

Positive Support Transition Plan Instructions (Form-6810B)

These instructions provide the requirements for the creation, review and reporting of Positive Support Transition Plans as identified in Minnesota Statutes 245D.06 subdivision 8.

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Chapter 1 Plan Required

Minnesota Statutes, section 245D.06, subdivision 5 prohibits the following procedures, known as behavior interventions, as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience:

1. Chemical Restraint
2. Mechanical Restraint
3. Manual Restraint, except in an emergency
4. Time Out
5. Seclusion
6. Aversive Procedures
7. Deprivation Procedures

These prohibitions are effective January 1, 2014 for MS 245D-license holders. Under previous regulations, teams may have used one or more of the prohibited procedures. License holders may continue to use certain prohibited procedures during a 1-year phase out process if they are included in a positive support transition plan (PSTP)¹ created according to the terms in these instructions and developed using DHS Form-6810. Chapter 3 identifies applicable procedures and standards for their use.

PSTPs must be written using DHS Form-6810. Instructions for completion of the plan are included within Form-6810 and this document. The creation of a Positive Support Transition Plan is required to:

- Eliminate the use of prohibited procedures identified in MS 245D;
- Avoid the emergency use of manual restraint; and

¹ 245D.06 subdivision 8

- Prevent the person from physically harming self or others

Positive Support Transition Plans direct the actions of a service provider; it outlines the support and procedures providers will use with the individual persons they serve. A PSTP is required when a person and their team identify a need for the therapeutic fading of a prohibited procedure. A PSTP is also required after a person receiving services requires an emergency use of manual restraint. License holders who do not use a prohibited procedure or the emergency use of manual restraint after Jan. 1, 2014 do not need to create a PSTP. Support teams are encouraged to fade the use of the prohibited procedure as soon as possible but no less than 11 months after the creation of the PSTP. The external support team must determine timelines for the fading of the emergency use of manual restraint.

Chapter 2 Creation of a Positive Support Transition Plan

Upon identification of the need for a plan, the expanded support team has 30 days to finalize an initial PSTP. **A qualified designated coordinator, behavior analyst or behavior professional, as defined in 245D**, must write the positive support transition plan in consultation with the person and their expanded support team.

Initial Plan:

Complete all queries in Parts A-G. Definitions of terms are located within the PSTP template. Additional guidance for each part follows:

Part A: Complete all sections of Part A. The team must identify the frequency reviews will occur for the plan. Plans must be reviewed, at minimum, on a quarterly basis.

Part B: Part B identifies the prohibited procedures a team has identified the need to continue to use on a limited basis, as well as the emergency use of manual restraint. If the team has identified more than one target intervention, number the interventions. Identify an alternative intervention to use in place of each target intervention. If identifying multiple alternative interventions, identify which alternative intervention is replacing which target intervention.

Identify a data collection method in Part F of the PSTP.

Part C: Target behaviors are the specific actions a person has performed that have resulted in the need for a behavioral intervention and are identified for elimination. To avoid the need for future behavioral interventions, the team must work to eliminate the underlying cause; in this case, the action that precipitated the intervention. If the team has identified multiple target behaviors for elimination, number the target behaviors. Identify a positive, alternative behavior for each target behavior. If identifying multiple alternative behaviors, identify which alternative behavior is replacing which target behavior.

Identify a data collection method in Part F of the PSTP.

Part D: Part D utilizes a crisis model as a framework for completion of a crisis support plan. For the purposes of positive support transition planning, the Minnesota Department of Human Services uses a crisis framework comprised of five stages as depicted in the picture below:



DHS uses this framework in order to promote a common understanding and reporting of crises – times when behavioral interventions can be necessary. For the purposes of the PSTP, “crisis” refers to situations that exceed a person’s resources and coping mechanisms *and* has the potential to endanger the health and safety of their self or others. The framework is also meant to assist expanded support teams to perform their own preliminary analysis of reoccurring crises.

The calm or ideal stage indicates what normal or calm functioning would look like for a person. ‘Calm or ideal’ varies for every individual and/or event. In this area, teams identify the person’s optimal state and support strategies to help the person maintain this state. Some support strategies include the use of psychotropic medication, counseling, emotional regulation training, skill building and participation in preferred activities.

The trigger stage indicates situations, words, people, decisions, critical periods, etc., that set a person or event towards an escalation towards a crisis. The idea behind crisis prevention is that a team assists a person to either avoid or cope with triggers. The person and their team must decide which method of crisis prevention is best suited for each trigger. Teams identify proactive and reactive ways to support a person when encountering triggers. Proactive strategies focus on strategies to use before a known trigger/antecedent will be encountered. Reactive strategies focus on strategies to use after encountering a trigger/antecedent.

The escalation stage refers to the happenings, events, behavior that typically occurs after a trigger and before a crisis. This is a critical period in which there is an opportunity to assist a person to avoid a crisis. De-escalation techniques, counseling strategies, PRN medication, crisis lines, etc. may be effective for a person in this stage.

The crisis stage is the stage when things are at their worst. As stated above, crises typically exceed a person’s resources or coping mechanism. Because crises endanger the health and safety of someone,

some sort of behavioral intervention is typically necessary. When a crisis poses a risk of injury to someone, and all other intervention methods have failed, the crisis becomes an emergency safety situation. According to 245D guidelines, this is the only stage in which the emergency use of manual restraint (EUMR) is allowable. For license holders who do not use EUMR another intervention strategy must be identified, such as calling a crisis line or 911.

The recovery phase refers to the period just after a crisis as people or events are on their way back to the calm or ideal phase. The goal of the recovery stage is to assist a person toward the calm or ideal stage. Strategies for support may include debriefing with the person, suggesting the person call a friend or ally, give the person space, etc.

Not every crisis follows this set pattern. Some crises move straight from a trigger phase to a crisis stage. Sometimes a de-escalation phase can escalate back into another crisis. Every crisis can be unique. Part F of the PSTP identifies ways to support the person in each phase. Strategies will vary from person to person, as different intervention methods will work for some people and not with others. Information provided in this portion of the plan should attempt to identify what a person typically “looks” like in each stage. This could include information about the person’s typical affect, behaviors, expressions, sounds, words, etc. they typically exhibit in each stage.

.Part E: A minimum of two (2) quality indicators must be identified in Part E of the PSTP. Quality indicators are reportable or observable outcomes that are important to or for the person. To the extent possible, quality indicators should be chosen that reflect things the person’s target behaviors prevent them from accessing/achieving. One (1) quality indicator must be chosen from at least two (2) of the following categories:

1. engagement in preferred activities,
2. physical integration,
3. social integration in the community,
4. physical health,
5. general positive affect,
6. opportunities for goal attainment,
7. increased independence/living skills,
8. work performance, and
9. memory and concentration

Identify in Part E which category an indicator belongs. Identify in Part F how quality indicators will be tracked and recorded.

Part F Identify a data collection method for Parts B, C and E. Definitions for each method are included in the PSTP template.

Part G. Informed consent is required before the use of a prohibited procedure. See chapter 4 of these instructions for further guidance.

Chapter 3 Standards for behavioral interventions

Positive support transition plans must phase out any existing plans for the emergency or programmatic use of aversive or deprivation procedure prohibited by the provisions of 245D². Procedures incorporated into a PSTP must not:

1. be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury, as defined in Minnesota statute section 626.556, subdivision 2;
2. be implemented with an adult in a manner that constitutes abuse or neglect as defined in Minnesota statute section 626.5572, subdivisions 2 and 17;
3. be implemented in a manner that violates a person's rights and protections identified in Minnesota statute section 245D.04;

When the following procedures are incorporated into a positive support transition plan, they must meet the following conditions:

1. Mechanical Restraint
 - a. The person's primary care physician must be consulted to determine whether implementing the procedure is medically contraindicated.
 - b. Use of mechanical restraint that results in restriction of two or fewer limbs or that does not restrict the person's movement from one location to another requires the following procedures:
 - i. Staff must check on the person every 30 minutes and document that each check was made.
 - ii. The person must be given an opportunity for release from the mechanical restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes that the mechanical restraints are used.
 - iii. Efforts to lessen or discontinue the mechanical restraint must be made at least every 15 minutes. The time each effort was made and the person's response to the effort must be noted in the person's permanent record.
 - c. Use of mechanical restraint that results in restriction of three or more of a person's limbs or that restricts the person's movement from one location to another must meet the conditions of items (1) and (2) and the following additional conditions:
 - i. Efforts to lessen or discontinue the mechanical restraint must be made at least every 15 minutes. The time each effort was made and the person's response to the effort must be noted in the person's permanent record.
 - ii. A staff member shall remain with a person during the time the person is in mechanical restraint and shall take the action specified in unit (a).
 - d. The use of mechanical restraints that prevent/impair a person's ability to remove a seat belt during transport in a motor vehicle

² 245D.06, subdivision 8

2. Manual Restraint procedures must meet the following conditions:
 - a. The person's primary care physician must be consulted to determine whether implementing the procedure is medically contraindicated.
 - b. The person must be given an opportunity for release from the manual restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes.
 - c. Efforts to lessen or discontinue the manual restraint must be made at least every 15 minutes, unless contraindicated. The time each effort was made and the person's response to the effort must be noted in the person's permanent record.
 - d. The procedures must comply with other standards in 245D.061
3. Timeout procedures must meet the following conditions:
 - a. When possible, time out procedures must be implemented in the person's own room or other area commonly used as living space rather than in a room used solely for time out.
 - b. When possible, the person must be returned to the activity from which the person was removed when the time out procedure is completed.
 - c. Persons in time out must be continuously monitored by staff.
 - d. Release from time out is contingent on the person's stopping or bringing under control the behavior that precipitated the time out and must occur as soon as the behavior that precipitated the time out abates or stops. If the precipitating behavior has not abated or stopped, staff members must attempt to return the person to an ongoing activity at least every 30 minutes.
 - e. If time out is implemented contingent on repeated instances of the target behavior for longer than 30 consecutive minutes, the person must be offered access to a bathroom and drinking water.
 - f. Placement of a person in room time out must not exceed 60 consecutive minutes from the initiation of the procedure.
 - g. Time out rooms must:
 - i. provide a safe environment for the person;
 - ii. have an observation window or other device to permit continuous visual monitoring of the person;
 - iii. measure at least 36 square feet and be large enough to allow the person to stand, to stretch the person's arms, and to lie down; and
 - iv. be well lighted, well ventilated, and clean.
4. Seclusion
 - a. The use of seclusion must only be used in emergency safety situation as a response to imminent danger to the person or others;
 - b. The use of seclusion must only be used when less restrictive interventions are determined to be ineffective;
 - c. The use of seclusion must end when the threat of harm ends;
 - d. The person must be constantly and directly observed by staff during the use of seclusion;

- e. The use of seclusion must be used under the supervision of a mental health professional or the designated coordinator;
- f. Staff must contact the mental health professional or designated coordinator to inform them about the use of seclusion and to ask for permission to use seclusion as soon as it may safely be done, but not later than 30 minutes after initiating the use of seclusion;
- g. When the use of seclusion ends, the person must be assessed to determine if the person can safely be returned to ongoing activity;
- h. Staff must treat the person respectfully throughout the procedure;
- i. The staff person who implemented the emergency use of seclusion must document its use immediately after the incident concludes.
- j. The room for seclusion must be well lit, well ventilated, clean, have an observation window which allows staff to directly monitor a resident in seclusion, fixtures that are tamperproof, with electrical switches located immediately outside the door, and doors that open out and are unlocked or are locked with keyless locks that have immediate release mechanisms; and
- k. Objects that may be used by a person to injure the person's self or others must be removed from the person and the seclusion room before the person is placed in seclusion.

Chapter 4 Informed Consent

Written informed consent must be obtained from the person receiving services or the person's legal representative acting within the scope of their authority before implementing the following:

1. a prohibited procedure or the emergency use of manual restraint;
2. a procedure for which informed consent has expired. Informed consent must be obtained annually for the emergency use of manual restraint;
3. a substantial change in the positive support transition plan.

If the team is unable to obtain written informed consent, the procedure must not be implemented.

Chapter 5 Plan Review

Complete Part H at each formal review. Review frequency is identified in Part A and must be no less frequent than every 2 months if a prohibited procedure is included in the plan.

Based on the review of the data regarding target interventions, target behaviors and quality of life, the team will decide if the plan needs revising. If the team does agree to revise the plan, the new plan must be in place within seven (7) working days of the review.

Attach a complete Part H to the back of the previous plan.

Requests for assistance

Teams must request assistance if a PSTP has been in place for six months and there is not a decrease in the incidence of target interventions. Assistance can be requested through another service provider when facilitated by the case manager or through the behavior intervention report form (DHS Form-5148).

Chapter 6 Revising the Plan

Plans containing a prohibited procedure must terminate 11 months after the implementation date. Plans may be updated during the 11-month period, but the initial termination date must stand. Plans can be updated at any time. Guidelines for revised plan are as follows:

Substantial changes in the PSTP require a revised plan and consent from team members. Substantial changes include:

- Changes to target interventions (PSTP Part B)
- Changes to target behaviors (PSTP Part C)
- Inserting a prohibited intervention to the crisis plan (PSTP Part D)
- Changing quality indicators (PSTP Part E)
- Changes to frequency of plan review (Part A)

Designated coordinators may update the following items without consent:

- Updating medication information in Part A of the PSTP
- Changing data collection methodology in Part F of the PSTP

Each time the plan is revised, note the date the plan was revised in Part A and complete Part G of the plan.

Chapter 7 Plan Termination

Plans including a prohibited procedure must terminate within 11 months of implementation. Plans including the emergency use of manual restraint terminate based on the recommendations of the expanded support team.

PSTPs may be terminated before the initial 11-month time limit. Plans may end when a prohibited technique has been phased out or the emergency use of manual restraint appears to be no longer necessary. Upon termination, any procedure prohibited by MS 245D cannot be used. Termination of the PSTP signals the cessation of a target intervention, not necessarily a target behavior. It is expected that the team will continue to utilize positive support strategies to support the person maintain their safety, independence, freedom and reduce the instance of identified target behaviors.

In the event that a plan has terminated and the emergency use of manual restraint is utilized, the team must create a new plan according the timeline in MS 245D.06, subdivision 8.

Chapter 8 External Reporting

Copies of a person's PSTP must be sent to the following individuals/entities:

1. The person's legal guardian/authorized representative;
2. The person's case manager;
3. Service providers involved in the implementation of the strategies in the PSTP;
4. The Department of Human Services; and
5. The Office of the Ombudsman for Mental Health and Developmental Disabilities

Each use of an Emergency Use of Manual Restraint (EUMR) must be reported according to the provisions of MS 245D.061. License holders must fully complete a Behavior Intervention Report Form, DHS Form-5148 to report each EUMR and the procedures below within the provided timelines:

Reporting of prohibited procedures incorporated into a PSTP:

Procedure	Report Frequency	Report Timeline
Mechanical Restraint	Weekly (Every 7 days)	15 working/business days after report timeframe
Mechanical Restraint – Seat Belt Clips/inhibitors	Weekly (Every 7 days)	15 working/business days after report timeframe
Manual Restraint, not emergency use	Each Incident	15 working/business days after incident
Emergency Use of Manual Restraint	Each Incident	15 working days after incident
Time out	Weekly (Every 7 days)	15 working days after report timeframe
Seclusion	Each Incident	15 working days after incident
Aversive Procedures	Weekly (Every 7 days)	15 working days after report timeframe
Deprivation Procedures	Weekly (Every 7 Days)	15 working days after report timeframe
Psychotropic PRN Administration when used to avert or in response to a target behavior	Each Incident	15 working days after incident
911 Calls	Each Incident	15 working days after the incident

A copy of the completed Behavior Intervention Report Form (DHS Form-5148) must be sent to each member of the expanded support team.

Appendix: Definitions

Aversive procedure: the application of an aversive stimulus contingent upon the occurrence of a behavior for the purposes of reducing or eliminating the behavior (245D.02, subd 2b).

Aversive stimulus: an object, event, or situation that is presented immediately following a behavior in an attempt to suppress the behavior. Typically, an aversive stimulus is unpleasant and penalizes or confines (245D.02, subd. 2c).

Baseline: an initial set of critical observations or data used for comparison or a control

Behavior Intervention: any application of a restraint and/or restrictive or penalty technique that staff uses in response to a person's displayed behavior

Chemical Restraint: 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 (245D.02, subd 3b).

Coordinated Service & Support Plan: "Coordinated service and support plan" has the meaning given in sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, or successor provisions

Crisis: A situation perceived or experienced by a person that exceeds the person's resources and coping mechanisms and has the potential to endanger the health and safety of an individual. 'Crisis' comprises both 'Incidents' and 'emergency safety situations'

Deprivation procedure: 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 the 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 (245D.02, subd 5a).

Designated Coordinator: the person providing oversight and evaluation of the license holder's responsibilities assigned in a person's coordinated service and support plan. Additional responsibilities and qualifications for the designated coordinator are provided in 245D.081, subd. 2.

Emergency safety situation: means unanticipated behavior by an individual that places the individual or others at serious threat of violence or injury if no intervention occurs and that requires an emergency safety intervention

Emergency safety intervention: means the use of a behavior intervention as an immediate response to an emergency safety situation

Expanded support team means the members of the support team 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

Incident: "Incident" means an occurrence that affects the ordinary provision of services to a person and includes any of the following:

- (1) serious injury as determined by section Minnesota Statute 245.91, subdivision 6;
- (2) a person's death;
- (3) any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition, or the mental health status of a person that requires calling 911 or a mental health crisis intervention team, physician treatment, or hospitalization;
- (4) any mental health crisis that requires the program to call 911 or a mental health crisis intervention team
- (5) an act or situation involving a person that requires the program to call 911, law enforcement, or the fire department
- (6) a person's unauthorized or unexplained absence from a program;
- (7) physical aggression by a person receiving services against another person receiving services that causes physical pain, injury, or persistent emotional distress, including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting, pushing, and spitting;
- (8) any sexual activity between persons receiving services involving force or coercion as defined under section 609.341, subdivisions 3 and 14;
- (9) any emergency use of manual restraint as identified in section 245D.061; or
- (10) a report of alleged or suspected child or vulnerable adult maltreatment under section 626.556 or 626.557 (245D.02, subd. 11)

Legal representative: means 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.

Manual Restraint: 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. (245D.02, subd. 15a)

Mental Health: A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community (definition taken from the World Health Organization)

Most Integrated Setting: A setting that enables individuals with disabilities to interact with nondisabled person to the fullest extent possible (245D.02, subd 20a)

Outcome: The behavior, action or status attained by a person that can be observed, measured and determined reliable and valid (245D.02, subd 21a)

Positive support strategy: a strategy that emphasizes teaching a person productive, alternative strategies/behaviors for dealing with times of stress without the use of aversive or punishing procedures

Positive Support Transition Plan: the plan required by 245D. 06, subdivision 5 to be developed by the expanded support team to implement positive support strategies to:

- (1) eliminate the use of prohibited procedures as identified in 245D.06, subd. 5, paragraph (a);
- (2) avoid the emergency use of manual restraint as identified in 245D.061; and
- (3) prevent the person from physically harming self or others (245D.02, subd 23b)

The plan will identify baseline, triggers, escalation, crisis and recovery stages for an individual and contain positive, person-centered strategies to intervene during each stage of crisis. The positive support transition plan replaces behavior support plans and/or individual program plans containing the use of a controlled procedure under Rule 40.

Psychotropic Medication: "Psychotropic medication" means 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 (245D.02, subd. 27)

Punishment: the contingent application of a penalty consequence that is either aversive or depriving in nature, and deters, reduces or eliminates undesired behavior. The consequence imposes a cost, loss, burden or presentation of noxious conditions

Quality indicators: reportable or observable outcomes that are important to or for the person

Restrictive Measures: Any measure that restricts or suspends the individual rights of a person served

Seclusion: the placement of a person alone in 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 (245D.02, subd 29)

Support team: means the service planning team identified in section [256B.49, subdivision 15](#) or the interdisciplinary team identified in Minnesota Rules, part 9525.0004, subpart 14. (245D.02, subd. 34)

Target interventions: Previously used behavioral interventions targeted for elimination

Target behavior: Observable or reportable actions that have previously resulted in behavior interventions and are identified for elimination. Examples of target behaviors are physical aggression towards others, self-injurious behavior, property destruction, elopement, behavior that endangers self or others (fire starting, etc.)

Team: See Expanded Support Team

Working Days: working days is synonymous with "business days"; excludes weekends and holidays