmental disability or related condition.[7]

To fulfill the settlement agreement obligation and legislative directives, the Department is now proposing a rule that governs positive support strategies for all licensed settings and services and, for providers not already governed by chapter 245D, applies the prohibitions and limits of that chapter to those non-245D licensed services. The rule accomplishes the latter by incorporating the pertinent requirements of chapter 245D by reference. As a result of the proposed rule, no Department-licensed service or facility will be permitted to use outdated and unacceptable practices for persons governed by the statute and rule.

One key statutory requirement is that existing use of restrictive interventions must be ended. Specifically, chapter 245D and the rule, via incorporation of the statutory requirements, require providers to phase out the use of any restrictive interventions over the course of 11months. So, if a provider had been programmatically using restraint to guide the behavior of a person with aggressive or self-injurious behavior, the provider would have 11 months to diminish the use of that intervention to the point of discontinuing it entirely.

Chapter 245D went into effect on January 1, 2014. Therefore, home and community-based service providers, the providers most typically serving persons with whom restraints have been used, have already been working to phase out the use of restrictive interventions. The timeline for full elimination of use of restrictive interventions in these settings for persons receiving services before January 1, 2014 is the end of calendar year 2014. More will be known about the success of the phase-out as home and community-based service providers report to the Department in the coming months about their ability to phase out restrictive interventions entirely.

As noted, an important distinction between the two categories of Department-licensed services is which persons are governed by the rule. The persons governed is different for home and community-based services than for other providers. For home and community-based services, the statute and the rule govern all persons with *any type* of disability *and* persons age 65 and over. In other words, for providers offering home and community-based services, the statute and rule

govern the providers' entire target population. For all other Department-licensed services, though, the rule applies only to persons with a developmental disability or related condition.

The proposed rule is a product of significant study, discussion and contributions of an advisory committee, known as the Rule 40 Advisory Committee. The appointment of the Rule 40 Advisory Committee was required by the Jensen Settlement Agreement, and the Department is legally bound to use the Rule 40 Advisory Committee recommendations as the basis for the rule.[8]

The Rule 40 Advisory Committee was comprised of members representing many different perspectives. This included persons receiving services; family members of persons receiving services; representatives from the Office of the Ombudsman for Mental Health and Developmental Disabilities; the Executive Director of the Minnesota Governor's Council on Developmental Disabilities; advocates for persons with disabilities, including a self-advocate and the Minnesota Disability Law Center; a representative from the Minnesota Association of County Social Service Administrators; representatives from the law firm representing the plaintiff class in the *Jensen* lawsuit; ARC Greater Twin Cities; and a recognized expert on community integration.

The Rule 40 Advisory Committee met 11 times for day-long meetings from January 2012 to June 2013. Subcommittees addressed key topics and reported back to the group.[9] The Rule 40 Advisory Committee work culminated in a comprehensive set of recommendations to the Department. These are compiled in a report of over 100 pages, entitled "Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40."[10]

Key elements of the Rule 40 Advisory Committee recommendations are:

- requiring providers to eliminate programmatic use of restraints and seclusion;
- requiring the use of positive support strategies and person-centered planning;
- requiring provider training and competency testing;
- establishing new Department monitoring and data collection from the field; and
- continuous Department updating of standards for emergency use of manual restraint.

The Department prepared a draft rule in 2014. The Department offered opportunities for input about the draft rule from all of the types of licensed services, programs, and facilities that will come under the purview of the rule, and advocates and families of persons receiving services.[11] To do so, the Department conducted seven informal public input forums in September and October 2014.[12] The forums included persons participating from throughout the State, using video conference technology from remote sites. The forums could also be watched through internet live streaming, with the option to proffer questions via email that were addressed during the forum. The Department considered the input and made changes to the draft rule as a result.

OBJECTIVE

To adopt the proposed rule, the Department must demonstrate that is has complied with all procedural and substantive requirements for rulemaking. These requirements are as follows: 1) there is statutory authority to adopt rule; 2) the rule is necessary and reasonable; 3) all necessary procedural steps have been taken; and 4) any additional requirements imposed by law have been

satisfied. This statement demonstrates that the Department has met all requirements.

STATUTORY AUTHORITY

In 2012, the Minnesota Legislature granted rulemaking authority on positive support strategies and safety interventions – but this authority was contingent on funding being allocated. That funding was not allocated.

In 2013, the Minnesota Legislature directed the Department to adopt rules "governing the use of positive support strategies, safety interventions, and emergency use of manual restraint."[13] The rule was originally intended to govern "facilities and services licensed under chapter 245D."

In 2014, in accordance with the Department's commitment to the federal court and to the plaintiffs as part of implementing the Jensen Settlement Agreement, the 2014 Legislature dramatically expanded the scope of the rule. The rulemaking authority was amended to cover all services and settings licensed by the Department when serving a person with a developmental disability or related condition. The authority now states:

> Subdivision 1. **Rules governing the use of positive support strategies and restrictive interventions.** The commissioner of human services shall, by August 31, 2015, adopt rules to govern the use of positive support strategies, and ensure the applicability of chapter 245D prohibitions and limits on the emergency use of manual restraint and on the use of restrictive interventions to facilities and services governed by the rules. The rules apply to all facilities and services licensed under chapter 245D, and all licensed facilities and licensed services serving persons with a developmental disability or related condition.[14]

The change made by the 2014 Legislature vastly expanded the number of licensed programs governed by the proposed rule. The number of governed programs or providers jumped from roughly 1,200 home and community-based service programs to over 22,000 licensed programs, in eighteen different classes of services.[15] It is important to keep in mind, though, that only for home and community-based services does the rule govern all persons receiving services. For all other licensed programs, the rule applies only to persons with a developmental disability, or a related condition. Collectively, the Department's licensed services serve roughly 220,000 persons. It is possible that any license holder may serve a person covered by the scope of the rule; however, according to our data, we believe the services to roughly 41,000 people may be affected by the rule.[16]

ALTERNATIVE FORMAT

Upon request, this information can be made available in an alternative format, such as large print, braille, or audio. To make a request, contact Karen E. Sullivan Hook at the Department of Human Services, P.O. Box 64941, Saint Paul, MN 55164-0941, or by phone at (651)431-5771, or by email at dhsrulecomments@state.mn.us.

REGULATORY ANALYSIS

Minnesota Statutes, section 14.131, sets out eight factors for a regulatory analysis that must be included in a SONAR. Paragraphs (1) through (8) below quote these factors and then give the agency's response.

"(1) a description of the classes of persons who probably will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule"

The classes of persons affected by this rule include persons with disabilities and their families, persons age 65 and older and their families, and providers located within the person's local trade area that are required to be licensed under the Human Services Licensing Act, chapter 245A

"(2) the probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues"

The Department projects that it will incur costs in two agency cost centers: the Disability Services Division and the Licensing Division. These are explained below.

The Disability Services Division anticipates costs related to training and technical assistance for providers. At a minimum, the Department will train providers about what the new rule requirements are. For example, the rule requires a provider to submit a behavior intervention report form when particular events occur. The Department estimates that it would incur upfront costs of approximately $60,000 to prepare and offer this training.

Whether and how much additional training to offer about how to operationally implement and comply with the requirements of the rule remains under evaluation. This would include, for example, training for direct care staff about how to develop positive support strategies, how to use person-centered planning, and how to develop and implement a positive support transition plan.

Minnesota Statutes, chapter 245D, governing home and community-based providers and containing largely similar requirements as those in the rule concerning positive supports and prohibitions on restrictive interventions, went into effect on January 1, 2014. In connection with those requirements, the Department hired the University of Minnesota's Institute for Community Integration to design and offer module training and technical assistance on these topics. That training is already in place and available. Given the overlap in the statutory and rule requirements, much of that training content could also be used for the additional providers that will be governed solely by the rule.

In addition, the Department's Licensing Division will incur costs to enforce the proposed rule. These include costs for licensors to be trained on the new requirements, and to enforce the rule through program audits, complaint investigations, provider challenges to enforcement actions, and related activities.

It should be noted that for services currently governed under Rule 40, the predecessor to the new rule, the enforcement work related to the proposed new rule will replace enforcement

work related to the old rule. Given the additional, more specific requirements in new rule, however, and the substantially expanded rule scope (i.e., that the proposed rule will apply to all DHS-licensed programs that serve an individual with a developmental disability or related condition), it is clear that additional resources will be needed for rule enforcement.

The broad rule scope especially has an impact on costs, as all of the thousands of programs licensed by the Department will be governed by the rule. The Department has addressed enforcement costs for the statute and rule collectively,[17] and estimates that the costs in the first year after rule adoption, in which the startup costs such as staff training are concentrated, will exceed $100,000.

County social services agencies will also incur costs. The commissioner of the Department of Human Services has delegated its responsibility to perform licensing functions related to family day care, child foster care, adult foster care and family adult day services programs to county agencies.[18] This includes responsibility to monitor compliance with applicable licensing rules; investigate allegations of license violations; and recommend negative licensing actions.[19] Counties also provide technical assistance upon request from providers that it licenses.

Rule 40 did not govern the four above-noted, county-licensed service types. This means that the proposed rule requirements apply to those services for the first time, and enforcement of the proposed rule is a new area of responsibility for county licensors.[20]

The majority of programs licensed by the counties are in-home, family child care programs. This is by far the single largest group of Department-licensed providers, comprised of over 10,000 providers. Importantly, except for programs governed by Minnesota Statutes, chapter 245D, the rule only applies when a program serves a person with a developmental disability or a related condition as defined in Minnesota Rules, part 9525.0016, subpart 2, items A to E. Thus, when a family day care program does not serve a child with a developmental disability, the rule does not apply.

The Department does not know how many family day care programs serve a child with a developmental disability, but it is expected the number will be a relatively small portion of the total of over 10,000 providers. The proposed rule will only apply to that portion. Still, it is worth noting that family child care is a fluid service, with children regularly coming into and moving out of a program. This means that all family day care providers will need to be aware of the proposed rule requirements so they will know the requirements exist if the program does enroll a child with a developmental disability. Counties can thus expect many requests for technical assistance from licensed providers seeking assistance with interpreting and complying with the proposed rule requirements.

“(3) a determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule”

With respect to positive support strategies, community integration, and person-centered planning, the Department did not substantially consider less costly or less intrusive methods to achieve the purposes of proposed requirements. This is because the Department agreed in the settlement agreement to appoint an advisory committee to inform the Department about current

best practices, and agreed in the court-approved Comprehensive Plan of Action[21] to modernize the predecessor rule, Rule 40, to be consistent with best practices and the Rule 40 Advisory Committee Recommendations. The proposed rule fulfills those obligations, and the Department is not aware of alternatives that would done so.

With respect to prohibitions and limits on the use of restrictive interventions, there are no less costly methods for achieving the purposes of the proposed rule. The Legislature directed the Department to adopt rules that ensure the prohibitions and limits on the use of restrictive interventions in Minnesota Statutes, chapter 245D, apply to all of its licensed services when serving a person with a developmental disability or related condition. Because the Department is directed to use rulemaking to cause the statutory requirements to govern all of its licensees, the Department does not have discretion to depart from this approach or use alternatives.

"(4) a description of any alternative methods for achieving the purpose of the proposed rule that were seriously considered by the agency and the reasons why they were rejected in favor of the proposed rule"

As discussed above, regarding adoption of requirements governing positive support strategies, community integration, and person-centered planning, the Department is legally obligated to develop rule content based on the Rule 40 Advisory Committee Recommendations and current best practices. As a result, the Department did not seriously consider alternative methods to achieve the purpose of those requirements. The Department focused on the Rule 40 Advisory Committee Recommendations and input from content experts about current best practices.

As also discussed above, the Department does not have discretion to depart from broadly imposing the prohibitions and limits on the use of restrictive procedures in chapter 245D to other licensed facilities and services. The Department therefore did not seriously consider other alternatives with respect to these requirements.

"(5) the probable costs of complying with the proposed rule, including the portion of the total costs that will be borne by identifiable categories of affected parties, such as separate classes of governmental units, businesses, or individuals"

As explained below, the costs of complying with the proposed rule will be borne by providers that are required to be licensed under the Human Services Licensing Act, Minnesota Statutes, chapter 245A. Health care payors may also bear some costs, including Minnesota's Medicaid program, Medical Assistance; health insurance companies; and other private payors.

The Department asked a provider governed under chapter 245D to project costs for rule compliance during the first year after the rule is adopted. This provider offers transitional and long-term adult foster care, supported employment services, independent living skills training to support persons in transition to an independent life, structured day programs, and other services. It works with families and social workers primarily dealing with mental illness, traumatic brain injuries, and addiction issues. For purposes of the rule compliance cost analysis, the provider focused on its residential services to 100 persons, which are governed under chapter 245D.

For this provider, both the positive supports requirements and the requirements to phase out the use of restraints through a positive support transition plan apply. In other words, the provider currently programmatically uses restraints with some residents, which the provider is required to phase out under Minnesota Statutes, section 245D.06, subdivision 8. Because chapter 245D governs this provider, the compliance cost related to phasing out the use of restraints is a cost related to *statutory* compliance, not compliance with the rule. Thus, the provider excluded any costs of phasing out the use of restraints from its analysis of costs of rule compliance.

The first year of coming into compliance with a rule is the most expensive year because policies must be developed, and staff training is most concentrated during this year. The provider considered the following rule compliance costs: person-centered planning; staff training and competency; preparing required program documentation and records; and quality assurance and improvement requirements. The provider determined the cost of compliance with the rule during the first year of implementation to be roughly $300 per resident. In total, with over 100 residents, the costs are roughly estimated to be just over $30,000 in the first year.

The cost projection for a program not governed by chapter 245D would be different. As explained above, the proposed rule incorporates the requirements of chapter 245D and extends them to providers not otherwise governed by chapter 245D. For such a provider who is programmatically using restraints, the cost of rule compliance would include any cost to phase out the use of restraints. It should be noted here that one reputable study shows the shift from use of restraints to use of positive behavior supports has a net positive fiscal effect.[22]

"(6) the probable costs or consequences of not adopting the proposed rule, including those costs or consequences borne by identifiable categories of affected parties, such as separate classes of government units, businesses, or individuals"

One of the consequences of not adopting the proposed rule is that persons with disabilities and persons age 65 and older in Minnesota would not experience the benefits of using positive support strategies and person-centered thinking in social services programs to the same extent that will result from the proposed new rule requirements. These are evidence-based approaches. Although some providers would adopt many of the proposed rule practices even absent regulation in order to conform to current best practices, the proposed rule will move services in this direction much more broadly and quickly than would otherwise be the case.

Another consequence of not adopting the proposed rule is that the Department would have failed to fulfill a legislative directive. The legislature directed the Department to adopt rules governing positive supports and to ensure that the prohibitions and limits in chapter 245D apply to all of its licensed services and settings when serving a person with a developmental disability or related condition.[23]

The Department is obligated by the terms of the court-approved Jensen Settlement Agreement to modernize Rule 40. If the Department did not adopt the new rule, the Department would be out of compliance with the Jensen Settlement Agreement. Under those circumstances, the Department would be subject to federal court sanctions and the potential cost of further litigation.

"(7) an assessment of any differences between the proposed rule and existing federal regulations and a specific analysis of the need for and reasonableness of each difference"

As explained below, the Department's promulgation of the proposed rule brings its programs into even closer alignment with federal requirements than is now the case. The Department is not aware of differences between the proposed rule and federal regulations.

Federal rules governing the Medicaid program require the Department to ensure that in services paid under the program, persons receiving home and community-based services and supports have full access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate.[24] The proposed rule aligns closely with this requirement. Specifically, provisions in part 9544.0030, subpart 2, require the provider to integrate the person into the community, and to promote community life and the person's direct involvement in his or her community. That rule subpart also requires the provider to identify goals to support the person in the most integrated setting.

In 2014, the Centers for Medicare and Medicaid Services (CMS) updated their rule to establish requirements for the qualities of home and community-based settings. Among other requirements, the federal rule as amended now requires that a home and community-based setting must:

- ensure an individual's rights of privacy, dignity, respect and freedom from coercion and restraint;
- optimize individual initiative, autonomy and independence in making life choices; and
- facilitate individual choices regarding services and supports.[25]

Here, also, the proposed rule provisions comport closely with the federal requirements. The proposed rule emphasizes personal autonomy, goal setting based on personal preferences, and choices regarding services and supports. In part 9544.0030, subpart 2, item G, the proposed rule requires that the person be placed at the center of the planning process, with the person's preferences and choices reflected in the selection of services and supports.

"(8) an assessment of the cumulative effect of the rule with other federal and state regulations related to the specific purpose of the rule. . . . '[C]umulative effect' means the impact that results from incremental impact of the proposed rule in addition to other rules, regardless of what state or federal agency has adopted the other rules. Cumulative effects can result from individually minor but collectively significant rules adopted over a period of time."

The Department is not aware of cumulative effects of federal requirements and the proposed rule. Federal and state regulations address the use of restraint, seclusion, and aversive procedures in settings other than those regulated by the Department. These include schools and nursing facilities. Because the proposed rule will not govern these settings, there is no cumulative effect of these requirements and the proposed rule.

Existing Department administrative licensing rules govern each of the various service types the proposed rule will govern. In some cases, Department rules identify standards for the use

of restraint and seclusion. Exhibit 1 sets out all of the licensed service types governed by the proposed rule and details whether existing rules governing those services contain standards for the use of restraint and seclusion, and, if so, what rule parts establish the standards.

There is no cumulative effect of the proposed rule requirements and the existing requirements. This is because proposed rule part 9544.0010, Applicability, provides that parts 9544.0060 and 9544.0070 *supersede* standards in existing rules. Parts 9544.0060 and 9544.0070 state the prohibitions on use of restraint, seclusion and aversive procedures, and outline the permissible emergency use of manual restraint. Because the requirements in the proposed rule override any other Department rule requirements about the use of restraint and seclusion, there is no cumulative effect.

PERFORMANCE-BASED RULES

In accordance with Minnesota Statutes, sections 14.002 and 14.131, the Department considered and implemented performance-based standards that emphasize superior achievement in meeting the agency's regulatory objectives and maximum flexibility for the regulated party and the agency in meeting those goals.

The proposed rule requirements establish outcome-oriented requirements to implement positive support strategies that focus on the nature and quality of individuals' experiences. As explained in greater detail in the Rule Part by Rule Part Analysis for proposed part 9544.0030, Positive Support Strategies and Person-Centered Planning, the requirements for positive support strategies and person-centered planning require the provider to maximize opportunities for individuals to make choices for themselves that enhance their quality of life and thus promote physical and behavioral health. Part 9544.0030 is also about maximizing community integration and involving the person directly with the person's community and network of connections and close personal relationships, all of which are outcome-focused.

Proposed rule part 9544.0030, subpart 1 permits flexibility because it permits providers to incorporate positive support strategies into any existing treatment, service, or other individual plan that is required. Different licensed services have varying requirements about a treatment plan, service plan, or other plan. The proposed rule provision avoids adding a requirement for yet another plan, and instead permits providers to work within existing service plan requirements to integrate the new requirements. Part 9544.0030, subpart 4, by specifying widely-accepted, reputable national standards for providers to choose from as a resource to develop positive support strategies, emphasizes superior achievement in meeting the agency's objective of moving licensees to the use of current best practices in positive behavior supports.

Arguably, the prohibitions on the use of restrictive interventions in Part 9544.0060 do not permit maximum flexibility because they preclude the continued use of physical restrictive interventions according to the requirements in chapter 245D. However, the Legislature has directed this outcome. As noted, Minnesota Statutes, section 245.8251, directs the Department to ensure the applicability of Minnesota Statutes, chapter 245D prohibitions and limits on restrictive interventions to all licensed services through rule adoption. The proposed rule carries out this directive by incorporating the prohibitions of Minnesota Statutes, section 245D.06, subdivision 5, in proposed rule part 9544.0060.

The rule permits maximum flexibility for the agency because part 9544.0130, subpart 3, assigns an external program review committee the responsibility to monitor implementation of the proposed rule and make recommendations to the commissioner about policy changes related to these requirements. The committee is comprised of members with expertise in positive supports. This framework permits the commissioner to exercise discretion about future policy direction based on informed input from the committee.

Subpart 3 also provides for the external program review committee to make recommendations to the commissioner after reviewing requests for continued use of a procedure that has been part of an approved positive support transition plan to prevent risk of injury due to self-injurious behavior. This approach also permits flexibility for the commissioner to make a decision deemed appropriate for the circumstances based upon informed input.

ADDITIONAL NOTICE

Notice of Hearing: Required Notices. In accordance with Minnesota Statutes, sections 14.131, 14.14, and 14.23, the Department will publish the Notice of Hearing and the proposed rules in the State Register in December 2014, and send the Notice of Hearing to all persons who have registered with the Department to receive rulemaking notices. As required by Minnesota Statutes, section 14.116, the Department will send copies of the Notice of Hearing, the proposed rules, and the Statement of Need and Reasonableness to the chairs and ranking minority party members of the legislative policy and budget committees with jurisdiction over human services matters. In the Notice of Hearing, the Department will state that a free copy of the proposed rules will be sent to anyone who contacts the Department and requests one.

Notice of Hearing: Additional Notice Plan. Minnesota Statutes, sections 14.131 and 14.23, require that this statement contain a description of the Department's efforts to provide additional notice of the proposed rule and hearing to persons who may be affected by the proposed rules.

Select divisions within the Department maintain email lists of stakeholders and/or case managers and lead agencies who have requested to be on such lists. Providers and recipients who have signed up for these lists will receive the Notice of Hearing directly from the Department by email. This will include providers and recipients of disability services, aging and adult services, health care programs, child safety and permanency services, children's mental health services, and chemical dependency services.

The Department's Disability Services Division facilitates the Positive Supports Community of Practice group. This is a group providing information and technical assistance on positive supports to providers of home and community-based services. Providers who have signed up for this group will receive the Notice of Hearing directly from the Department by email.

The Department will send the Notice of Hearing by email to all persons who served on the Rule 40 Advisory Committee or registered for the informal public input sessions during the development of this rule, or submitted a comment at any time related to this rulemaking.

In addition, the Department will send the Notice of Hearing to provider associations and advocacy organizations that focus on disability services, aging and adult services, child safety and permanency, mental health services, children's mental health services, chemical dependency services, health care programs, and child care. Notice will be provided by U.S. mail when a postal address is available and by email otherwise.

The Department will also send the Notice of Hearing to managed care organizations and their associations, the Minnesota minority councils, legal services providers, and advisory councils and committees on disabilities, aging, child welfare, mental health, children's mental health, chemical dependency, and child care. Notice will be provided by U.S. mail when a postal address is available, and by email otherwise.

Finally, the Department will send the Notice of Hearing to government agencies, boards and offices whose work intersects with the subject of the proposed rule. These will include the county social services and attorneys, the Departments of Education, Health, Human Rights, and Corrections, boards regarding medical services and social work, and the Attorney General's Office. Notice will be provided by U.S. mail when a postal address is available and by email otherwise.

The Department will publish the Notice of Hearing and the proposed rule on the Department's public website. The Department will also publicize the Notice of Hearing on Provider News, an electronic newsletter for providers enrolled to receive reimbursement from Minnesota's health care programs published twice a month on the Department's website.

CONSULTATION WITH MMB ON LOCAL GOVERNMENT IMPACT

As required by Minnesota Statutes, section 14.131, the Department is in the process of consulting with Minnesota Management and Budget (MMB). On or about December 12, 2014, the Department sent MMB substantially the same documents as those sent to the Governor's Office for review and approval on November 24, 2014. This was done before the Department caused the Notice of Hearing to be published in the State Register. The documents provided include: the Governor's Office Proposed Rule and SONAR Form; the proposed rules; and the SONAR. The Department will submit a copy of the cover correspondence and any response received from Minnesota Management and Budget at the hearing for review by Administrative Law Judge Eric Lipman.

DETERMINATION ABOUT RULES REQUIRING LOCAL IMPLEMENTATION

As required by Minnesota Statutes, section 14.128, subdivision 1, the agency has considered whether these proposed rules will require a local government to adopt or amend any ordinance or other regulation in order to comply with these rules. The agency has determined that they do not because there are no requirements in the rule that apply to local government. The rule governs services to persons with disabilities or age 65 or older, which is not an area in the purview of local units of government.

COST OF COMPLYING FOR SMALL BUSINESS OR CITY

As required by Minnesota Statutes, section 14.127, the Department has considered whether the cost of complying with the proposed rules in the first year after the rules take effect will exceed $25,000 for any small business or small city. The Department has determined that the cost of complying with the proposed rules in the first year after the rules take effect will not exceed $25,000 for a small business. The proposed rule will have no impact on cities.

The Department made this determination based on the information from the provider described in the Regulatory Analysis (5) above, and other information. First, the provider costs as estimated in the above-noted Regulatory Analysis are roughly $300 per resident during the first year after the rule takes effect, or just over $30,000 for that year. That provider offers an array of services, including residential services to 100 persons. A small business would be expected to serve a far smaller target population, and, indeed, likely a population with far fewer persons with high needs. Its costs would therefore be only a fraction of $30,000, and would not exceed $25,000.

Similar to the analysis performed by the above-noted provider, the Department also evaluated specific cost factors related to rule implementation. For this estimate, the Department solicited input from a commercial business that serves as a consultant and offers training to Minnesota providers about positive support strategies. The consultant estimated costs to develop policies on positive supports and train staff about using positive supports. The consultant reviewed the proposed rule requirements to develop its estimates. This cost estimate could arguably be on the high side, because a small business could choose to do the policy development in-house more cost-effectively than by hiring a professional, outside consultant.

Based on the consultant's estimates, the cost of policy development during the first year would be roughly $2,400, and the cost of training would be roughly $7,900. This amounts to a total of $10,300. Even if one adds on to this estimate the expense for employee time during training (because employees cannot perform other duties during training), the cost only increases by a few thousand dollars. Thus, the cost for a small business to develop policies and train staff falls substantially below $25,000.

This analysis does not yet add cost estimates for person-centered planning and quality assurance. Based on the raw data from the above-noted provider, these costs only amount to a fraction of the total cost per person. Some fraction of $10,300 (or a slightly higher amount, if costs for employee time during training are included in the total), cannot bring the total over $25,000. Thus, the Department concludes that the cost for a small business during the first year after the rule becomes effective will not exceed $25,000.[26]

LIST OF WITNESSES

The Department will have staff, including content experts, testify in support of the need for and reasonableness of the proposed rule. The Department does not anticipate having any non-agency witnesses testify in support of the need for and reasonableness of the rule.

RULE-BY-RULE ANALYSIS: PROPOSED NEW RULES.

Part 9544.0005 **PURPOSE**.

This provision is necessary to identify the underlying rule objectives. The primary, overarching objective is to improve of the quality of life of persons with disabilities or age 65 or older who receive Minnesota licensed social services. The rule then generally lays out, in conceptual terms, broad themes about how the objective is meaningfully carried out in the community and in residential settings. Those broad themes provide a preliminary vision for the regulated party about how the rule requirements should play out. Because these are merely broad conceptual approaches, the items are not intended to be rule requirements that the licensing division will enforce by the letter.

Item A. Item A reflects goals consistent with the terms of the Jensen Settlement Agreement, in which the Department agreed to abide by the principles outlined in the landmark U.S. Supreme Court decision *Olmstead v. L.C.*, 527 U.S. 582 (1999). *Olmstead* is a ruling interpreting the Americans with Disabilities Act that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. In 2009, President Obama issued a proclamation launching the "Year of Community Living" and directed the United States Department of Justice to work with state officials, disability rights groups and attorneys around the country, and with representatives of the Department of Health and Human Services, to fashion an effective, nationwide program to enforce the integration mandate of the decision. As part of the terms of the Jensen Settlement Agreement, the Department agreed to lead the State of Minnesota to adopt a state Olmstead Plan, under which all Minnesota state agencies commit to work cooperatively to achieve the vision of *Olmstead* for full community integration. The federal court overseeing the implementation of the *Olmstead* decision recently directed the state to enhance its proposed Olmstead Plan further by identifying more specific, actionable goals in the Plan, and these efforts are underway now.

Item A states two specific community integration goals in keeping with the *Olmstead* decision. These two goals, community participation and receiving services in the most integrated setting, are also recommendations of the Rule 40 Advisory Committee.[27] It is now well-accepted that community integration generally leads to more enriched and fulfilling lives for persons with disabilities, as distinguished from the historical practice of segregating persons with disabilities in separate residences and activities. Indeed, it has been found that persons with disabilities often have greater opportunities for learning and development when integrated with others who do not have disabilities. It is necessary and reasonable to describe a vision for a principle that is required under the Americans with Disabilities Act, consistent with the Department’s legal obligations in the settlement agreement, and consistent with well-accepted, modern best practices.

The other specific goal stated in item A is person-centeredness. This goal is also reflective of the Rule 40 Advisory Committee’s recommendations and consistent with current best practices in providing services to persons with disabilities or age 65 or older. Research shows that when a person-centered thinking approach is adopted in which people make their own choices and determine their own goals, this typically leads to exhibiting lower levels of challenging behavior and enhances the individual's skills for independent living. Person-centeredness has been found to more successfully create an

environment that promotes the skills needed for independent living.[28]

It is also worth noting that person-centered principles are paralleled by advancements in human rights philosophy around the world. Most international authorities now recognize self-determination as an inalienable right guaranteed to every person. Shifts in the treatment of persons with disabilities or age 65 or older in this country are reflective of that trend, especially when contrasted with historical practices of the state or a guardian making decisions for a person, rather than placing the person and his or her individual values and needs at the center of planning for services, supports, where to live, and daily activities.

Item B. Item B is also consistent with the Rule 40 Advisory Committee's emphasis on enhancement of a person's quality of life.[29] Enrichment of lives is a cornerstone of the positive behavior supports model.[30] Likewise, this principle is inherent in the Department of Human Services' expressed mission. The Department's mission includes providing safety nets and tools to empower persons to progress from basic needs to self-determination and a higher quality of life. It is reasonable to describe a vision that is consistent with the objectives of positive support strategies, and consistent with the Department's own mission.

Item C. Item C incorporates current best practices and the Rule 40 Advisory Committee recommendations that the rule require collaborative decision-making.[31] Collaboration is another basic tenet of the model of positive behavior supports.[32] The professional literature supports that when a person is involved in creating their own goals, the person is ordinarily far more motivated to achieve them. It is reasonable to describe this quality for an environment in which positive support strategies are to be developed.

Item D. Item D incorporates current best practices and the Rule 40 Advisory Committee recommendations that the rule focuses on improving a person's skills and facilitating their ability to achieve personal goals.[33] Skill-building serves the other goals of the positive supports model, and is another basic tenet. It is reasonable to describe a vision for activities that foster a person's autonomy.

Item E. Item E sets out the goal of increasing a person's self-determination abilities by actively encouraging, supporting, training and recognizing a person's freedom to make their own choices. This also supports the purpose of self-determination. Research supports the value of self-determination. Persons who display challenging behavior often exhibit lower rates of challenging behavior when they are encouraged to make their own choices among tasks or activities.[34]

Item F. Item F describes the importance of person-centered planning, to show that an optimal environment entails organizational staff who work to promote outcomes valued by the person and their circle of support, as distinguished from the outcomes valued by service providers and service planners. As noted in Regulatory Analysis factor (6), the Centers for Medicare and Medicaid have updated regulation describing the qualities of home and community-based services, and one of these qualities is person-centered planning. It is necessary for the Department to fulfill its obligation to ensure that Minnesota's Medical

Assistance program fully complies with the letter and spirit of federal law.

Item G. Item G reflects the goal that all persons receiving services be treated with respect. This goal speaks to abhorrent and outdated practices, when, years ago, and even in some outlier situations in our state and country today, persons with disabilities were treated in a demeaning, derogatory manner. It is reasonable to state a basic expectation that is consistent with the positive behavior support model.

Item H. Item H reflects the principle that any use of an aversive or deprivation procedure diminishes the quality of life of a person. This is consistent with fulfilling a major focus of the Jensen Settlement Agreement. Consistent with current best practices, aversive or deprivation procedures are now generally considered to be a form of abuse. It is necessary and reasonable that the rule recognize the broad objective of eliminating aversive and deprivation procedures in Minnesota licensed social services.

Item I. Item I describes a vision in which a consistent set of standards is established for all Department-licensed providers for responding to behavior. It is reasonable to foster practices such that persons served by multiple providers will receive similar treatment across different settings. It is also reasonable to ensure that providers who operate under multiple licenses have a consistent set of standards across services.

Item J. Item J describes the vision of building the knowledge and competence of providers to support organizational culture change and a shift in practices consistent with the principles of person-centered planning, community integration, and positive support strategies. This item speaks to the need for provider training components, which is a foreshadowing of specific and enforceable requirements to this end in proposed rule part 9544.0090.

Part 9544.0010 **APPLICABILITY.**

This provision identifies who is governed by the rules. It is necessary and reasonable to clearly describe which entities the rule will govern.

Subpart 1. **Applicability to providers licensed under Minnesota Statutes, chapter 245D.** The rule applies to all services and facilities licensed by the Department under Minnesota Statutes, chapter 245D. The provision is consistent with the legislative directive in Minnesota Statutes, section 245.8251, subdivision 1. It is reasonable and necessary that the rule set out requirements that are consistent with the rulemaking authority established by the legislature.

Subpart 2. **Applicability to other licensed services and settings.** The rule also applies to all Department-licensed services and facilities when providing services to persons with a developmental disability or related condition. All services licensed by the Department are governed by the Human Services Licensing Act, Minnesota Statutes, chapter 245A. Thus, any service governed by that chapter is also governed by the proposed new rule. This is consistent with the legislative directive in the rulemaking authority in Minnesota Statutes, section 245.8251, subdivision 1. It is reasonable and necessary that the rule set out requirements that are consistent with the rulemaking authority established by the legislature. The provision also fulfills an

objective of the Rule 40 Advisory Committee that the rule have broad application to all Department licensees.[35]

Subpart 3. **Related law.** The rule supplements existing rules and statutes applicable to providers, depending on their license type. Providers continue to be governed by those requirements; the application of the proposed rule is in conjunction with those requirements. Specific situations in which standards in existing Department rules must be read in conjunction with the requirements of the proposed new rule are discussed in Regulatory Analysis factor (7). It is reasonable to outline the specific rules and statutes that must be considered in the application of the proposed rule.

Subpart 4. **Standards governing the use of restrictive interventions.** This rule part states that the new rule will supersede any existing standards in other state rules regarding the use of restrictive interventions. Exhibit 1 lists Department-licensed services and shows instances when a provision about the use of restraint and seclusion already exists in rule for that service type. This provision eliminates confusion about which requirements will apply when existing rules governing a particular service also address the use of restraint and seclusion. It is reasonable and necessary to make clear which rule provision will control.

Part 9544.0020 **DEFINITIONS.**

This rule part defines words and phrases that have a meaning specific to parts 9544.0005 to 9544.0140, that may have several possible interpretations, or that need exact definitions to be consistent with statute. It is necessary to define such words and phrases to ensure that the meaning of the rule is clear.

Subpart 1. **Scope.** This provision is needed to clarify that the definitions apply to the entire sequence of parts 9544.0005 to 9544.0140. It is also necessary and reasonable to clarify that the terms used in parts 9544.0005 to 9544.0140 that are defined in Minnesota Statutes, chapter 245D, have the meanings given in Minnesota Statutes, chapter 245D. The requirements in Minnesota Statutes, chapter 245D, "Home and Community- Based Services Standards," are used in the rule and form a foundation for the rule. The incorporation of the statutory requirements into the rule makes these chapter 245D requirements, in effect, applicable to all Department-licensees governed by the rule and provides consistency and clarity among the rules parts and other applicable statutes.

Subpart 2. **Aversive procedure.** This provision is needed to specify what is meant by the term "aversive procedure" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 2b.[36] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 3. **Behavior intervention report form.** This definition is necessary because the term "behavior intervention report form" has a meaning specific to these rule parts and providers governed by these rules need to know what data elements are in a behavior intervention report form in order to comply. A behavior intervention report form will be used by providers to report certain instances of the use of restrictive interventions and incidents. It is reasonable to state that the data collected in the form will be in accordance with Minnesota Statutes, section 245.8251,

subdivision 2, because this subdivision states that the commissioner, with stakeholder input, will identify data elements specific to incidents of emergency use of manual restraint and positive support transition plans.

Subpart 4. **Case manager.** This provision is needed to specify what is meant by the term "case manager" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 3.[37] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 5. **Chemical restraint.** This provision is needed to specify what is meant by the term "chemical restraint" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 3b.[38] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 6. **Child with severe emotional disturbance.** This provision is needed to specify what is meant by the term "child with severe emotional disturbance" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245.4871, subdivision 6.[39] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 7. **Commissioner.** This definition is needed to establish that the "commissioner" referred to throughout the rule parts is the commissioner of the Department of Human Services. The commissioner of human services is the commissioner specifically directed by Minnesota Statutes, section 245.8251, to promulgate the rules. Substituting the word "commissioner" instead of "commissioner of the Department of Human Services" or "commissioner of human services" contributes to the brevity and clarity of the rule parts.

Subpart 8. **Crisis respite services.** This definition is necessary to clarify the meaning of "crisis respite services" in the rules. It is reasonable to clarify that crisis respite services can be either in-home or out-of-home short-term care since respite services might take place in either setting and are supposed to be short-term temporary services. It is also reasonable to clarify that crisis respite services are "intervention strategies to a person to address medical or behavioral needs" because the goal of crisis respite services are to provide solutions to resolve crisis and could address either a person's medical or behavioral needs. It is reasonable to state that the purpose of crisis respite services is to "support the caregiver or protect the person or others living with the person" because crisis respite services can be used to support a caregiver when the caregiver is unable to provide the necessary intervention to a person receiving services. Additionally, crisis respite services could be used to protect a caregiver or persons living with the person to prevent or minimize future crisis situations and increase the likelihood of maintaining the person receiving services in the community.

Subpart 9. **Cultural competence.** This provision is needed to specify what is meant by the term "cultural competence" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 4e.[40] This definition is necessary to clarify that the use of

the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart. 10. **Deprivation procedure.** This provision is needed to specify what is meant by the term "deprivation procedure" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 5a.[41] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 11. **Developmental disability or related condition.** This provision is needed to specify what is meant by the term "developmental disability or related condition" and to clarify that the term has the same meaning given in Minnesota Rules, part 9525.0016, subpart 2, items A to E.[42] This definition is necessary to clarify that the use of the term in the proposed rule parts is consistent with the definition of the term given in the rules that establish the standards to be met by county boards or others authorized by the commissioner to provide case management and govern the planning, development, and provision of services to persons with developmental disabilities. Referencing the rule definition where the term is defined is a reasonable way to ensure consistency.

Subpart 12. **Direct support staff.** This provision is needed to specify what is meant by the term "direct support staff" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 6a.[43] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 13. **Emergency use of manual restraint.** This provision is needed to specify what is meant by the term "emergency use of manual restraint" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 8a.[44] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 14. **Expanded support team.** This provision is needed to specify what is meant by the term "expanded support team" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 8b.[45] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 15. **External program review committee.** This provision is needed to specify what is meant by the term "external program review committee" which is a specific term used in the rules. It is necessary to clarify that the term "external program review committee" means the committee appointed by the commissioner as described in Minnesota Statutes, section 245.8251, subdivisions 3 and 4, because the statute describes the purpose and the composition of the external program review committee. Referencing the statute where the committee is described is a reasonable way to ensure consistency.

Subpart 16. **External qualified professional.** This subpart is needed to define the term "external qualified professional." This definition is reasonable because recipients receiving services that are

governed by the rule may require a functional behavior assessment which must be performed by a qualified professional or an external qualified professional. It is reasonable to distinguish between a qualified professional and an external qualified professional and to state that an external qualified professional must possess the same credentials and qualifications as a qualified professional as defined under subpart 46. This ensures that an external qualified professional has the same credentials and qualifications as a qualified professional and ensures consistency and quality between persons performing a functional behavioral assessment.

Subpart 17. **Family foster care.** This provision is needed to specify what is meant by the term "family foster care" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 8c.[46] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 18. **Faradic shock.** This term requires definition because it is a term with a specific meaning in the rules. Faradic shock is a prohibited technique. "Faradic shock" means of or pertaining to a discontinuous, asymmetric, alternating or direct current from the second winding of an induction coil. This definition is reasonable because the Rule 40 Advisory Committee studied the literature, regulations from other States, and standards for current best practices, and determined this was the best, current definition.

Subpart 19. **Forms and instructions.** This provision is needed to specify that the term "forms and instructions" referenced in the rule are the same forms and instructions referenced in Minnesota Statutes, section 245D.06, subdivision 8, paragraph (a). Minnesota Statutes, section 245D.06, subdivision 8, paragraph (a) states that license holders will develop a positive support transition plan on the forms and in a manner prescribed by the commissioner. It is reasonable and necessary to reference Minnesota Statutes, section 245D.06, subdivision 8, paragraph (a), because the positive support transition plan is written on the forms and instructions referenced in the statute and the positive support transition plan is a central part of a person's care.

Subpart 20. **Functional behavior assessment**. This term requires definition because it is a term with a specific meaning in the rules. A "functional behavior assessment" is an assessment that operationally defines the interfering behaviors, identifies the situations in which the interfering behaviors are likely to occur and not occur, and generates a hypothesis of why the behavior occurs. This definition is reasonable because the Rule 40 Advisory Committee studied the literature, regulations from other States, and standards for current best practices, and determined this was the best, current definition. This definition is standard in the industry of behavioral sciences.

> **Item A.** It is reasonable for Item A to require that a functional behavior assessment include biological factors such as medical assessment or dental assessment since an interfering behavior may be triggered by a medical or dental condition. An important part of a functional behavior assessment is to look beyond the behavior and evaluate all factors, including medical factors, that could trigger an interfering behavior.
>
> **Item B.** It is reasonable for item B to require that a functional behavior assessment include psychological factors such as a diagnostic assessment or a suicidality assessment, since an interfering behavior may be triggered by a co-existing psychological disorder. It is not uncommon for persons with developmental disabilities to also have a mental illness. Some

common mental illnesses among persons with developmental disabilities may be personality disorders, affective disorders, anxiety disorders, psychotic disorders, avoidant disorders, and paranoid personality disorders. An important part of a functional behavior assessment is to look beyond the behavior and evaluate all factors, including psychological factors, that could trigger an interfering behavior.

Item C. Item C is a reasonable factor to include in a functional behavior assessment because environmental factors may be associated with the occurrence of an interfering behavior. It is reasonable to state that data may be collected through direct observation because other data collection procedures such as surveys, reports, or questionnaires may not be as effective as observing the person in their usual environment. It is also reasonable to include interviews with a significant individual in the person's life because these significant individuals are typically the ones who care the most about the person receiving care and know the most about him or her. As a result, they would be better situated than most others to understand the history and behavior of the person, and possibly an interfering behavior.

Item D. It is reasonable for item D to include an assessment of the quality of life indicators based on a person's goals and needs within each domain of a meaningful life in a functional behavior assessment because if quality of life indicators are addressed, a variety of interfering behaviors may be eliminated or reduced.

Subpart 21. **Home and community-based services.** This provision is needed to specify what is meant by the term "home and community-based services" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 10.[47] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 22. **Interfering Behavior.** This term requires definition because it is a term with a specific meaning in the rules. "Interfering behavior" means a behavior or psychiatric symptom that prevents a person from a more integrated setting or from participation in the most integrated setting. This definition is reasonable because the Rule 40 Advisory Committee studied the literature, regulations from other States, and standards for current best practices, and determined this was the best, current definition.

Subpart 23. **Legal representative.** This provision is needed to specify what is meant by the term "legal representative" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 12.[48] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 24. **Level program.** This term requires definition because it is a term with a specific meaning in the rules. Level programs are prohibited if they entail a response cost procedure. "Level program" means a type of program in which participants move up and sometimes down a hierarchy of levels contingent on meeting specific performance criteria with respect to target behavior. Moving up a level gains access to more privileges and the person is expected to demonstrate more independence. Moving down a level reduces privileges and provides access to a

smaller universe of opportunities, which may be a response cost procedure (i.e., negative punishment). This definition is reasonable because the Rule 40 Advisory Committee studied the literature, regulations from other States, and standards for current best practices, and determined this was the best, current definition.

Subpart 25. **License.** This provision is needed to specify what is meant by the term "license" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245A.02, subdivision 8.[49] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 26. **License holder**. This provision is needed to specify what is meant by the term "license holder" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 15.[50] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 27. **Manual restraint.** This provision is needed to specify what is meant by the term "manual restraint" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 15a.[51] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 28. **Mechanical restraint.** This provision is needed to specify what is meant by the term "mechanical restraint" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 15b.[52] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

It is further reasonable to clarify that a mechanical restraint does include use of an auxiliary device used to ensure that a person does not unfasten a seat belt as the Rule 40 Advisory Committee members deemed that seat belt restraints were indistinguishable from other mechanical restraints.

Item A. It is reasonable to differentiate that a mechanical restraint does not include a seat belt required under Minnesota Statutes, section 169.686, since seat belts are required by law and protect vehicle occupants, reduce the impact of collisions, and minimize injuries.

Item B. It is reasonable to differentiate that a mechanical restraint does not include a child passenger restraint system under Minnesota Statutes, section 245A.18, subdivision 1, since child passenger restraint systems are required by law and protect vehicle occupants, reduce the impact of collisions, and minimize injuries.

Subpart 29. **Medication.** This provision is needed to specify what is meant by the term "medication" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 16.[53] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 30. **Mental health mobile crisis intervention services.** This provision is needed to specify what is meant by the term "mental health mobile crisis intervention services" and to clarify that the term has the same meaning given in Minnesota Statutes, section 256B.0624, subdivision 2, paragraph (d).[54] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 31. **Mental illness.** This provision is needed to specify what is meant by the term "mental illness" for adults. For adults, "mental illness has the same meaning given in Minnesota Statutes, section 245.462, subdivision 20.[55] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 32. **Most integrated setting.** This provision is needed to specify what is meant by the term "most integrated setting" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 20a.[56] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 33. **Normal goods and services**. This term requires definition because it is a term with a specific meaning in the rules. The definition given is necessary because a variety of definitions may exist for the term "normal goods and services" and it is used here to describe a prohibited technique under the rules. In order to achieve or monitor compliance with the requirements of the rules, those governed by and those administering the rule parts need to be able to determine when the requirements apply and what is meant by "normal goods and services." It is reasonable to define normal goods and services as "…access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing, or to any protection required by state licensing standards and federal regulations governing the program" because these are normal goods and services that are essential for everyday living and any protections required by state licensing standards and federal regulations governing the program would also be applicable to persons receiving services under the rules. The definition is reasonable because it provides an understandable definition for recognizing what is meant by normal goods and services.

Subpart 34. **Outcome.** This provision is needed to specify what is meant by the term "outcome" and to clarify that it has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 21a.[57] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 35. **Pain.** This term requires definition because it is a term with a specific meaning in the rules. Pain is a prohibited technique. "Pain" includes physical pain, mental pain, or emotional distress. This definition is reasonable because the Rule 40 Advisory Committee studied the literature, regulations from other States, and standards for current best practices, and determined this was the best, current definition.

Subpart 36. **Person**. This provision is needed to specify what is meant by the term "person" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02,

subdivision 22, and Minnesota Statutes, chapter 245A. This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 37. **Person-centered planning.** This term requires definition because it is a term with a specific meaning in the rules. "Person-centered planning" is part of a family of approaches to organizing and guiding community change in alliance with people with disabilities and their families and friends. It means a strategy used to facilitate team-based plans for improving a person's quality of life as defined by the person, their family and other members of the community and that focuses on the person's preferences, talents, dreams and goals. This definition is reasonable because the Rule 40 Advisory Committee studied the literature, regulations from other States, and standards for current best practices, and determined this was the best, current definition.

Subpart 38. **Person with a disability.** This provision is needed to specify what is meant by the term "person with a disability" and to clarify that it has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 23.[58] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 39. **Physician.** This provision is needed to specify what is meant by the term "physician" and to clarify that it has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 23a.[59] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 40. **Positive support strategy.** It is necessary to define this term so that those governed by and those administering compliance with the rule parts will know what is meant by the term "positive support strategy." The definition given is necessary because a variety of definitions for the term "positive support strategy" exist and the differences typically reflect the different professional disciplines. For example, the meaning of the term may vary in the fields of education or psychology. The definition given is reasonable because the Department and the Rule 40 Advisory Committee felt it represents the term in a manner that is technically accurate but also comprehensible to people who may not be familiar with the language of positive supports. The definition also embodies what the Department and the Rule 40 Advisory Committee felt were integral and important parts of positive support strategies such as individualized assessments and alternative strategies that are used in lieu of restrictive interventions.

Subpart 41. **Positive support transition plan**. This provision is needed to specify what is meant by the term "positive support transition plan" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 23b.[60] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 42. **Program.** This provision is needed to specify what is meant by the term "program" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 26.[61] This definition is necessary to clarify that the use of the term in the rule parts is

consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 43. **Prone restraint.** This provision is needed to specify what is meant by the term "prone restraint" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.061, subdivision 3(a)(7).[62] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 44. **Psychotropic medication.** This provision is needed to specify what is meant by the term "psychotropic medication" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 27.[63] This definition is necessary to clarify that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 45. **Punishment.** This term requires definition because it is a term with a specific meaning in the rules. Punishment is a prohibited technique. "Punishment" is defined as either Type I - the contingent application of an aversive stimulus; or Type II - the contingent removal of a positive reinforcer. This definition is reasonable because the Rule 40 Advisory Committee studied the literature, regulations from other States, and standards for current best practices, and determined this was the best, current definition.

Item A. Item A describes Type I action as the contingent application of an aversive stimulus. Positive or Type I punishment means decreasing the rate or future likelihood of a target behavior by applying an aversive intervention. As described below, Type I punishment includes overcorrection techniques (such as positive practice overcorrection) or restitutional overcorrection.

Positive practice overcorrection is the use of a behavioral change tactic based on positive punishment in which, contingent on the selected target behavior, the learner is required to engage in effortful behavior directly or logically related to fixing the damage caused by the selected target behavior. An example of this would be a circumstance in which a person failed to make his bed when asked to do so. Overcorrection would occur if the person was then required to make his bed ten times as a result of the behavior, or to make his bed and those of all of his housemates.

Restitutional overcorrection is a form of overcorrection where contingent on the selected target behavior, the person is required to clean, repair, or correct the damage or return the environment not only to the original state, but to a condition vastly better than it was before the target behavior occurred. An example of this would be when a person spills a cup of milk. Restitutional overcorrection in response to the target behavior would mean that the person is required not only to clean up the milk and safely dispose of the broken glass, but also to vacuum and mop the entire house (the overcorrection). The Rule 40 Advisory Committee studied the literature, regulations from other States, and standards for current best practices, and determined this was the best, current definition.

Item B. Item B describes Type II action as the contingent removal of a positive reinforcer. Negative or Type II punishment means decreasing the rate or future likelihood of a target behavior by removing a positive reinforcer. Negative punishment is exemplified by a response cost, or loss of privileges, as described below.

Response cost means the use of negative punishment in which, contingent on a behavior, a specific amount of a reinforcer is removed. Loss of privileges means a reduction in status, or a reduction in access to reinforcers, due to a change in "levels" in a levels-based program. An example of a levels-based program would be a token economy. The Rule 40 Advisory Committee studied the literature, regulations from other States, and standards for current best practices, and determined this was the best, current definition.

Subpart 46. **Qualified professional.** This provision is needed to define the term "qualified professional." This definition is necessary and reasonable because a functional behavior assessment must be performed by a professional having sufficient capability to perform a meaningful assessment likely to result in desired outcomes.

It is reasonable to have the term "qualified professional" defined separately for each type of service and license. Proposed new rule part 9544.0040 requires that the license holder perform a functional behavior assessment when specific circumstances arise. This is a new requirement for providers. The Department considered establishing a higher and uniform threshold for all service providers to define what type of professional is qualified to perform the assessment. Assuming unlimited resources, the optimal person to perform a functional behavior assessment would be an experienced behavior professional or equivalent professional who has demonstrated competence in conducting functional behavior assessments. However, the Department did not want to establish a threshold that would require all providers to hire a consultant when a functional behavior assessment is required. The Department is cognizant of the impact of the proposed rules on the regulated community and that not all service providers have ready access to a behavior specialist, nor is there an adequate capacity of trained and knowledgeable behavior specialists to meet the demand for services if all license holders were required to use this specialist. Because each of the services involve staff of differing experience and credentials, the Department sought to identify a responsible and capable professional that would already be part of each service provider's staff, who would be in the best position to capably perform an assessment in the particular setting. It is expected that a responsible and capable professional will recognize when additional expertise is needed and will seek out such assistance.

The qualified professionals described in items A through C are licensed mental health professionals. Licensed mental health professional are required to meet specific education and clinical requirements to become licensed.[64] Furthermore, the knowledge base of mental health professionals and area of expertise translates well to an assessment of behavior, given that mental health treatment services generally entail human behavior to some degree. Thus, it is reasonable to identify a licensed mental health professional as competent to perform the functional behavior assessment.

It is reasonable to state that the qualified professionals defined in items D through J must meet additional requirements and demonstrate writing proficiency and the ability to implement positive support plans or treatment plans. The requirements ensure that the functional behavior

assessment is performed by a professionally qualified person, so that service recipients are assured of appropriate and effective care. The additional requirement for proficiency in the area of positive supports strategies is needed to ensure that a standard of quality is met in performing the assessment. The additional requirements are necessary to protect the integrity of the assessment process.

Item A. Item A states that, for residential facilities for adults with mental illness governed under Minnesota Rules, parts 9520.0500 to 9520.0670, a qualified professional includes a licensed mental health professional identified in Minnesota Statutes, section 245.462, subdivision 18. Minnesota Rules, parts 9520.0500 to 9520.0670, establish standards for mental health programs providing residential treatment and rehabilitation services to adults with mental illness on a 24-hour per day basis. For the reasons described above, it is reasonable to include a licensed mental health professional identified in Minnesota Statutes, section 245.462, subdivision 18, as a qualified professional under the rule in this context.

Item B. Item B states that, for residential mental health treatment for children with severe emotional disturbance governed under Minnesota Rules, parts 2960.0010 to 2960.0120 and parts 2960.0580 to 2960.0700, a qualified professional includes a licensed mental health professional as identified in Minnesota Statutes, section 245.462, subdivision 18, clauses (1) through (6). Minnesota Rules, parts 2960.0010 -2960.0220, establish general licensing standards for residential programs serving children in out of home placements. Minnesota Rules, parts 2960.0580 -2960.0700, establish additional certification standards for residential programs providing mental health services to children with severe emotional disturbances. For the reasons described above, it is reasonable to include a licensed mental health professional identified in Minnesota Statutes, section 245.462, subdivision 18, clauses (1) through (6), as a qualified professional under the rule in this context.

Item C. Item C states that, for sexual psychopathic personality and sexually dangerous person treatment programs governed under Minnesota Rules, parts 9515.3000 to 9515.3110, a qualified professional includes a licensed mental health professional as identified in Minnesota Statutes, section 245.462, subdivision 18, or a licensed psychologist as defined in Minnesota Statutes, section 148.907. Minnesota Rules, parts 9515.3000 to 9515.3110 govern operation, maintenance, and licensure of the secure treatment facilities at Moose Lake and St. Peter Security Hospital for persons committed as sexual psychopathic personalities or as sexually dangerous persons. It is reasonable to include the mental health professionals that operate in these programs as qualified professionals under the rule in this context.

Item D. Item D states that, for home and community-based services governed under Minnesota Statutes, chapter 245D, a qualified professional includes a designated coordinator as identified in Minnesota Statutes, section 245D.081, subdivision 2, paragraph (b); a behavior professional as identified in Minnesota Statutes, section 245D.091, subdivision 2; or a behavior analyst as identified in Minnesota Statutes, section 245D.091, subdivision 3. Minnesota Statutes, chapter 245D, is known as the “Home and Community- Based Services Standards.” Home and community-based services refers to assistance with daily activities that generally helps people with disabilities to remain in the

community. It is reasonable to include the behavior and care professionals that operate in these programs as qualified professionals under the rule in this context.

Item E. Item E states that, for chemical dependency treatment programs governed under Minnesota Rules, parts 9530.6405 to 9530.6505, a qualified professional includes a licensed alcohol and drug counselor defined in Minnesota Rules, part 9530.6450, subpart 5. Minnesota Rules, parts 9530.6405 to 9530.6505, establish the licensing standards for treatment programs for persons with chemical dependency and abuse problems. It is reasonable to include the care professionals that operate in these programs as qualified professionals under the rule in this context.

Item F. Item F states that, for detoxification programs governed under Minnesota Rules, parts 9530.6510 to 9530.6590, a qualified professional includes a chemical dependency assessor as defined under part 9530.6510, subpart 3a. Minnesota Rules, parts 9530.6510 to 9530.6590, establish the licensing standards applicable to detoxification programs. It is reasonable to include the assessment professionals that operate in these programs as qualified professionals under the rule in this context.

Item G. Item G states that, for chemical dependency treatment programs for children governed under Minnesota Rules, parts 2960.00100 to 2960.0120 and Minnesota Rules, parts 2960.0430 to 2960.0500, a qualified professional includes an individual as identified in Minnesota Rules, part 2960.0460, subparts 4 and 5. Minnesota Rules, parts 2960.0010 to 2960.0220, establish general licensing standards for residential programs serving children in out-of-home placements. Minnesota Rules, parts 2960.0430 to 2960.0500, establish additional certification standards for licensed residential programs providing chemical dependency treatment to children. Minnesota Rules, part 2960.0460, subpart 4, outlines criteria for alcohol and drug counselor supervisor qualifications and Minnesota Rules, part 2960.0460, subpart 5, outlines criteria for alcohol and drug counselor qualifications. It is reasonable to include the care professionals that operate in these programs as qualified professionals under the rule in this context.

Item H. Item H states that, for children's residential facilities governed under Minnesota Rules, parts 2960.0010 to 2960.0120, a qualified professional includes an individual as identified in Minnesota Rules, part 2960.0020, subpart 57. Minnesota Rules, parts 2960.0010 to 2960.0220, establish general licensing standards for residential programs serving children in out-of-home placements. Minnesota Rules, part 2960.0020, subpart 57, defines a program director as an individual who is designated by the license holder to be responsible for overall operations of a residential program. It is reasonable to include the program directors that operate in these programs as qualified professionals under the rule in this context.

Item I. Item I states that, for child care centers governed under Minnesota Rules, chapter 9503, a qualified professional includes a teacher as defined under Minnesota Rules, part 9503.0032; a staff person who meets the qualification requirements under subpart 46, items A or D of this rule; or a person's case manager as required under Minnesota Statutes, section 256B.092, subdivision 1a, paragraph (e). Minnesota Rules, parts 9503.0005 to 9503.0170, set standards for licensing child-care centers including programs that provide day care, night care, drop-in and sick care for less than 24 hours a day in a setting that is not

a residence. These facilities may be less likely to have ready access to the care and behavior professionals described in other items; however, the individuals identified in this item will be most responsible and capable professionals in these settings. It is reasonable to include them as qualified professionals under the rule in this context.

Item J. Item J states that, for family foster settings governed under Minnesota Rules, parts 2960.3000 to 2960.3100, a qualified professional includes qualified staff from the county or private child placing agency. Minnesota Rules, parts 2960.3000 to 2960.3100, establish general licensing standards for foster care programs, including treatment foster care settings and foster residence settings. These settings may be less likely to have ready access to the care and behavior professionals described in other items. Therefore, it is reasonable to require that qualified staff from the county or private child placing agencies provide the qualified professionals under the rule in this context.

Item K. Item K lists a number of settings and services that may be less likely to have ready access to the care and behavior professionals described in other items. For these listed settings and services, it is reasonable to define a qualified professional as a person who meets the qualification requirements under subpart 46, items A or D of this rule, or a person's case manager as required under Minnesota Statutes, section 256B.092, subdivision 1a, paragraph (e).

In identifying qualified professionals, the Department balanced the interests of providers that will need a qualified professional against the cost to affected providers of hiring an outside consultant. The Department determined that a person who meets the qualification requirements under subpart 46, items A or D of this rule or a person's case manager would have the knowledge, responsibility, expertise, and be in the best position to perform the duties of a qualified professional for these settings. These settings include:

(1) family child care governed under chapter 9502. Minnesota Rules, parts 9502.0300 to 9502.0445, govern licensure of providers of child care in a setting other than a day care center, usually the provider's residence, for less than 24 hours per day.
(2) family adult day services governed under Minnesota Statutes, section 245A.143. Minnesota Statutes, section 245A.143, establish licensing standards to obtain and maintain a license to provide family adult day services.
(3) adult day centers governed under Minnesota Rules, parts 9555.9600 to 9555.9730. Minnesota Rules, parts 9555.9600 to 9555.9730, set standards for the licensure of adult day care centers that regularly provide care for six or more functionally impaired adults.
(4) adult foster care governed under Minnesota Rules, parts 9555.5105 to 9555.6265. Minnesota Rules, parts 9555.5105 to 9555.6265, set standards for licensing, administering and providing social services to functionally impaired adults in adult foster homes so they receive an assessment of need for foster care and are offered community, health, and social services that may be needed and requested.
(5) child foster care governed under parts Minnesota Rules, parts 2960.3000 to 2960.3340. Minnesota Rules, parts 2960.3000 to 2960.3100, establish general licensing standards for foster care programs, including treatment foster care settings and foster residence settings. Minnesota Rules, parts 2960.3200 to 2960.3230, establish additional certification standards for foster residence settings which are programs staffed by shift staff. These are distinguished from family foster care homes. Minnesota Rules, parts 2960.3300 to

2960.3340, establish additional certification standards for family foster care settings that provide treatment services to children in care.

(6) independent living assistance for youth governed under Minnesota Statutes, section 245A.22. Minnesota Statutes, section 245A.22, govern independent living assistance for youth which means a nonresidential program that provides a system of services that includes training, counseling, instruction, supervision, and assistance provided to youth according to the youth's independent living plan, when the placements in the program are made by the county agency. Services may include assistance in locating housing, budgeting, meal preparation, shopping, personal appearance, counseling, and related social support services needed to meet the youth's needs and improve the youth's ability to conduct such tasks independently.

(7) residential programs and services for persons with physical disabilities governed under Minnesota Rules, chapter 9570. Minnesota Rules, parts 9570.2000 to 9570.3600, set standards for licensing community-based residential facilities and services for persons with physical disabilities.

(8) any other residential or nonresidential program licensed under Minnesota Statutes, chapter 245A, the Human Services Licensing Act.

Subpart 47. **Quality of life indicator.** This definition is necessary to clarify the meaning of "quality of life indicator" in the rules. Quality of life indicators are critical to person-centered planning and positive support strategies. It is reasonable to define a quality of life indicator as a reportable or observable outcome that is measurable and important to a person because quality of life indicators need to be quantifiable in order to measure progress or to gauge a person's values preferences, and opinions. Additionally, it is reasonable to note that quality of life indicators will be used to assess changes desired for a person to achieve a more enriched life with dignity.

Subpart 48. **Restraint.** This provision is needed to specify what is meant by the term "restraint" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 28.[65] This definition is necessary to ensure that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 49. **Restrictive intervention.** This provision is needed to specify what is meant by the term "restrictive intervention" and to clarify that the term means prohibited procedures defined in Minnesota Statutes, section 245D.06, subdivision 5, and prohibited procedures described in parts 9544.0060 and subpart 8 .[66] This definition is necessary to ensure that the use of the term in the rule parts is consistent with the definition of the term given in the statute and in other rule parts. Referencing the statutory definition and the rule parts where the term is defined is a reasonable way to ensure consistency.

Subpart 50. **Seclusion.** This provision is needed to specify what is meant by the term "seclusion" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 29.[67] This definition is necessary to ensure that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 51. **Self-injurious behavior.** This term requires definition because it is a term with a specific meaning in the rule, and it is a term which has various meanings across professional

disciplines. It is important to differentiate the meaning of "self-injurious behavior" from other interfering behaviors. This is necessary as self-injurious behavior may prompt the emergency use of a restrictive intervention to protect a person from imminent risk of serious injury. It is reasonable to define "self-injurious behavior" as behavior which results in damage to the person's own body.

Subpart 52. **Service.** This provision is needed to specify what is meant by the term "service" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 30.[68] This definition is necessary to ensure that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 53. **Target behavior.** This term requires definition because it is a term with a specific meaning in the rule. "Target behavior" means an observable behavior that is made the object of efforts to reduce or eliminate the behavior. This definition is reasonable because the Rule 40 Advisory Committee studied the literature, regulations from other States, and standards for current best practices, and determined this was best, current definition.

Subpart 54. **Token reinforcement program**. This term requires definition because it is a term with a specific meaning in the rule. Token reinforcement programs are prohibited if they entail a response cost procedure. "Token reinforcement program" means a program that requires a person to earn an outcome that is of value to the person. Tokens are earned or lost based on behavior. Tokens are traded in exchange for activities, events, goods, or services that may not otherwise be available to the person. This definition is a reasonable way to explain how a token reinforcement program operates.

Subpart 55. **Trauma-informed care.** This term requires definition because it is a term with a specific meaning in the rule. "Trauma-informed care" means an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. The Rule 40 Advisory Committee drafted this definition based on the definition of trauma-informed care from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This definition is reasonable because the Rule 40 Advisory Committee studied the literature, regulations from other States, and standards for current best practices, and determined this was best, current definition.

Subpart 56. **Treatment.** This provision is needed to specify what is meant by the term "treatment" and to clarify that the term has the same meaning given in Minnesota Statutes, section 245D.02, subdivision 35a.[69] This definition is necessary to ensure that the use of the term in the rule parts is consistent with the definition of the term given in statute. Referencing the statute where the term is defined is a reasonable way to ensure consistency.

Subpart 57. **Variance.** It is necessary to define the term "variance" in the rule and to specify the procedures for requesting a variance to the rule's standards. The need for procedures to vary from adopted standards arises when a party governed by the standard proposes to undertake or maintain an activity which cannot meet the standard. In cases where there are other means of achieving the same result as that intended by the standard, it is reasonable to grant a variance from the standard if all other conditions can be met. The commissioner has authority to regulate a wide variety of areas

related to care and services. The authority to regulate carries with it the responsibility to set reasonable standards and enforce them fairly and equitably, to the extent necessary to assure that health and safety is protected. Notification of the commissioner's decision on a variance request needs to be in writing so all parties concerned have a clear understanding of what is expected of each and also to specify with certainty what the terms and conditions of the variance are.

Part 9544.0030 **POSITIVE SUPPORT STRATEGIES AND PERSON-CENTERED PLANNING.**

Subpart 1. **Positive support strategies required.** Current best practices in behavioral guidance for persons with disabilities embrace a positive behavior strategy model.[70] In keeping with this philosophy, the Department's objective is to ensure that people receiving licensed services are able to function with as much self-determination and independence as possible. The proposed rule provision requiring the use of positive supports requires providers to assess each person served and create strengths-based strategies to teach productive and self-determined skills, or, in some instances, alternative strategies and behaviors.

The requirement to use positive support strategies is reasonable because positive support strategies have been shown to be far more effective than the historically-common practice of punishment. It was once assumed that punishment procedures were useful for teaching skills. Research has now shown that punishment is only useful for gaining immediate compliance, and any skills possibly learned are unlikely to transfer to settings outside the area in which punishment is used.[71]

The movement away from punishment and toward the use of positive supports is evidence-based. Research shows that the negative side effects of punishment usually outweigh the positives, as follows:

- The use of punishment has the potential for abuses by caregivers/therapists[72];
- Punishment can escalate challenging behavior or create new, unwanted behavior[73];
- Prior experience with punishing stimulus can decrease sensitivity to that punishment.[74] This means that to be effective, intensity of punishment must increase;
- Punishment arouses emotion in both the punisher and the punished. The punisher may feel excited, satisfied or more aggressive impulses – which may cause the punisher to get carried away. The punished may feel pain, discomfort or humiliation, fear, hate, a desire to escape or self-contempt – emotions which may be counterproductive to the situation and/or relationship[75];
- Punishment teaches about power. It can teach that powerful people get to hurt less-powerful people. For this reason, it has been found that parents who were abused as children may become child abusers themselves.[76]

In contrast, positive support strategies have the potential to teach skills that the person is able to generalize and maintain with little ongoing support. Punishment teaches people what not to do; positive supports teach a person what *to* do. And, as noted, positive support strategies generally do not entail negative side effects, as punishment procedures do.

This subpart also requires that providers incorporate the use of positive support strategies into any existing service plan. This is necessary to ensure that providers have properly planned for the

use of positive support strategies and allows the Department to monitor compliance. It is also consistent with the recommendation of the Rule 40 Advisory Committee that the number of plans for a person be limited as much as possible, and that each plan incorporate positive approaches and person-centeredness.[77] Thus, the proposed new rule provision requires the license holder to infuse *existing* service plans, which are otherwise required for the particular service, with positive strategies. This is in lieu of creating a requirement for yet another new plan, one focused only on positive supports.

Subpart 2. **Positive support strategy standards.** This provision sets out requirements for developing and implementing positive support strategies. It is necessary to articulate standards for a provider to ensure that positive support strategies used are thorough and effective.

Item A. Item A requires that a person's strengths, needs and preferences be assessed when identifying and creating positive support strategies. It is reasonable to require that positive support strategies be based on an assessment. Research shows that interventions are more effective when based on the results of an assessment.[78] Many types of assessments exist: functional assessments, preference assessments, strengths assessments, and more. This provision does not require a particular assessment, but instead permits the provider to choose an appropriate assessment in light of the given context and needs of the individual.

Item B. Item B states six basic requirements necessary to ensure that certain quality standards are met.

(1) This subitem requires that positive support strategies be evidence-based. It is reasonable to limit positive support strategies to those that have been proven, and to exclude approaches or strategies that are experimental, outdated, or unethical. The use of proven strategies ensures the effectiveness of the strategies for persons served.

(2) This subitem requires that positive support strategies be person-centered. This provision ensures that positive support strategies are chosen by the person in collaboration with the person's team and focus on the person's preferences, talents, dreams and goals. It is reasonable and necessary that treatment strategies are chosen with the person's input and integrate the person's goals. The requirement is consistent with best practices, the Rule 40 Advisory Committee recommendations, and the principles and goals of the rule in general.

(3) This subitem requires that positive support strategies be ethical. At its simplest level, this provision requires that any chosen strategy will do no harm. "First, do no harm" is, of course, a basic tenet of medical practice. It is reasonable to require the same for licensed social services.

(4) This subitem requires that positive support strategies seek to integrate the person into the community. Community integration is one of the broad,

over-arching themes of the modern movement toward creating a more fulfilling life for persons with disabilities. As described in the Introduction, the *Olmstead* decision interprets the Americans with Disabilities Act to require State and local governments to ensure community integration of persons with disabilities. It is reasonable that the rule be consistent with existing law and the principles of current best practices. The requirement also fulfills an obligation arising from the Jensen Settlement Agreement and the Comprehensive Plan of Action to ensure community integration in the Department's licensed services.

(5) This subitem requires that positive support strategies be the least restrictive to the person. It is generally accepted that the least restrictive alternative in many settings is the approach that is most respectful of a person's rights. Respect for the dignity and autonomy of a person leads to a higher quality of life. It is reasonable to require that positive support strategies permit a high level of autonomy.

(6) This subitem requires that positive support strategies be effective. This will require providers to monitor their implementation of positive support strategies to assure that they accomplish their goals. This requirement means that continued use of a positive support strategy that is not effective is not acceptable. It is reasonable to require that positive support strategies be effective to further the goals of a person.

Item C. Item C requires that person-centered planning be consistent with the requirements in Minnesota Statutes, section 245D.07, subdivision 1a, paragraph (b), clause (1). It is necessary and reasonable that the provisions of this rule be consistent with similar provisions of existing law.

Item D. Item D requires providers to promote a person's self-determination in accordance with Minnesota Statutes 245D.07, subdivision 1a, paragraph (b), clause (2). It is necessary and reasonable that the provisions of this rule be consistent with similar provisions of existing law.

Item E. Item E requires providers to provide the most integrated setting and inclusive service delivery in accordance with Minnesota Statutes 245D.07, subdivision 1a, paragraph (b), clause (3). It is necessary and reasonable that the provisions of this rule be consistent with similar provisions of existing law. This provision is also consistent with the requirements of the *Olmstead* decision and Minnesota's Olmstead Plan.

Item F. Item F emphasizes the provider's responsibility for improving a person's quality of life through inclusive, supportive and therapeutic environments. Research shows that persons living in therapeutic, supportive settings report higher levels of quality of life than do those who live in restrictive settings.[79] It is necessary and reasonable that providers of DHS-licensed services seek to create the most inclusive, supportive and therapeutic environments possible.

Item G. Item G requires providers to use person-centered planning in regards to the most integrated setting. Person-centered planning includes a less formal, more naturalistic assessment process in which information is made accessible to the person.[80] It is necessary and reasonable for the rule to articulate the goals and mechanics of person-centered planning.

(1) requires that the person be placed at the center of the planning process. The person's preferences and choices must be reflected in the selection of services and supports. Research shows that when a person is allowed to make their own choices and determine their own goals, they exhibit lower levels of challenging behavior and are generally more successful.[81] It is reasonable that services and supports are developed around a person's preferences rather than those of the service provider. This provision encompasses the recommendations of the Rule 40 Advisory Committee regarding person-centered planning.[82]

(2) requires that the person-centered planning process involve the person directly with their community, personal networks and relationships to build on the person's capacity to engage in activities and promote community life. This sub-item meshes the tenets of person-centeredness with most integrated settings. It is necessary and reasonable that the goals of person-centered planning seek to integrate a person in their community to the greatest extent possible and desired by the person. This provision encompasses the recommendations of the Rule 40 Advisory Committee regarding person-centered planning.[83]

(3) requires that the person-centered planning process identify goals to support the person in the most integrated setting. It is reasonable that the goals of person-centered planning seek to integrate a person into their community to the greatest extent possible and desired by the person. This is also consistent with the principles of the *Olmstead* decision.

Subpart 3. **Person-centered principles.** This subpart requires license holders to incorporate person-centered principles into the services it provides. This requirement is consistent with the principles of Minnesota Statutes, chapter 245D.07, subdivision 1a, and operates to support a person's preferences, daily needs and activities and the accomplishment of the person's goals. This section also incorporates by reference the Code of Federal Regulations, section 441.725, paragraph (a), clauses (1) – (4), which governs person-centered service plans for home and community-based services. It is necessary and reasonable that the provisions of this rule be consistent with existing law.

Person-centered planning has proven to be effective in increasing community participation, enhancing social support and facilitating access to employment for persons with disabilities.[84] These are effects that further the specific and general goals and purposes of the rule. It is reasonable to require person-centered planning as it will aid in accomplishing the goals of the rule.

This subpart also requires a provider to evaluate the services provided to determine

whether they support the person's preferences, needs and activities, and goals, and whether they comply with law. The person receiving services must be involved in the evaluation and the evaluation must be completed at least every six months. If it is determined that changes are necessary, those changes must be made. This ongoing quality assurance measure is necessary to ensure that the implementation of services remains true to the principles of person-centeredness and in compliance with existing law. It is reasonable to require such evaluation on a regular basis and to require that a provider respond to the findings of the evaluation to maintain quality services.

Subpart 4. **Professional standards for positive support strategies.** This subpart requires providers to use professional standards that are consistent with the rule in developing and implementing positive support strategies and provides examples of professional standards that meet this requirement. This subpart is necessary to ensure that all providers have a uniform understanding of what constitutes a positive support strategy and have access to a number of quick-reference resources to draw from.

> **Items A through E**. These items include specific professional standards from national organizations recognized for their work in positive supports with varying specific populations. The rule will govern the use of positive support strategies for persons with a wide range of disabilities in a wide range of settings. It is reasonable, therefore, to allow for the use of positive support strategies acknowledged as best practice for differing populations. It is further reasonable to utilize national best practices standards as this ensures that providers use tools that are in step with national research, current best practices and new initiatives.
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> **Item F**. Item F allows for other, evolving standards to meet the requirements of this subpart. It is reasonable to create a process and articulate criteria by which future developments may be recognized as resources for providers under this subpart.

Part 9544.0040 **FUNCTIONAL BEHAVIOR ASSESSMENT.**

Most researchers and experts in positive supports recommend that interventions for challenging behavior be based on an assessment that determines, to the extent possible, the purpose of the challenging behavior. Interventions that do not target the specific issue are not as likely to be successful.[85]

The practice of conducting a functional behavior assessment also dignifies the process of developing a treatment by including the person in discovering why he or she is engaging in problem behavior.[86] This is consistent with requirements surrounding person-centered planning throughout the rule.

The Rule 40 Advisory Committee included a section of recommendations on functional behavior assessments. Foremost, the Rule 40 Advisory Committee noted that it must be assumed, absent a mental health finding, that a person's challenging behavior is intended to control their environment or to communicate something. A functional behavior assessment is used to determine what the person is trying to control or communicate so that it can be addressed through positive support strategies.

The Rule 40 Advisory Committee specifically recommended that the Department develop criteria to determine when a functional behavior assessment is necessary, and spent some time describing who should conduct the assessment and what it should include.[87] This provision is necessary to provide these guidelines for functional behavior assessments.

Subpart 1. **Who must conduct.** It is necessary to identify who may conduct a functional behavior assessment. As noted by the Rule 40 Advisory Committee, a functional behavior assessment requires an assessor with the skills, knowledge and experience to integrate findings from a number of professional assessments, hypothesize about the purpose of challenging behavior, and develop a plan to address it. While not a formal recommendation, some committee members believed functional behavior assessments should only be conducted by positive behavior support experts.[88]

It would place an undue burden on providers to require that all employees be trained and competent to conduct functional behavior assessments and create positive support strategies based upon the assessments, or if every provider were required to employ a positive behavior support expert. On the other hand, it could cause irreparable harm if unqualified staff obtained functional behavior assessment materials and simply filled them in without engaging in the evidence-based practices that lead to effective assessments. There is a balance to be struck between these options.

This provision requires that a functional behavior assessment be conducted by a qualified professional. Qualified professional is defined in the rule in detail and separately by service and license. This part is also to be read in concert with the training requirements in 9544.0090 which requires that persons who develop positive supports must have additional training and competency to ensure they can perform these duties. It is a reasonable balance to require that the functional behavior assessment be completed by a person with the necessary training and education detailed in these various rule parts.

Subpart 2. **When required.** It is important that a functional behavior assessment be conducted at the appropriate point in providing services, and it is necessary for the rule to identify when that is. This provision requires that a functional behavior assessment be conducted when an intervention is designed to change a target behavior.

Research defines a functional [behavior] assessment as a "process by which the variables influencing a problem behavior are identified."[89] Conducting a functional behavior assessment increases treatment precision and effectiveness.[90] It is reasonable that providers conduct functional behavior assessments at the point in providing services that will enable them to develop treatment strategies that are tailored to the person and effective.

Subpart 3. **Required elements.** A functional behavior assessment is not meant to be a rigid, fill-in-the-blank form. It is a dynamic process that continues to be developed by researchers and practitioners.[91] It is necessary, however, to provide guidance to providers on what is expected in a quality functional behavior assessment. This provision therefore identifies required elements of a functional behavior assessment.

A functional behavior assessment must include direct observation of the person assessed by the qualified professional. While a functional behavior assessment may include indirect assessments such as questionnaires and interviews of collateral contacts, research shows that direct

assessments such as data recording and functional analyses of behavior are much more reliable.[92] It is reasonable to require that providers use the most reliable procedures.

Items A through D provide factors to be addressed by the functional behavior assessment. These specific evaluations are generally accepted as the basis for a quality functional behavior assessment.[93] Not all assessments will call for every item. Accordingly, this provision requires that the qualified professional select one or more items as appropriate to the situation and base their evaluation on the selected items. It is reasonable to require that providers conduct the necessary evaluations to complete a quality functional behavior assessment in order to best serve the person receiving services.

Subpart 4. **Scope of evaluation.** When the chosen positive support strategies do not have the desired effect, it may become necessary to conduct a more comprehensive functional behavior assessment. This provision details what is expected in a more comprehensive functional behavior assessment. In that event, the qualified professional must select additional items identified in subpart 3 for evaluation. It is reasonable to require that providers seek out additional evidence in conducting a more comprehensive functional behavior assessment in order to support a new hypothesis and positive support strategy development.

Part 9544.0050 **PERMITTED PROCEDURES.**

Subpart 1. **Specific procedures permitted.** It is necessary to identify procedures providers are permitted to use that are not identified in Minnesota Statutes, section 245D.06, subdivision 7, and which may otherwise meet the definition of aversive or deprivation procedures in Minnesota Statutes, section 245D.02, subdivisions 2b, 2c, and 5a. Minnesota Statutes, section 245D.06, subdivision 7, identifies two categories of permitted procedures which may be used on an intermittent or continuous basis:

1. Physical contact or instructional techniques that are the least restrictive alternative possible to meet the needs of the person to calm a person, protect a person from frequent falls due to a medical condition, facilitate completion of a task, teach a skill, or provide comfort; and
2. Manual or mechanical restraint used as an intervention procedure to allow medical examination or treatment or healing from an acute medical condition, assist in safe emergency evacuation, or to position a person with physical disabilities. Any use of a manual restraint under these circumstances must comply with the restrictions identified in Minnesota Statutes, section 245D.06, subdivision 6, paragraph (b).

Also, use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.

It is reasonable that the use of these procedures be approved by a person's expanded support team and that this approval is documented. This approval ensures participation in the decision to use these procedures and techniques as part of a person's service plan by the expanded support team, which has specific knowledge about the individual and his or her unique needs and capabilities. The approval ensures that the provider does not make a decision for such use independently and without oversight by knowledgeable others, who can contribute to a more

fully-informed evaluation and conclusion.

It is important to distinguish in the rule that in the case of a child, the expanded support team also includes a parent or parents. It is reasonable to include the parent or parents of the child in this definition since they are not specifically included in the statutory definition of expanded support team and parents should have decision-making authority and input for the care of their child. In most cases, a child's parents are the persons who care the most about their child and know the most about him or her. As a result, parents are better situated than most others to understand the unique needs of their child and to make decisions that are in the child's interests. Furthermore, since many planning choices for person-centered planning will also affect the child's family, parents can factor family issues and values into person-centered planning decisions about their children.

Item A. Item A identifies the conditions governing the use of a positive verbal correction as an intervention procedure specifically focused on the behavior being addressed with a person. Allowing the use of this intervention procedure is reasonable to assist a person in exhibiting a behavior when it is the least restrictive alternative possible to meet the needs of the person.

Item B. Item B identifies an intervention procedure that allows the temporary withholding or removal of objects from a person that the person is using to harm themselves or others. Allowing the use of this intervention procedure is reasonable as it is less restrictive than emergency use of manual restraint as a means to achieve safety when immediate intervention is needed to protect the person or others from imminent risk of physical harm. Temporary withholding or removal for a brief period of lasting no more than several minutes is reasonable until the person's behavior is redirected and normal activities can be resumed.

Subpart 2. **Documentation required.** It is reasonable and necessary to require the provider to maintain documentation of permitted procedures. The documentation allows the department to verify compliance with the requirements of the rule and evaluate the effectiveness of the interventions.

Part 9544.0060 **PROHIBITIONS AND RESTRICTIONS.**

Subpart 1. **General prohibitions**. This subpart fulfills the statutory directive in Minnesota Statutes, section 245.8251, to ensure that the prohibitions on restrictive interventions contained in Minnesota Statutes, chapter 245D, apply to all Department-licensed services and facilities. The Department therefore incorporates Minnesota Statutes, section 245D.06, subdivision 5. Minnesota Statutes, section 245D.06, subdivision 5, is a key section that establishes the prohibited procedures. The effect of the incorporation in the rule, which governs all Department-licensed services and facilities, is to apply the prohibitions contained in the statute to all licensed services and facilities.

The statutory list is broad, and uses descriptions of categories rather than listing specific techniques. The intent is to encompass all types of unacceptable aversive and deprivation procedures in the descriptions of the categories. The subdivision concludes with a catch-all provision prohibiting "any…aversive or deprivation procedure."

The statutory subdivision also qualifies the list by stating that these techniques are prohibited "when used as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience." [94] The qualification allows for the possibility of the rare, unforeseeable circumstance in which a practice that is ordinarily unacceptable may have a momentary, acceptable purpose. Therefore, it is when the practices are used for the prohibited reasons that the practice is prohibited. The inclusion of the phrase "for a behavioral or therapeutic program to reduce or eliminate behavior" demonstrates that planned, programmatic use of the prohibited practices is not permitted.

It is reasonable to adopt policy that the Legislature has vetted and adopted. Further, incorporating the statutory prohibitions on use of restrictive interventions is also consistent with the Department's agreement to preclude use of restraints and seclusion both in the Jensen Settlement Agreement and in the Comprehensive Plan of Action. The terms of the Jensen Settlement Agreement require the Department to "immediately and permanently discontinue" the use of mechanical restraints, medical restraints, and medications as a method of punishment, or in lieu of adequate staff training or behavior support plans, convenience, or as a form of behavior modification in the program that was the subject of the lawsuit. As noted, the Department also agreed more broadly in the Comprehensive Plan of Action to prohibit restraint and seclusion in all licensed facilities and settings, consistent with the above-noted legislative directive in Minnesota Statutes, section 245.8251. As detailed in the "DHS Respect and Dignity Practices Statement" signed by the commissioner, "it is our goal to prohibit procedures that cause pain, whether physical, emotional or psychological, and prohibit use of seclusion and restraints for all programs and services licensed or certified by the department."

Subpart 2 **Specific prohibitions.** Although Minnesota Statutes, section 245D.06, subdivision 5, takes the approach of more broadly describing categories of prohibited techniques, the Rule 40 Advisory Committee approached the matter differently. The Rule 40 Advisory Committee studied the prohibitions in a number of other states and reviewed current best practices from a number of reputable sources in positive behavior supports.[95] The Rule 40 Advisory Committee determined that, given the broad range and severity of aversive and deprivation procedures that have been used over the years, it is important to specify some of the most abhorrent techniques as prohibited.

The Department agreed in the Comprehensive Plan of Action to abide by the Rule 40 Advisory Committee Recommendations. When the Department is legally bound to abide by the Recommendations, it is necessary to adhere closely to these recommendations. It is reasonable to list specific techniques because this leaves no room for doubt or argument that the listed procedures cannot be used for improper purposes under any circumstances. Therefore, listing specific prohibited techniques is necessary and reasonable. Nevertheless, a number of the prohibited procedures merit further comment, as analyzed below.

The list below is taken directly from the Rule 40 Advisory Committee Recommendations. The list is not intended to diminish the all-encompassing nature of the prohibition against use of procedures that fall within the broad categories set out in Minnesota Statutes, section 245D.06, subdivision 5. In other words, even without itemizing the specific techniques, these procedures would still be prohibited by virtue of the incorporation into rule of the broader statutory prohibition.

Item A. Item A describes prone restraint as a prohibited technique. Prone restraint is defined as any manual restraint that places the person in a face-down position. Prone restraint is specifically prohibited because of the now widely-known danger in using this procedure, namely, the risk of positional asphyxiation. Both Attachment A to the Jensen Settlement Agreement (setting out new policies for the program that was the subject of the lawsuit) and the Rule 40 Advisory Committee Recommendations prohibit the use of prone restraint.

Item A also prohibits the use of metal handcuffs or leg hobbles. Both of these techniques were also present in the program that was the subject of the *Jensen* lawsuit. It is reasonable to prohibit the use of these procedures as they are outdated and are not best practices in the field.

Item B. Item B prohibits the use of faradic shock. "Faradic shock" means the use of an electrical shock applied to a person, typically as an aversive consequence to a behavior. Electric shock was once considered to be a best practice for decreasing negative behavior in persons with a developmental disability[96] but is now considered immoral and abusive.[97] It is necessary and reasonable to specifically identify some abusive practices as prohibited.

Item C. Item C prohibits the interacting with a person or others in a manner that ridicules, demeans, threatens, or is abusive to the person. Item C describes an outdated and ineffective aversive technique that would constitute emotional or verbal abuse, such as humiliation, name-calling, using profanities, and making degrading remarks to a person receiving services. It is necessary and reasonable to specifically identify some abusive practices as prohibited.

Item D. Item D prohibits the use of physical intimidation or a show of force. Examples include shaking, striking, or spanking. This prohibition is also consistent with Minnesota Statutes, section 626.5572, subdivision 2, paragraph (a), which defines "hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult" or the "use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening" to be a form of abuse.

Item E. Item E describes containment without monitoring as a prohibited technique. Containing without monitoring describes an outdated deprivation technique in which a person is restricted, isolated, secluded or otherwise removed from the course of ordinary daily activities. The technique also includes fully or partially immobilizing a person without monitoring the person for medical and psychological distress. An example is directing a person to go to and remain in a bedroom to let the person's emotions settle, when there is no plan to monitor the person who will be isolated in this manner. The use of seclusion is problematic because it strips a person of dignity, privacy and, potentially, safety.[98] The use of seclusion also raises other issues, including physical injuries, the unique vulnerabilities of high-risk populations, and potentially even medical danger leading up to death.[99] It is reasonable and necessary to include this as a prohibited procedure since it is a specific example of an aversive or deprivation technique that presents unacceptable risks and deleterious effects on persons receiving services.

Item F. Item F describes restricting or denying access to adaptive devices or equipment as a prohibited technique. Many persons receiving services have conditions associated with physical or sensory disorders that require correction, amplification, adaption or prosthetic substitution. The absence or restriction of these devices and equipment may result in dramatically reduced functional abilities and increased dependence on others. Since these devices and materials are essential to a person's basic functioning, any restriction in access to these materials must be limited to extraordinary circumstances. The only circumstances that warrant the restriction of such essential equipment and devices are those where the safety of the person or others is jeopardized, or serious damage to the equipment is likely. Therefore, it is reasonable and necessary to prohibit the practice in all circumstances except when a risk of injury to the person or others or serious damage to the equipment is present.

Item G. Item G describes the use of "painful techniques" as a prohibited procedure, which may include intentional infliction of pain or injury, dehumanization and degradation. The Association for Positive Behavioral Supports makes it clear that the use demeaning or painful procedures to suppress behavior is not acceptable. The Association provides evidence that such approaches are ineffective in producing durable changes in people's behavior and do not improve the quality of their lives.[100] It is reasonable and necessary to include this as a prohibited technique since such techniques are widely-known in current times to be unacceptable.

Item H. This item elaborates on the prohibition in Item G regarding painful techniques by prohibiting the hyperextension or twisting of a person's body parts. This does not prevent license holders from completing therapies such as range of motion exercises, because the prohibition only pertains to hyperextending or twisting of a person's body parts when used as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience. It is reasonable and necessary to include this as a prohibited technique since these are examples of aversive or deprivation techniques that the Rule 40 Advisory Committee recommended to be prohibited.

Item I. Item I prohibits a license holder from tripping or pushing a person receiving services. This is consistent with Minnesota Statutes, section 626.5572, subdivision 2, paragraph (b), which defines prohibited practices that are deemed to be maltreatment of vulnerable adults. It is reasonable and necessary to include this as a prohibited technique because tripping or pushing an individual with a developmental or other disability may amount to illegal maltreatment of program recipients.

Item J. Item J describes any action or procedure used as punishment as a prohibited technique. In the past, punishment and isolation were the two primary aversive and deprivation techniques used to change behavior.[101] Experience since then, which is supported by data, has shown that these techniques not only did not work, but increased negative behavior.[102] It is reasonable and necessary to specify as prohibited a technique that had previously been a classic and accepted method, but is now widely viewed as unacceptable, because this signifies the shift away from methods that were not respectful of the individual toward use of the more positive behavior support techniques that the rule seeks to establish. In the event any program has lasting vestiges of the earlier, common use

of punishment, the requirement also provides clear notice that this practice is now prohibited.

Items K through P. All of these items specify a particular means of imposing an aversive or deprivation procedure that has been used in the past. The items also represent techniques that by today's standards are considered to be abusive. As noted, the Rule 40 Advisory Committee studied the current literature and regulation in other states, and concluded that such techniques are not effective and are inconsistent with current best practices. It is reasonable to expressly prohibit the use of specific techniques that have been used in the past and are both abusive and ineffective.

Item Q. Item Q describes the use of token reinforcement and level programs which include a response cost or negative punishment component as prohibited techniques. The goal of token reinforcement and level programs is to use reinforcements to teach new behaviors or teach a person to stop a behavior or engage in a behavior more, or less, frequently. Such methods represent a movement away from more severe aversive and deprivation methods, such as punishment and isolation. However, when they include a response cost or negative punishment component, the flaw is that they still focus on consequences, correction, and looking too much at the behavior, rather than the communicative function of the behavior.[103] It is reasonable and necessary to include these as prohibited techniques because it is no longer a best practice and is inconsistent with better-informed behavior support techniques now known to be more effective.

Item R. Item R prohibits license holders from using a person receiving services to discipline another person receiving services. This procedure can create power struggles between persons receiving services and potentially be considered abuse by Minnesota Statutes, section 625.5572, subdivision 2, paragraph (d). It is necessary and reasonable that the rule be consistent with the Rule 40 Advisory Committee recommendations and prohibit potentially dangerous and abusive practices.

Item S. Item S prohibits the use of any action or procedure which is medically or psychologically contraindicated. It is reasonable and necessary to prohibit techniques that have been specifically identified as deleterious to a specific individual. It is reasonable and necessary to honor the individuality of all program recipients.

Item T. Item T prohibits a license holder from using an action or procedure that might restrict or obstruct a person's airway or impair breathing, including techniques whereby individuals use their hands or body to place pressure on a person's head, neck, back, chest, abdomen, or joints. These actions could place a person in danger of harm and in many cases may be considered assault in the first through fifth degrees as defined in Minnesota Statutes, sections 609.221 to 609.224. This prohibition was recommended by the Rule 40 Advisory Committee. It is necessary and reasonable that the rule be consistent with the Rule 40 Advisory Committee recommendations and prohibit potentially dangerous and abusive practices.

Item U. Item U prohibits interfering with protections established through state licensing standards or federal regulations governing the program, except as allowed by Minnesota Statutes, section 245D.04, subdivision 3, paragraph (c). This item is meant to correspond to the Rule 40 Advisory Committee Recommendation that the "fundamental rights" of persons receiving services be preserved. This is the only item in which a material change was made to the nomenclature used in the list from the Recommendations. Although the Department agrees in principle that the fundamental rights of individuals should be protected, the phrase is arguably not well-defined. To establish enforceable standards that provide fair notice to license holders about what is prohibited, the Department found it necessary to circumscribe the reference to fundamental rights to a standard that is more clear.

The purpose of federal and state licensing standards is to establish requirements for programs and services that are tailored to the specific setting and target population for the given service. To the extent any specific protections are spelled out in law for a particular service or setting, it is necessary and reasonable to expressly prohibit interference with those standards to preserve the specific rights of persons receiving services.

The Department cites an exception to this general prohibition in that actions that are consistent with Minnesota Statutes, section 245D.04, subdivision 3, paragraph (c) are permitted. Citing this statutory provision is necessary and reasonable because the statute spells out the exceptional occasions in which it is appropriate to take action that is ostensibly intrusive, which occurs only in a narrow set of circumstances when the specified conditions are met, while broadly preserving individual rights in all other instances.

Item V. Item V prohibits the use of mechanical restraint in accordance with Minnesota Statutes, section 245D.06, subdivision 5. Although subpart 1 applies all the prohibitions from Minnesota Statutes, section 245D.06, subdivision. 5, to all license holders subject to this rule, a Rule 40 Advisory Committee member advocated that the rule lay out all of the techniques specified in the Rule 40 Advisory Committee Recommendations for ease of reference and to establish compliance with the Department's agreement to abide by the Recommendations.

Item W. Item W prohibits the use of chemical restraint in accordance with Minnesota Statutes section 245D.06, subdivision 5. Although subpart 1 applies all the prohibitions from Minnesota Statutes, section 245D.06, subdivision. 5, to all license holders subject to this rule, a Rule 40 Advisory Committee member advocated that the rule lay out all of the techniques specified in the Rule 40 Advisory Committee Recommendations for ease of reference and to establish compliance with the Department's agreement to abide by the Recommendations.

Item X. Item X prohibits any use of manual restraint that is not consistent with the emergency use of manual restraint as allowed in Minnesota Statutes, section 245D.061. Regulations in many states permit the use of manual restraint in emergency situations. The statutory safeguards represent current best practices for the use of such restraint. Incorporating the statutory permissions and requirements for the emergency use of manual restraint into rule fulfills the directive in Minnesota Statutes, section 245.8251, to ensure

that the prohibitions in the Home and Community-Based Services Standards apply to all Department-licensed services and facilities. This standard practice is also consistent with terms in the Jensen Settlement Agreement.

Item Y. Item Y prohibits the use of any other interventions or procedures that may constitute an aversive or deprivation procedure. The recommended prohibitions against aversive or deprivation procedures represent the Rule 40 Advisory Committee's understanding of current best practices. Moreover, the broader description of types of prohibited procedures at the end of the list signifies to persons who must comply with the rule that the itemized list is not all-inclusive. It is reasonable and necessary to include language that clarifies this intent.

Subpart 3. **Restrictions.** As with subpart 1, this subpart fulfills the statutory directive in Minnesota Statutes, section 245.8251, to ensure that the prohibitions and limits on restrictive interventions contained in Minnesota Statutes, chapter 245D, apply to all Department-licensed services and facilities when serving a person with a developmental disability or related condition. This subpart is needed because it incorporates the restrictions and the use of certain procedures identified in Minnesota Statutes, section 245D.06, subdivision 6. The Legislature has fully vetted these limitations on use of procedures and has pronounced its policy determination about the restrictions on use of procedures in statute. It is necessary to incorporate that policy when directed to do so by statute; and it is reasonable to adopt policy for other Department-licensed services and settings that the Legislature has already adopted for home and community-based services.

Part 9544.0070 **EMERGENCY USE OF MANUAL RESTRAINT.**

Subpart 1. **Governing law and requirements.** Although phasing out of seclusion and restraint is the general, overarching objective of both chapter 245D, and, by incorporation, this rule chapter, the risk of danger that can be presented by some behavior must be considered. Certainly, among the most challenging of behaviors to manage are behaviors that are self-injurious, threaten the safety of others, or interfere with a person's ability to independently function adaptively in a community environment. Professional literature shows that when an aversive or deprivation procedure is abruptly terminated, the behavior that was being managed may accelerate, putting the person and others at serious risk of injury. Current best practices factor in the risks associated with this behavior, and it has become somewhat standard practice to include an exception for the use of manual restraint in emergency situations.

Minnesota Statutes, section 245D.061, embodies current best practices in establishing such an exception. The exception is only available when "immediate intervention" is required to protect the person or others from "imminent risk" of physical harm. There are many attendant safeguards, such as monitoring the person during the use, reporting the use to responsible authorities, undertaking both internal and external reviews, and more. The statutory exception is consistent with Rule 40 Advisory Committee Recommendations,[104] and the Committee, as noted, studied current best practices and regulation from a number of other states.

Minnesota Statutes, section 245.8251, requires the Department to ensure that the prohibitions and limits on use of restrictive interventions apply to all Department-licensed facilities and services when serving a person with a developmental disability or related condition.

If the structure of prohibited, restricted, and permitted techniques found in Minnesota Statutes, section 245D.06, is incorporated, then, for the reasons just noted, it is imperative that the exception for behavior which poses an imminent risk of physical harm also be included. It is therefore necessary and reasonable to incorporate Minnesota Statutes, section 245D.061, into the rule.

Importantly, this provision incorporates by reference Minnesota Statutes, section 245D.06, subdivision 8. That provision both requires and permits the use of a positive support transition plan (PSTP). A PSTP is required and permitted "for a person who requires intervention in order to maintain safety when it is known that the person's behavior poses an immediate risk of physical harm to self or others."[105] The PSTP "must phase out any existing plans for the emergency or programmatic use of restrictive interventions [that are otherwise] prohibited."[106] Thus, the requirement is to gradually diminish the continued use of an intervention when that intervention had regularly been part of the programmatic approach to managing a person's behavior before the requirement went into effect. The provision thus allows for a gradual transition, or shift, to the new requirement.

The statutory duration of time to reduce the use of an intervention to the ultimate phase-out or elimination is eleven months, as detailed in Minnesota Statutes, section 245D.06, subdivision 8(a). When a public policy shift is being made in Minnesota, first, for home and community-based services according to statute, and next, through the rule, to other Department-licensed services and facilities, it is necessary and reasonable that the policy for transitioning to the new standards as determined by the legislature be used for both groups. It is therefore necessary and reasonable to incorporate Minnesota Statutes, section 245D.06, subdivision 8, by reference.

This is deliberately one of only two references in the rule to a PSTP. Rule 40 Advisory Committee representatives advocated strongly for this convention, so that the use of a PSTP did not become the proverbial "rule, rather than the exception." In other words, it was thought that minimizing the rule references to a PSTP will minimize the frequency of use of PSTPs. It is reasonable to abide by recommendations from Rule 40 Advisory Committee representatives.

The statute also requires that the license holder abide by the requirements in the forms and instructions for the PSTP. This requirement applies to all license holders, as well, by virtue of the incorporation by reference

Subpart 2. **Record keeping.** It is reasonable and necessary to require the provider to maintain documentation of information required by the rule. The documentation allows the department to verify compliance with the requirements of the rule and evaluate the effectiveness of the interventions.

Part 9544.0080 **INFORMED CONSENT.**

Informed consent is a widely accepted process by which persons make decisions regarding their own care. It is a basic tenet of self-determination and it is necessary to include it in the provision of services by providers in order to serve the broad purpose of the rule, improving the quality of life of persons receiving services.

Subpart 1. **When informed consent is required.** A provider must have a policy regarding the

emergency use of manual restraint. This policy may allow the emergency use of manual restraint, or it may prohibit it and set out alternative courses of action.[107] It is reasonable to require providers to obtain informed consent regarding their emergency use of manual restraint policy. This serves the broader purposes of person-centered planning and contributes to the improvement of quality of life of persons receiving services. It is also reasonable to require that informed consent be obtained at service initiation or when the provider's policy changes. This will ensure that informed consent is in place prior to the implementation of the policy with a particular person.

Similarly, when a restrictive intervention is temporarily allowed pursuant to a positive support transition plan in accordance with statute, it is reasonable to require providers to obtain informed consent to the use of those restrictive interventions before their implementation. This is crucial to the broader purposes of person-centered planning and improving the quality of life of persons receiving services. It is also reasonable to require that informed consent to the use of restrictive interventions be obtained in the manner set out in the forms and instructions, along with the other varied requirements of a positive support transition plan.

Subpart 2. **Authority to give consent.** It is necessary to identify who is authorized to give informed consent under the proposed rules. Informed consent is to be obtained from the person it concerns when that person is competent to give consent. If a person has been determined not to be competent to give consent, it is reasonable to empower the person's legal representative to give consent on their behalf, so that the person's interests are represented in the decision-making process.

It is further reasonable to encourage the legal representative to consider the preferences of the person concerned in making their decision. The Rule 40 Advisory Committee specifically identified as a training topic the difference between substitute decision-making and making a decision in a person's best interests. Encouraging consideration of the person's preferences, within the framework of the legal representative's authority, serves the purposes of person-centered planning and self-determination.

Part 9544.0090 **STAFF QUALIFICATIONS AND TRAINING.**

This provision details the minimum qualifications and training requirements for providers and their staff, depending upon the role they play in providing services. It also sets out requirements for verifying competency and maintaining documentation of staff qualifications, training and competency.

It is important that those involved in providing services have adequate skills and knowledge to provide safe and effective services. It is necessary that the rule require minimum qualifications and training to ensure adequate skills and knowledge. It is also necessary to verify that, in addition to qualifications and training, staff members are actually competent in the performance of these duties.

Subpart 1. **Core training for staff.** This provision requires that all staff who develop, implement, monitor, supervise or evaluate positive support strategies, a positive support transition plan or the emergency use of manual restraint complete core training. These techniques are tools of behavioral science and as such, are based on academic theories, study, research and evidence. As

expressed throughout the rule, the strategies and techniques used with persons receiving services must be evidence-based and proven effective and must be implemented properly. To ensure this, it is important that staff involved in providing services have an understanding of the science behind the strategies and techniques as well as a solid grasp on the logistics and technicalities of applying them. It is reasonable to require a core training program presented by a qualified individual to ensure adequate knowledge in these areas.

This provision also notes that previous equivalent training may fulfill this requirement. This acknowledges that some providers may already be engaging in core training, or that as staff move between providers, they carry their core training with them. It is reasonable to recognize this continuing competency.

Subpart 2. **Function-specific training.** There is a wide range of roles to be played in the organizations of the providers governed by the rule, and necessary skills and knowledge vary based on those roles. It is reasonable to require additional training specific to the function and role of each staff member. Specialized training of staff results in prevention of harm, more positive interactions, and improved quality of life for persons receiving services. It is reasonable to require that this additional training be completed before staff take on the noted responsibilities to ensure consistent competent performance of their duties.

This provision also notes that previous equivalent training may fulfill this requirement. This acknowledges that some providers may already be engaging in function-specific training, or that as staff move between providers, they carry their training with them. It is reasonable to recognize this continuing competency.

Item A. Item A requires that direct support staff complete four hours of additional training in the areas outlined in items (1) to (13). Direct support staff is defined by Minnesota Statute section 245D.02, subdivision 6a, as staff "who have direct contact with persons served by the program." It is reasonable to require specialized training for staff providing such service to ensure safe, effective implementation of techniques, provider policies, and overall care.

(1) through (13) detail the areas identified by experts as important to the competent performance of direct support staff. They include training on relevant law, policies specific to a provider, and general concepts and principles of providing direct care to persons receiving services. It is reasonable to require additional training in these areas to ensure competent direct support staff.

Item B. Item B requires that staff who implement positive support strategies complete four hours of additional training in the areas outlined in items (1) to (11). Quality implementation of positive support strategies involves knowledge and skills specific to positive supports. It is reasonable to require specialized training for staff providing such service to ensure safe, effective implementation of positive support strategies.

(1) through (11) detail the areas identified by experts as important to the competent implementation of positive support strategies. They include training on

the theory of positive supports and skills specific to the implementation of positive support strategies in a service plan. It is reasonable to require additional training in these areas to ensure competent implementation of positive support strategies.

Item C. Item C requires that staff who develop positive support strategies complete four hours of additional training in the areas outlined in items (1) to (5). Quality development of positive support strategies involves knowledge and skills specific to positive supports. It is reasonable to require specialized training for staff providing such service to ensure safe, effective development of positive support strategies.

(1) through (5) detail the areas identified by experts as important to the competent development of positive support strategies. They include training on the theory of positive supports, supervision skills, and continuing education relevant to the staff member's field. It is reasonable to require additional training in these areas to ensure competent development of positive support strategies.

Item D. Item D requires that staff who oversee the development and implementation of positive support strategies complete four hours of additional training in the areas outlined in items (1) to (6). Supervision of the development and implementation of positive support strategies requires a solid base of knowledge and understanding of positive supports. It is reasonable to require specialized training for staff providing such service to ensure meaningful supervision of the development and implementation of positive support strategies.

(1) through (6) detail the areas identified by experts as important to the competent oversight of the development and implementation of positive support strategies. They include training on higher order behavioral science concepts, person-centered planning, supervision skills, and knowledge of available resources. It is reasonable to require additional training in these areas to ensure competent oversight of the development and implementation of positive support strategies.

Item E. Item E requires that providers, their management and owners complete four hours of additional training in the areas outlined in items (1) to (6). It is important that providers understand and prioritize positive supports and person-centeredness at the organizational level. It is reasonable to require specialized training for owners and management of providers to ensure that the concepts and purposes advanced by the rule are adopted at an organizational level.

(1) through (6) detail the areas identified by experts as important to the education of owners and management of providers in the areas of positive support strategies and person-centered planning. It is reasonable to require this additional training to ensure organization-wide understanding of these concepts.

Subpart 3. **Annual refresher training.** This provision requires that staff complete four hours of refresher training each year and that the refresher training cover topics applicable to the staff's responsibilities. It is reasonable to require ongoing training to maintain competencies and promote

fidelity to good practices in the delivery of services.

Subpart 4. **Determining competency of the staff.** This provision requires that the provider determine competency of staff to perform assigned duties. It is reasonable to verify competency to ensure quality services. This determination of competency must be made by a trainer or instructor through knowledge testing or observed skill assessment. It is widely acknowledged that knowledge testing and observed skill assessment are effective methods of determining competency.[108] It is reasonable to require that a knowledgeable individual verify competency and that the method used is effective in order to have confidence in the accuracy of the verification, such that there is a degree of assurance that persons receiving services are guaranteed safe, effective treatment and care. Items A to C detail the timing and substance of the required competency determinations.

> **Item A.** Item A requires that staff tasked with implementing positive support strategies demonstrate competency in the positive support strategies prior to implementation and that the competency be specific to the primary disability, diagnosis or interfering behavior of the person receiving services. As discussed above, positive support strategies are based on the theories and studies of behavioral science. It is important that a positive support strategy be implemented with accuracy and with consideration of the specific strengths, needs and challenges of the person receiving services. It is reasonable to require staff implementing positive support strategies to demonstrate competency to ensure this.
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> **Item B.** Item B requires that staff tasked with implementing restrictive procedures, as permitted, demonstrate competency in the procedures prior to implementation, that the competency be specific to the primary disability, diagnosis or interfering behavior of the person receiving services, and that the procedure be applied in the manner described in the positive support transition plan. Restrictive procedures have been shown to be particularly traumatic, both to the person receiving services and to the staff applying the intervention.[109] It is critical that proper methods and best practices be followed in the implementation of restrictive procedures to ensure the safety and well-being of everyone involved. It is reasonable to require staff implementing restrictive procedures to demonstrate their competency to do so.
>
> **Item C.** Item C requires that updated training and demonstration of competency must accompany any change to the relevant content in a positive support transition plan or a permitted restrictive intervention. It is reasonable to require updated training and demonstration of competency to ensure that proper techniques and practices are being used in the implementation of the most recent plan and procedures.

Subpart 5. **Documentation.** It is reasonable and necessary to require the provider to maintain documentation of information required by the rule. The documentation allows the department to verify compliance with the requirements of the rule.

Part 9544.0100 **DOCUMENTATION AND RECORD KEEPING REQUIREMENTS.**

This provision is necessary to allow the Department to monitor the implementation of positive support strategies by providers subject to the rule. It is necessary and reasonable that documentation and records be kept by a provider to ensure compliance with the rule.

Subpart 1. **Documentation of use of positive support strategies.** This subpart clarifies types of data a provider must maintain and document.

Item A. Item A requires providers to maintain data revealing progress towards each outcome of a goal of a person. It is reasonable to require providers to document progress for their own review and evaluation, as well as review by the Department, to ensure ongoing improvement and effective practices.

Item B. Item B requires providers to maintain data that ensures they are accountable for the services provided to the person. It is reasonable to require providers to document that services billed for are performed.

Item C. Item C requires providers to maintain data that ensures their services can be monitored and evaluated by the provider and by the Department. It is reasonable to require providers to document progress for their own review and evaluation, as well as review by the Department, for quality assurance purposes.

Subpart 2. **Exemption.** This part exempts several types of providers from documenting general positive support strategies. One or two individuals with limited support staff typically administer family child care, family foster care and family adult day services. They also typically provide services to only a limited number of persons receiving services. It is necessary to recognize that documentation and record keeping take time and resources, and carry a financial burden. As the providers of these services are typically self-employed and serve few persons, it is reasonable to balance the burden of documentation against the capacities of these providers, and exempt them from documenting general positive support strategies.

This subpart does require these specific provider types to create a positive support transition plan for any person receiving services that requires it. The Department anticipates that relatively few people receiving these services will require a positive support transition plan, but it is necessary and reasonable that any person meeting the threshold for a positive support transition plan have one developed regardless of what service they are receiving.

Subpart 3. **Documentation of outcomes.** This subpart requires providers to maintain data revealing progress towards each outcome that relates to the person's goals, and on quality of life indicators. It is necessary and reasonable that providers document progress for their own review and evaluation, as well as review by the Department.

Subpart 4. **Record keeping.** This subpart provides guidance on the retention of the documentation required under this part. It is reasonable in that it is consistent with other documentation requirements existing for providers subject to this rule contained in Minnesota Statutes section 245A.041, subdivision 3, paragraph (a), item (1), which requires license holders to maintain service recipient records for five years.

Part 9544.0110 **REPORTING USE OF RESTRICTIVE INTERVENTIONS AND INCIDENTS.**

This provision is necessary to allow the Department to monitor the implementation and impact of this rule for persons receiving services, and keeps the Department abreast of developments in the field. It is reasonable that the Department should monitor the use and impact of restrictive interventions, incidents, and the effects of this rule. The Rule 40 Advisory Committee strongly encouraged the use of reporting and monitoring of restrictive interventions to ensure that the use of restraints is reduced and eliminated as well as to allow for "trend analysis, incident analysis and moving the entire system away from past practices toward positive approaches."[110]

Minnesota Statutes, section 245.8251, subdivision 2, requires the commissioner to collect a set of data elements pertaining to the emergency use of manual restraint and positive support transition plans. In July 2013, the Department launched an electronic data collection form called the Behavior Intervention Report Form (DHS-5148). This form allows providers to report all required data elements including the emergency use of manual restraint in compliance with Minnesota Statutes, section 245D.061, subdivision 8, to both the Department and the Office of the Ombudsman for Mental Health and Developmental Disabilities. This provision would extend the requirement to report using the behavior intervention report form to providers not previously subject to Minnesota Statutes, chapter 245D.

Item A. Item A requires all providers to report the emergency use of manual restraint. This requirement is consistent with the conditions of Minnesota Statutes, section 245D.061, subdivision 8, and extends its provisions to providers not subject to Minnesota Statues, chapter 245D. This requirement also incorporates the provisions of Minnesota Statutes, section 245.8251, subdivision 2, requiring the commissioner to collect data on the emergency use of manual restraint from licensed facilities and licensed services governed under Minnesota Statutes, chapter 245D, and in other Department-licensed facilities and services serving persons with a developmental disability or related condition. The Rule 40 Advisory Committee also recommended that the Department require providers to report the emergency use of manual restraint.[111] It is necessary and reasonable that this rule is consistent with applicable state and federal regulation, and the recommendations of the Rule 40 Advisory Committee.

Item B. Item B requires all providers to report any medical emergency occurring as the result of a restrictive intervention that results in a call to 911 or treatment by a physician or hospital. These reports allow the Department to monitor the possibly negative physical impact the use of restrictive interventions have on persons receiving services. This item is consistent with the definition of "incident" in Minnesota Statutes, section 245D.02, subdivision 11(3), but would create a requirement for providers to report these incidents via the behavior intervention report form. This data is also useful to determine the impact this rule has on the emergency response system. Data obtained by these reports could drive future policy direction on its use for persons receiving services. It is necessary and reasonable that the Department monitor incidents related to behavioral interventions for the purposes of monitoring quality and implementation of the rule.

Item C. Item C requires providers to report any behavioral incident that results in a call to

911. These reports allow the Department to monitor the possibly negative impact the use of restrictive interventions have on persons receiving services. This item is consistent with the definition of "incident" in Minnesota Statutes, section 245D.02, subdivision 11(5), but would create a requirement for providers to report these incidents via the behavior intervention report form. This data is also useful to determine the impact this rule has on the emergency response system. Data obtained by these reports could drive future policy direction on its use for persons receiving services. It is necessary and reasonable that the Department monitor incidents related to behavioral interventions for the purposes of monitoring quality and implementation of the rule.

Item D. Item D requires providers to report via the behavior intervention report form whenever a mental health crisis results in a provider calling 911 or a mental health crisis service. Mental health crisis services include crisis assessment, crisis intervention, and crisis stabilization services. This item is consistent with the definition of "incident" in Minnesota Statutes, section 245D.02, subdivision 11(4), but would create a requirement for providers to report these incidents via the behavior intervention report form. This data is also useful to determine the impact this rule has on the emergency response system. Data obtained by these reports could drive future policy direction on its use for persons receiving services. It is necessary and reasonable that the Department monitor incidents related to behavioral interventions.

Item E. Item E requires providers to report calls to mental health mobile crisis intervention services for any reason. This item is consistent with the definition of "incident" in Minnesota Statutes, section 245D.02, subdivision 11(4), but would create a requirement for providers to report these incidents via the behavior intervention report form. This data is also useful to determine the impact this rule has on the emergency response system. Data obtained by these reports could drive future policy direction on its use for persons receiving services. It is necessary and reasonable that the Department monitor incidents related to behavioral interventions for the purposes of monitoring quality and implementation of the rule.

Item F. Item F requires providers to report a person's use of crisis respite services due to use of a restrictive procedure. This allows the Department to collect data on the use of crisis respite services for this purpose and to identify teams and cases that may require additional assistance or expertise. The use of crisis respite services is meant to provide an emergency placement for persons experiencing a crisis. Crisis respite services assist people to avoid institutional placement. Crisis respite services use may indicate that a problem is occurring. Currently, the Department can only track the use of crisis respite services through paid claims, a process that does not allow the Department to act immediately in crises. Oftentimes, claims do not come through for several months, meaning that the Department cannot currently identify individuals in need until several months after a crisis occurred. Item F will reasonably assure that the Department receives notification closer to an actual crisis and can intervene and offer assistance when necessary.

Item G. Item G requires providers to complete a behavior intervention report form when pro re nata (PRN) medication is used to intervene in a behavioral situation. This would mean that PRN medication provided to avert or respond to a behavioral situation requires

reporting. It is necessary and reasonable that the Department monitor potentially inappropriate practices. The use of any medication to respond to a behavioral situation may qualify as chemical restraint and therefore be prohibited under the proposed rule. Alternatively, some studies have shown that initiatives to reduce restraint drive results in an increase in the use of psychotropic medication.[112] It is necessary and reasonable that the Department monitor incidents related to behavioral interventions for the purposes of monitoring quality and implementation of the rule.

Item H. Item H requires providers to report any incident that a person's positive support transition plan requires the program to report. Such incidents may include: serious injury of a person; a person's death; any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition of a person that requires the program to call 911, physician treatment, or hospitalization; any mental health crisis that requires the program to call 911, a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate; an act or situation involving a person that requires the program to call 911, law enforcement, or the fire department; a person's unauthorized or unexplained absence from a program; conduct by a person receiving services against another person receiving services that (i) is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support, (ii) places the person in actual and reasonable fear of harm, (iii) places the person in actual and reasonable fear of damage to property of the person, or (iv) substantially disrupts the orderly operation of the program; any sexual activity between persons receiving services involving force or coercion; or a report of alleged or suspected child or vulnerable adult maltreatment.[113] Reporting requirements may come from either the positive support transition plan instructions or the written plan. Expanded support teams may determine whether procedures or incidents not expressly required to be reported should be reported to the team or the Department. It is necessary and reasonable that expanded support teams have the opportunity to determine additional reporting needs.

Item I. Item I requires license holders to report any restrictive intervention that a person's positive support transition plan requires the program to report. Reporting requirements may come from either the positive support transition plan instructions or the written plan. Expanded support teams may determine whether procedures or interventions not expressly required to be reported should be reported to the team or the Department. It is necessary and reasonable that expanded support teams have the opportunity to determine additional reporting needs.

Part 9544.0120 **QUALITY ASSURANCE AND PROGRAM IMPROVEMENT.**

A quality assurance system is necessary to maintain effectiveness and fidelity to best practices in the implementation of positive support strategies and person-centered planning and to support the goals of improved quality of life and protection of rights of persons receiving services. It is reasonable to require the license holder to engage in this system on a regular basis and to address potential issues to ensure that the license holder is alerted and will promptly take remedial actions when warranted. It is reasonable to require the license holder to submit documentation of the quality assurance system and its data and outcomes upon request to enable the department to

monitor compliance with the requirements of the proposed rules.

Part 9544.0130 **EXTERNAL PROGRAM REVIEW COMMITTEE.**

Subpart 1. **Appointment.** Subpart 1 states that the commissioner shall appoint members to an external program review committee to monitor the rules. Appointing an external review committee to monitor the rules is mandated by Minnesota Statutes, section 245.8251, subdivision 4. It is reasonable and necessary for the Department to appoint and convene an external program review committee to ensure the protection of persons' rights and safety governed by the rules, and to follow the legislative directive.

Subpart 2. **Membership.** Subpart 2 states that the commissioner must select members of an external program review committee based on their expertise and knowledge on the use of positive support strategies as alternatives to the use of restrictive interventions. It is necessary for the commissioner to appoint an external program review committee in order to comply with Minnesota Statutes, section 245.8251, subdivision 4. The representation specified in the subpart is reasonable because it provides for involvement of professionals in the field with the greatest expertise and knowledge of positive support strategies.

Subpart 3. **Duties and responsibilities.** Subpart 3 outlines the duties and responsibilities of the external program review committee. It is reasonable and necessary for the rule to clarify the nature of the duties and responsibilities of the committee because the committee will operate within the context of the rule parts.

Item A. Item A explains that the external program review committee will establish criteria to approve or deny requests made in accordance with Minnesota Statutes, section 245D.06, subdivision 8, paragraph (b), for the emergency use of procedures that have been part of an approved positive support transition plan when necessary to protect a person from imminent risk of serious injury due to self-injurious behavior, and will make a recommendation to the commissioner to approve or deny these requests. The external program review committee would consist of a panel of professionals with expertise to establish criteria and make recommendations to the commissioner based upon whether certain emergency use of procedures should be approved to prevent self-injurious behavior.

This item is necessary to establish criteria for making these decisions. It is reasonable to assign these duties to the external program review committee to advise the commissioner in the limited authority to grant approval for the emergency use of procedures identified in Minnesota Statutes, section 245D.06, subdivision 8, paragraph (b). It is further reasonable for the external program review committee to include additional terms or conditions that the license holder must meet in order to be granted approval for the emergency use of such procedures, as the license holder would need to be put on notice about what conditions it would need to meet.

Item B. Item B states that the external program review committee will review requests for use of a prohibited procedure that is not specifically permitted by part 9544.0050 (Permitted Procedures) or specifically prohibited by part 9544.0060 (Prohibitions and

Restrictions), and make a recommendation to the commissioner to approve or deny these requests based on criteria established by the external review committee. This is a reasonable duty to assign to the external program review committee because the program review committee would consist of a panel of professionals with expertise to make recommendations to the commissioner based upon whether an exception should be granted for the use of certain restrictive or emergency procedures.

Item C. Item C states that the external program review committee will evaluate the programs and systems of license holders making requests under items A or B to ascertain the license holder's overall capacity to serve persons who are the subject of the request. A license holder should have systems and controls employed in their programs to ensure that they are running adequately and to provide reasonable assurance that their objectives are being accomplished and that these systems and controls are working effectively. The effect of using the external program review committee to review the license holder's program when a special request is made is reasonable since special requests should only be granted under exceptional circumstances. Also, the license holder should be able to meet or exceed their program's expectations if they are granted approval so that they are not using a restrictive or emergency procedure in lieu of adequate staff training or behavior support plans, convenience, or as a form of behavior modification.

Item D. Item D states that the external program review committee will review each reported emergency use of manual restraint and the license holder's response to it. The external program review committee will also develop criteria to provide license holders with guidance to address emergency use when guidance is warranted. It is reasonable for the external program review committee to review the use of emergency manual restraint since emergency manual restraint should only be used in exceptional circumstances. By having the external program review committee review instances in which it is used, the committee will be able to monitor if it is being used properly. It is also reasonable for the external program review committee to develop criteria to provide license holders with guidance to address emergency use when guidance is warranted since the external program review committee has specialized knowledge and expertise regarding positive support strategies and the use of manual restraint. The external program review committee is in a position to be able to provide license holders with steps to be taken to limit the use of manual restraint or provide alternative options to the use of manual restraint.

Subpart 4. **Number of external program review committees.** Subpart 4 states that the commissioner may designate more than one external program review committee based on the number of requests for emergency use of procedures reviewed by the interim review panel. Indicating that the commissioner will appoint more committees if needed rather than indicating a specified number is reasonable because the number of requests that will require committee review can only be estimated at this point. Requiring that the criteria used to review requests according to subpart 3, items B to C must be uniform across committees is also reasonable to ensure consistency in the reviewing process regardless of which committee is involved.

Part 9544.0140 **VARIANCES.**

Minnesota Statutes, section 14.055, subdivision 3, requires an agency to grant a variance

from its rule if the agency finds the application of the rule in the given circumstance would not serve the purpose of the rule. Subdivision 4 of that section sets out criteria under which an agency may grant a discretionary variance; and subdivision 5 states that an agency may grant variances based on standards specified in other law. Minnesota Statutes, section 245A.04, subdivision 9, supplies the standards to be applied when considering a variance for services licensed under the Minnesota Human Services Licensing Act, chapter 245A.[114]

It is necessary and reasonable to acknowledge the statutory provisions for variances. The Department expects the granting of variances to this rule to be rare and to be subject to strict limits and oversight, in order to serve the purposes of the rule.

CONCLUSION

Based on the foregoing, the proposed rules are both needed and reasonable.

This Statement of Need and Reasonableness is being made available for public review on the date shown below.

_December 15, 2014____

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ENDNOTES

[1] See, e.g., State Policies on the Use of Restrictive Procedures (a comprehensive listing of state laws regarding the emergency or planned use of physical, chemical, mechanical, or other restraints). Retrieved from http://www.nasddds.org/resource-library/behavioral-challenges/state-policies-on-the-use-of-restrictive-procedures/

[2] *Jensen, et al. v. Minnesota Department of Human Services, et al*., Federal District Court File No. 09-CV-1775. The lawsuit is still pending in United States District Court – District of Minnesota, and is assigned to the Honorable Judge Donovan Frank who continues to supervise settlement implementation.

[3] Some of these broad initiatives were later embraced in a statement issued by the Department, known as the "DHS Respect and Dignity Practices Statement." Retrieved from https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6756-ENG

[4] Rule 40 was promulgated in 1987 and amended in 1993. The path to rule adoption was challenging and followed a number of years of development.

[5] 42 CFR Part 441.301. Home and community-based services provide supports and services needed to keep an individual living in an integrated community setting when they would otherwise require institutional care.

[6] 2013 Session Laws, Chapter 108, Article 8, Section 4 (codified at Minnesota Statutes, section 245.8251).

[7] 2014 Session Laws, Chapter 312, Article 27, Section 5 (amending Minnesota Statutes, section 245.8251, subdivision 1).

[8] A court-adopted Comprehensive Plan of Action now facilitates timely implementation of the settlement agreement. The Comprehensive Plan of Action, Part II of which governs "Modernization of Rule 40," is available on the Department's public web site at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6920-ENG. In its entirety, the Plan is a detailed spreadsheet containing over 100 "Evaluation Criteria and Actions" or measures the Department is required to take to implement the settlement terms. Bi-monthly, the Department reports its progress on each criteria to a court-appointed monitor. Part II of the Plan requires the Department to base the rule on the Rule 40 Advisory Committee's determinations.

[9] Rule 40 Advisory Committee members studied and reviewed hundreds of pages of materials and heard a wide variety of presentations on best practices, including a presentation by Derrick Dufresne and Michael Mayer, two national leaders in helping states implement shifts to best practices.

Pursuant to the Jensen Settlement Agreement, the Rule 40 Advisory Committee was provided and reviewed "the Arizona Department of Economic Security, Division of Developmental Disabilities, Policy and Procedures Manual, Policy 1600 Managing Inappropriate Behaviors" as part of its review of best practices. The corresponding Arizona Administrative Code section was also provided.

The Department provided additional resource materials both in original format and summary format for the Rule 40 Advisory Committee's use. The materials were provided in print at Rule 40 Advisory Committee meetings, via email to committee members and interested parties, and on the Department's public Rule 40 Advisory Committee website. Resource materials included:

- Professional and scholarly works regarding best practices (e.g., Association of Positive Behavior Supports, Substance Abuse and Mental Health Services Administration - SAMHSA);

- All other states' rules, statutes and manuals (particularly Georgia, Nebraska, Arizona, Kansas, Michigan);

- Subject matter expert presentations and resource materials; and

- Presentations on statutes, standards and rules used by other Minnesota agencies.

The Rule 40 Advisory Committee adopted a framework based on the Jensen Settlement Agreement, which included six principles. The Committee therefore established six work groups. Work group sessions were open to anyone from the public interested in attending and participating. Each work group considered policies, processes and standards for its assigned topic. These were:

- Person-centered planning. The group addressed what is most important in person-centered planning and how to evaluate a person-centered plan.

- Positive support strategies. The group addressed the components of positive support strategies, various assessments that can be used, and who can perform particular roles.

- Emergency use of restraints. The group addressed use of restraints, and expanded its topic to encompass other prohibited physical intervention techniques.

- Training. The group addressed training goals, recommended training topics for the different roles fulfilled in service delivery (e.g., direct care staff, policy staff, and case managers), and methods to evaluate training.

- Implementation of the new standards. The group addressed initial, broad implementation of the standards, how implementation will affect individuals, and how to sustain changes.

- Monitoring, reporting, review and oversight of the use of restraints. The group addressed the multiple aspects and levels of reporting and oversight.

[10] The Rule 40 Advisory Committee Recommendations are available on the Department's public web site at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6748-ENG.

[11] The Department licenses the following services: chemical dependency programs; detoxification programs; mental health-related programs and services; child care services; services for children placed out-of-home and youth; residential services for persons with disabilities or older adults; home and community-based service providers licensed under Minnesota Statutes, chapter 245D; non-residential services for persons with disabilities or older adults. In addition, the Department invited comment from State and county departments, agencies and boards whose work intersects with the subject of the new rule.

[12] A Request for Comments had originally been published on January 30, 2012 (36 SR 878). As described in the *Statutory Authority* section of this SONAR, this Request for Comments corresponded with the first grant of rulemaking authority in 2012. That authority, however, was contingent on funding being allocated for related initiatives -- but no 2012 funding was allocated. The Department published a second Request for Comments on August 26, 2013 (38 SR 277), which superseded the first Request for Comments. This Request corresponded with the rule scope as directed by the 2013 Legislature. When the 2014 Legislature expanded the scope of the rules to include all Department-licensed facilities and licensed services serving persons with a developmental disability or a related condition, the Department determined that another Request for Comments was required and published that on August 25, 2014 (39 SR 266). The third Request superseded the second Request. The third Request coincided with the Department's broad notice to stakeholders about the September and October public input sessions.

[13] 2013 Session Laws, Chapter 108, Article 8, Section 4 (codified at Minnesota Statutes, section 245.8251).

[14] 2014 Session Laws, Chapter 312, Article 27, Section 5 (amending Minnesota Statutes, section 245.8251, subdivision 1). See also Minnesota Statutes, section 245.8251, subdivision 3.

[15] The four largest provider groups comprise, by far, the vast majority of all licensed programs. These are, in order of size: in-home, family child care (about 10,200 programs); adult foster care (about 4,700 programs); child foster care (about 3,150 programs); and child care centers (about 1,600 programs). Other programs include chemical dependency programs, detoxification centers, and residential facilities for adults with mental illness. The rule will not apply to programs certified, rather than licensed, by the Department, except when the certification is a supplement to an existing license.

[16] This number is calculated by adding the number of people served by a 245D license holder on 11/20/14 (25,548) and the total number of people who have a current valid screening document indicating that they have a developmental disability or a related condition submitted to the Department (29,030 on 11/20/14), and then removing persons counted in both numbers.

[17] Identifying enforcement costs related solely to the rule is challenging. As noted, Minnesota Statutes, chapter 245D establishes the key policy components governing positive supports and the shift away from use of restraint and seclusion for home and community-based service providers. Those key requirements are incorporated by reference into the rule and extended to other Department-licensed services. Because of the overlapping statutory and rule requirements, it is somewhat difficult for the Department to separate the costs of enforcing the statutory requirements, and the additional costs to enforce the rule that will be incurred when the rule becomes effective in or about July or August 2015. Therefore, the Department has estimated its costs for statutory and rule enforcement collectively.

[18] See Minnesota Rules, part 9543.0030, subpart 1.

[19] Id.

[20] The Department's Licensing Division is responsible for providing training and technical assistance to county licensors. The Department's estimated costs include costs for the Department to provide initial and ongoing training and technical assistance to county licensors, as well as developing tools for monitoring compliance at the county level.

[21] See endnote number 10 (public web site address for Comprehensive Plan of Action).

[22] In 2011, the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) prepared a white paper addressing the costs of preventing and reducing uses of restraint and seclusion. See The Business Case for Preventing and Reducing Restraint and Seclusion Use, HHS Publication No. (SMA) 11-4632 Rockville, MD; SAMHSA 2011. Retrieved from http://www.store.samhsa.gov/shin/content/SMA11-4632/SMA11-4632.pdf.
In this report, the author, Janice LaBel, Ed.D., evaluated the economic burden of restraint and seclusion use; the costs associated with reducing restraint and seclusion; and the savings that result from restraint and seclusion reduction. LaBel found that restraint and seclusion are violent, expensive, and largely preventable events. The net budgetary effect of shifting to use of positive supports is therefore positive, due to the enhanced environment of care and overall decrease in violence and injuries.

[23] See Minnesota Statutes, section 245.8251.

[24] See Title 42 CFR Part 441.301.

[25] See Title 42, CFR Part 441.301; see also U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Fact Sheet: Summary of the Key Provisions of the Home and Community-Based Services Settings Final Rule* (January 10, 2014.)

[26] This does not include costs that may be incurred if the small business is not governed by chapter 245D, and employs the programmatic use of restraints. For such a provider, costs incurred to phase out the programmatic use of restraints would be a cost of *rule* compliance rather than a cost of *statutory* compliance. See discussion in Regulatory Analysis factor (5). It is unknown whether such a provider exists. Persons whose needs are so high that a restraint is programmatically used are believed unlikely to be served by a small business. Also, as previously noted, the overwhelming majority of providers serving a person with high needs are home and community-based service providers, which *are* governed under chapter 245D. As such, their costs for phasing out restraints are a cost of statutory compliance, not rule compliance.

[27] See Recommendations, pp 7 and 13.

[28] See Miltenberger, R., et al. (2002); Wehmeyer, M.L. & Palmer, S.B. (2003); Wehmeyer, M.L. & Schwartz, M. (1997); cited in Shogren, K.A., et al. (2014).

[29] See Recommendations, pp 7, 15, 16, 17, 18 and 27.

[30] See Sailor, W., et al. (2009).

[31] See Recommendations pp 60, 75 and 76.

[32] See Sailor, W., et al. (2009).

[33] See Recommendations pp 15, 16 and 27.

[34] See Bambara, L.M., Koger, F., Katzer, T. & Davenport, T.A. (1995); Berotti, D. (1996); Clarke, S., et al. (1995); Dunlap, G., Kern-Dunlap, L., Clarke, S. & Robbins, F.R. (1991); Dyer, K., Dunlap, G. & Winterling, V. (1990); Moes, D.R. (1998); cited in Romaniuk, C. & Miltenberger, R.G. (2001).

[35] See Recommendations, p 13.

[36] Minnesota Statutes, section 245D.02, subdivision 2b, defines “aversive procedure” as “…the application of an aversive stimulus contingent upon the occurrence of a behavior for the purposes of reducing or eliminating the behavior.”

[37] Minnesota Statutes, section 245D.02, subdivision 3, defines “Case manager” as “…the individual designated to provide waiver case management services, care coordination, or long-term care consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49, or successor provisions. For purposes of this chapter, "case manager" includes case management services as defined in Minnesota Rules, part 9520.0902, subpart 3.”

[38] Minnesota Statutes, section 245D.02, subdivision 3b, defines “chemical restraint” as “…the administration of a drug or medication to control the person's behavior or restrict the person's freedom of movement and is not a standard treatment or dosage for the person's medical or psychological condition.”

[39] Minnesota Statutes, section 245.4871, subdivision 6, defines “child with severe emotional disturbance” as “For purposes of eligibility for case management and family community support services, "child with severe emotional disturbance" means a child who has an emotional disturbance and who meets one of the following criteria: (1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or (2) the child is a Minnesota resident and is receiving

inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or (3) the child has one of the following as determined by a mental health professional: (i) psychosis or a clinical depression; or (ii) risk of harming self or others as a result of an emotional disturbance; or (iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or (4) the child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year."

[40] Minnesota Statutes, section 245D.02, subdivision 4e, defines "cultural competence" as "'Cultural competence' or 'culturally competent' means the ability and the will to respond to the unique needs of a person that arise from the person's culture and the ability to use the person's culture as a resource or tool to assist with the intervention and help meet the person's needs."

[41] Minnesota Statutes, section 245D.02, subdivision 5a, defines "deprivation procedure" as "…the removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Oftentimes the positive reinforcer available is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer."

[42] Minnesota Rules, part 9525.0016, subpart 2, items A to E, define "developmental disability or related condition" as "…a person who has been diagnosed under this part as having a severe, chronic disability that meets all of the following conditions: (1) is attributable to cerebral palsy, epilepsy, autism, Prader-Willi syndrome, or any other condition, other than mental illness as defined under Minnesota Statutes, section 245.462, subdivision 20, or an emotional disturbance, as defined under Minnesota Statutes, section 245.4871, subdivision 15, found to be closely related to developmental disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with developmental disabilities and requires treatment or services similar to those required for persons with developmental disabilities; (2) is manifested before the person reaches 22 years of age; (3) is likely to continue indefinitely; and (4) results in substantial functional limitations in three or more of the following areas of major life activity: (a) self-care; (b) understanding and use of language; (c) learning; (d) mobility; (e) self-direction; or (f) capacity for independent living. B. 'Person with developmental disability' means a person who has been diagnosed under this part as having substantial limitations in present functioning, manifested as significantly subaverage intellectual functioning, existing concurrently with demonstrated deficits in adaptive behavior and who manifests these conditions before the person's 22nd birthday. C. Deficits in adaptive behavior" means a significant limitation in an individual's effectiveness in meeting the standards of maturation, learning, personal independence, and social responsibility expected for the individual's age level and cultural group, as determined by clinical assessment and, generally, standardized scales. D. 'Significantly subaverage intellectual functioning' means a full scale IQ score of 70 or less based on assessment that includes one or more individually administered standardized intelligence tests developed for the purpose of assessing intellectual functioning. Errors of measurement must be considered according to subpart 5. E. 'Substantial functional limitations' means the long-term inability to significantly perform an activity or task."

[43] Minnesota Statutes, section 245D.02, subdivision 6a, defines "direct support staff" as "…employees of the license holder who have direct contact with persons served by the program and includes temporary staff or subcontractors, regardless of employer, providing program services for hire under the control of the license holder who have direct contact with persons served by the program."

[44] Minnesota Statutes, section 245D.02, subdivision 8a, defines "emergency use of manual restraint" as "…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, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own do not constitute an emergency."

[45] Minnesota Statutes, section 245D.02, subdivision 8b, defines “expanded support team” as “…the members of the support team defined in subdivision 34 and a licensed health or mental health professional or other licensed, certified, or qualified professionals or consultants working with the person and included in the team at the request of the person or the person's legal representative.”

[46] Minnesota Statutes, section 245D.02, subdivision 8c, defines “family foster care” as “…a child foster family setting licensed according to Minnesota Rules, parts 2960.3000 to 2960.3340, or an adult foster care home licensed according to Minnesota Rules, parts 9555.5105 to 9555.6265, where the license holder lives in the home.”

[47] Minnesota Statutes, section 245D.02, subdivision 10, defines “home and community-based services” as “…the services identified in section 245D.03, subdivision 1, and as defined in: (1) the federally approved waiver plans governed by United States Code, title 42, sections 1396 et seq., including the waivers for persons with disabilities under section 256B.49, subdivision 11, including the brain injury (BI) waiver plan; the community alternative care (CAC) waiver plan; the community alternatives for disabled individuals (CADI) waiver plan; the developmental disability (DD) waiver plan under section 256B.092, subdivision 5; the elderly waiver (EW) plan under section 256B.0915, subdivision 1; or successor plans respective to each waiver; or (2) the alternative care (AC) program under section 256B.0913.”

[48] Minnesota Statutes, section 245D.02, subdivision 12, defines “legal representative” as “…the parent of a person who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about services for a person. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.”

[49] Minnesota Statutes, section 245A.02, subdivision 8, defines “license” as “…a certificate issued by the commissioner authorizing the license holder to provide a specified program for a specified period of time and in accordance with the terms of the license and the rules of the commissioner.”

[50] Minnesota Statutes, section 245D.02, subdivision 15, defines “license holder” as having, “the meaning given in section 245A.02, subdivision 9.” Minnesota Statutes, section 245A.02, subdivision 9, defines "license holder" as “an individual, corporation, partnership, voluntary association, or other organization that is legally responsible for the operation of the program, has been granted a license by the commissioner under this chapter or chapter 245D and the rules of the commissioner, and is a controlling individual.”

[51] Minnesota Statutes, section 245D.02, subdivision 15a, defines “manual restraint” as, “physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint.”

[52] Minnesota Statutes, section 245D.02, subdivision 15b defines “mechanical restraint” as “…the use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. The term applies to the use of mechanical restraint used to prevent injury with persons who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury.”

[53] Minnesota Statutes, section 245D.02, subdivision 16, defines “medication” as “…a prescription drug or over-the-counter drug. For purposes of this chapter, "medication" includes dietary supplements.”

[54] Minnesota Statutes, section 256B.0624, subdivision 2, paragraph (d), defines “mental health mobile crisis intervention services” as “…a face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize

available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning. The services, including screening and treatment plan recommendations, must be culturally and linguistically appropriate."

[55] Minnesota Statutes, section 245.462, subdivision 20, defines "mental illness" as "…an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation."

[56] Minnesota Statutes, section 245D.02, subdivision 20a, defines "most integrated setting" as "…a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."

[57] Minnesota Statutes, section 245D.02, subdivision 21a, defines "outcome" as "…the behavior, action, or status attained by the person that can be observed, measured, and determined reliable and valid."

[58] Minnesota Statutes, section 245D.02, subdivision 23, defines "person with a disability" as "…a person determined to have a disability by the commissioner's state medical review team as identified in section 256B.055, subdivision 7, the Social Security Administration, or the person is determined to have a developmental disability or a related condition as defined in Minnesota Rules, part 9525.0016, subpart 2, items A to E."

[59] Minnesota Statutes, section 245D.02, subdivision 23a, defines "physician" as " a person who is licensed under chapter 147."

[60] Minnesota Statutes, section 245D.02, subdivision 23b, defines "positive support transition plan" as the plan required in section 245D.06, subdivision 8, to be developed by the expanded support team to implement positive support strategies to: (1) eliminate the use of prohibited procedures as identified in section 245D.06, subdivision 5; (2) avoid the emergency use of manual restraint as identified in section 245D.061; and (3) prevent the person from physically harming self or others.

[61] Minnesota Statutes, section 245D.02, subdivision 26, defines "program" as "…either the nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14."

[62] Minnesota Statutes, section 245D.061, subdivision 3(a)(7), defines "prone restraint" as use of manual restraint that places a person in a face-down position. This does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, and the person is restored to a standing, sitting, or side-lying position as quickly as possible. Applying back or chest pressure while a person is in the prone or supine position or face-up is prohibited.

[63] Minnesota Statutes, section 245D.02, subdivision 27, defines "psychotropic medication" as any medication prescribed to treat the symptoms of mental illness that affect thought processes, mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior.

[64] See Minnesota Statutes, section 245.462, subdivision 18, and 245.4871, subdivision 27.

[65] Minnesota Statutes, section 245D.02, subdivision 28, defines "restraint" as "…manual restraint as defined in subdivision 15a or mechanical restraint as defined in subdivision 15b, or any other form of restraint that results in limiting of the free and normal movement of body or limbs."

[66] Minnesota Statutes, section 245D.06, subdivision 5, states, "The license holder is prohibited from using chemical restraints, mechanical restraints, manual restraints, time out, seclusion, or any other aversive or deprivation procedure, as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience."

[67] Minnesota Statutes, section 245D.02, subdivision 29, defines "seclusion" as "…(1) removing a person involuntarily to a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room; or (2) otherwise involuntarily removing or separating a person from an area, activity, situation, or social contact with others and blocking or preventing the person's return."

[68] Minnesota Statutes, section 245D.02, subdivision 30, defines "service" as "care, training, supervision, counseling, consultation, or medication assistance assigned to the license holder in the coordinated service and support plan."

[69] Minnesota Statutes, section 245D.02, subdivision 35a, defines "treatment" as "…the provision of care, other than medications, ordered or prescribed by a licensed health or mental health professional, provided to a person to cure, rehabilitate, or ease symptoms."

[70] See Carr, E.G., et al. (2002); Dunlap, G., et al. (2010); Horner, R.H., et al. (2005); Sailor, W., et al. (2009); Seligman, M.E., et al. (2005).

[71] See Lerman, D.C. & Vorndran, C.M. (2002).

[72] See Vollmer, T.R. (2002).

[73] See Mazur, J.E. (2002); Spradlin, J.E. (2002).

[74] See Lerman, D.C. & Vorndran, C.M. (2002).

[75] See Funder, D.C. (2004).

[76] See Funder, D.C. (2004); Hemenway, D., Solnick, S. & Carter, J. (1994); Widom, C.S. (1989).

[77] See Recommendations, p 14.

[78] See Hanley, G.P. (2012); Sailor, W., et al. (2009).

[79] National Core Indicators. Chart Generator 2012-13. National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. Retrieved from http://www.nationalcoreindicators.org/charts/

[80] See Hagner, D. (2010); Holburn, S., et al. (2004); O'Brien, J. (2002); cited in Hagner, D., et al. (2014).

[81] See Hagner, D., et al. (2014).

[82] See Recommendations, pp 17-18.

[83] See Recommendations, p 18.

[84] See Cloutier, H., Malloy, J., Hagner, D. & Cotton, P. (2006); Hagner, D., McGahie, K. & Cloutier, H. (2001); Holbum, S., Jacobson, J., Schwartz, A., Flory, M. & Vietze, P. (2004); Menchetti, B. & Garcia, L. (2003); Robertson, J., et al. (2006); Wolf-Branigan, M., Daeschlein, M. & Cardinal, B. (2000).

[85] See Hanley, G.P. (2012); Sailor, W., et al. (2009).

[86] See Hanley, G.P. (2012).

[87] See Recommendations, pp 15 – 17.

[88] See Recommendations, p 16.

[89] See Hanley, G.P. (2012).

[90] See Carr, E.G. & Durand, V. (1985); Iwata, B.A., Pace, G.M., Cowdery, G.E. & Miltenberger, R.G (1994); Meyer, K.A. (1999); Newcomber, L.L. & Lewis, T.J. (2004); Taylor, J. & Miller, M. (1997); cited in Hanley, G.P. (2012).

[91] See Hanley, G.P. (2012).

[92] Id.

[93] See Hanley, G.P. (2012); Lerman, D.C. & Vorndran, C.M. (2002).

[94] Minnesota Statutes, section 245D.06, subdivision 5.

[95] See Recommendations, p 11.

[96] Lovaas, O.I., Schaeffer, B. & Simmons, J.Q. (1965).

[97] Freagon, S., (1990); Sailor, W., et al. (2009).

[98] United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Roadmap to Seclusion and Restraint Free Mental Health Services, Retrieved from http://store.samhsa.gov/shin/content//SMA06-4055/SMA06-4055-B.pdf

[99] Id.

[100] Association for Positive Behavior Support (APBS). Positive Consequence Strategies. Retrieved from http://www.apbs.org/files/consequencestrat.pdf

[101] Sailor, W., et al. (2009).

[102] Mazur, J.E. (2002); Spradlin, J.E. (2002).

[103] See Kappel, B., Dufresne, D. & Mayer, M. (2012). From Behavior Management to Positive Behavioral Supports: Post-World War II to Present. Minnesota Governor's Council on Developmental Disabilities. Retrieved from http://mn.gov/mnddc/positive_behavior_supports/pdf/From-Behavior-Management-to-Positive-Behavioral-Supports.pdf

[104] See Recommendations, p 20.

[105] Minnesota Statutes, section 245D.06, subdivision 8.

[106] Id.

[107] Minnesota Statutes, section 245D.061, subdivision 9.

[108] Carraccio, C., Wolfsthal, S.D., Englander, R., Ferentz, K. & Martin, C. (2002).

[109] Substance Abuse and Mental Health Services Administration (SAMHSA). The Business Case for Preventing and Reducing Restraint and Seclusion Use. Retrieved electronically from http://store.samhsa.gov/shin/content/SMA11-4632/SMA11-4632.pdf

[110] See Recommendations, pp. 25-27.

[111] See Recommendations, p 26.

[112] (Konetzka, R.T., et al. (2014).

[113] Minnesota Statutes, section 245D.02, subdivision 11.

[114] See also Minnesota Statutes, section 245D.03, subdivision 3.

Exhibit 1

List of Protective Procedures by Service Types Under Chapter 245A and Administrative Licensing Rules

Type of Service	Governing Rule or Statute	Allow for protective procedures*	Applicable Rule Part(s)or Statute	Description
Residential programs for children	2960.0010 to 2960.0710	Yes, but only for DHS programs with a mental health or shelter certification.	2960.0710	Allows for seclusion and physical holding. Mechanical restraints may only be used during the transporting of a client.
Residential programs for adults with a mental illness	9520.0500 to 9520.0670	Yes	9520.0630 subpart 10	Allows for seclusion, restraints and crisis medications.
Residential programs for adults with a mental illness but operating under the Intensive Residential Treatment Services (IRTS) variance.	R36V.01 to R36V.16	No	R36V.04 subdivision 7	Does not allow for seclusion or restraints.
Detox services	9530.6510 to 9530.6590	Yes	9530.6535	Allows for seclusion, physical holding, and mechanical restraint.
Chemical Dependency treatment services (residential and outpatient)	9530.6450 to 9530.6505	No	9530.6475	Does not allow for seclusion or restraints.
Independent living assistance for youth	245A.22	No	NA	The statute is silent about the use of protective procedures. The is considered an outpatient service that happens in a residential setting,

MN Sexual Psychopathic Personality Treatment Center	9515.3000 to 9515.3110	Yes	9515.3090 subparts 3 and 4.	The rule allows for seclusion and protective isolation. Protective Isolation may result in being placed in a locked room. There is also a statutory provision that allows for the use of administrative restriction as defined in MN statute 253D.18.
Child care center	9503.0005 to 9503.0170	Yes	9503.0055 Subpart 3 9503.0055 Subpart 4 9503.0055 Subpart 5	Prohibits the use of physical restraint "other than to physically hold a child when containment is necessary to protect a child or others from harm." Prohibits mechanical restraints. Allows for separation from the group within an unenclosed part of the classroom where the child can be continuously seen and heard by a program staff person. (Listing FYI, don't think this is seclusion.) For children with developmental disabilities or children under the age of five, as specified in parts 9525.0004 to 9525.0036, the standards governing the use of aversive and deprivation procedures in parts 9525.2700 to 9525.2810 apply.
Adult day center	9555.9600 to 9555.9730	No	NA	The rule is silent about the use of protective procedures.

Family child care	9502.0300 to 9502.0445	No	9502.0395 Subpart 2	Allows separation of a child from a group to guide behavior for no longer than ten minutes in an area or separate room that is open to view of caregivers. Prohibits placing child in a locked room. (Listing FYI, don't think this is seclusion.) The rule is otherwise silent about the use of protective procedures.
Family adult day services	245A.143	No	NA	The statute is silent about the use of protective procedures.
Child foster care	2960.3000 to 2960.3340	No	2960.3080 Subpart 8 B	Use of mechanical restraint and seclusion (defined as "confining a person in a locked room") is prohibited. License holder must meet the requirements of part 9525.2700, subpart 2, item F, regarding the use of aversive or deprivation procedures with a foster child with a developmental disability
Adult foster care	9555.5105 to 9555.6265	No	NA	The rule is silent about the use of protective procedures.