



Minnesota Department of **Human Services**

Bulletin

NUMBER

#14-76-01

DATE

April 29, 2014

OF INTEREST TO

County Directors

Social Services Supervisors
and Staff

All DHS staff

State Court Judges

County Attorneys

Consumers of
Developmental Disabilities
Services, their families,
advocates and legal
representatives

ACTION/DUE DATE

Please read information
and prepare for
implementation of changes

EXPIRATION DATE

April 29, 2016

Transition of Minnesota Specialty Health System (MSHS) – Cambridge to Minnesota Life Bridge: Admission and Discharge Processes, Transition Planning and Community Mobile Support Services

TOPIC

Minnesota Specialty Health System (MSHS)-Cambridge has transitioned to Minnesota Life Bridge, a community-based residential treatment program (Program), with mobile support services for individuals with developmental disabilities who exhibit severe behaviors that present a risk to public safety. This Program furthers the provisions and spirit of the Settlement Agreement in Jensen, et al. v. Minnesota Department of Human Services et al. and is subject to Federal Court orders.

PURPOSE

Provide information regarding the admission and discharge processes, transition planning and community mobile support services for individuals with developmental disabilities who exhibit severe behaviors that present a risk to public safety and are referred for admission to the Program as admissions to MSHS-Cambridge is closed and to replace Bulletin #12-76-01.

CONTACT

Transition Coordinator
1425 East Rum River Drive South,
Cambridge, MN 55008
Phone: (763) 689-7326

SIGNED

ANNE M BARRY
Deputy Commissioner

TERMINOLOGY NOTICE

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.

BACKGROUND

This Program is for individuals who are developmentally disabled (DD) and exhibit severe behaviors which present a risk to public safety. Placement in the Program's treatment homes would only be sought when other community options and mobile support services cannot effectively or safely support the individual and crisis stabilization services are necessary. Transition planning and community services will begin on admission and a Transition Plan will be developed within 30 days. This Program is not intended to be a long-term residential placement. Individuals need not be civilly committed to have access to the Program.

DESCRIPTION OF THE PROGRAM

- The Program is designed to provide crisis stabilization and transition services to enable individuals to live successfully in the community.
- The Program works to help individuals stay in their homes whenever possible.
- The Program is a community-based program offering residential placement in the Program's treatment homes and mobile support services to service individuals in their current setting.
- Currently, the Program has two homes in Isanti County, one just west of Cambridge, and the other a few miles south of the City of Isanti. These are homes in a community residential setting. DHS is evaluating the need for other homes in other areas of the state.
- If residential placement at the Program is necessary, Program staff will work with the DHS Disabilities Services Division and the county to plan for a smooth transition back to the community with proper supports to avoid future crises so that individuals may stay in their homes.
- The Program uses positive behavioral supports and person-centered planning approaches consistent with best practices. Program staff are highly trained in the use of these techniques.
- The Program has experienced and qualified staff, including clinical treatment teams with Behavioral Analysts and Psychologists.
- The Program prohibits the use of mechanical restraints of any kind, prone restraint, chemical restraint, seclusion and time out, and all other aversive or deprivation practices.

- Only manual restraint is allowed, and only when a client poses an imminent risk of physical harm to self or others, and such restraint is the least restrictive intervention that would achieve safety. Client refusal to receive or participate in treatment shall not constitute an emergency.

INDIVIDUALS SERVED

The eligibility requirements for admission to the Program have not changed from those for MSHS – Cambridge. The Program will continue to support and admit adults who have developmental disabilities and exhibit severe behaviors that present a risk to public safety.

RESIDENTIAL PLACEMENT IN THE PROGRAM

ADMISSION PROCESS

In the event residential placement in the Program is sought, below is an outline of the admission process.

STEP 1:

Contact the Transition Coordinator at (763) 689-7326 to inform the Program of the intent to seek admission, and submit the following:

1. Completed [Admission Review Information Form \(DHS-6598-ENG\)](#).
2. A summary of the success the individual has had within the community and what has happened to indicate the individual may need to be relocated from the current community environment.
3. Copy of the most recent Coordinated Service and Support Plan (CSSP) or Individual Program Plan (IPP).
4. Copy of the most recent Individualized Education Program (IEP), if applicable.
5. Copy of the most recent Individual Abuse Prevention Plan (IAPP).
6. Copies of the most recent assessments pertinent to treatment (e.g. Functional Behavior Assessments, Person Centered Assessments, Person Centered Plans, Positive Behavior Support Plans, diagnostic assessments, psychological assessments, psychiatric assessment, comprehensive social history, etc.).
7. Copies of any pertinent community based provider/crisis service provider reports regarding the individual's treatment needs and/or most recent observations of the individual.

8. Copies of pertinent court documents, if applicable.

STEP 2:

Once the application materials are received, the Transition Coordinator will review them and will seek additional clarification, if necessary.

STEP 3:

The Transition Coordinator then distributes the material to the Clinical and Administrative Team (Team) for a full review of the records in order to determine an individual's eligibility for residential placement in the Program.

STEP 4:

The Team meets to discuss the application and the individual's eligibility.

STEP 5:

If the Team needs additional information, the Team may seek an in-person visit with the individual.

STEP 6:

The Team may determine that: (i) the individual is eligible for admission to the Program and placement at one of the Program's treatment homes; or (ii) recommend a different course of action such as an alternative deployment of resources in the individuals' own home; or (iii) refer the individual to a more appropriate service.

TRANSITION PLANNING SERVICES

The Program undertakes its best efforts to ensure that each individual is served in the most integrated setting appropriate to meet their individualized needs, including home or community settings. The Program actively pursues the appropriate transition of individuals and provides them with adequate and appropriate transition plans, protections, supports, and services consistent with their individualized needs, in the most integrated setting and where the individual does not object. Each individual and their family and/or legal representative are involved in the team evaluation, decision making, and planning process to the greatest extent practicable, using whatever communication methods the individual prefers. To foster each individual's self-determination and independence, the Program will use person-centered planning principles at each stage of the process to facilitate the identification of the individual's specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs. Each individual shall be given the opportunity to express a choice regarding preferred activities that contribute to a quality life. The Program will undertake best efforts to provide each individual with reasonable placement alternatives. It is the Program's goal that all individuals are served in integrated community

settings with adequate protections, supports, and other necessary resources which are identified as available by service coordination. The above will be implemented in accord with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).

DISCHARGE PROCESS

Discharge planning shall begin upon the date of admission and shall include the individual, his or her support team, the county case manager, and the treatment team. The goal being to assure that the individual will transition to an integrated community setting of his or her choice with services important to and for the individual and which provide adequate protections, supports, and other necessary resources as identified in the individual's Person Centered Plan and Transition Plan. The discharge planning process will explore whether there are existing community services and living situations available to meet the individual's preferences, and if the needed community supports are not in place, create the support team, alterations, enhancements, and additional supports will be added whenever appropriate to ensure robust community supports which meet the essential needs for assistance, structure, and support as outlined in the individual's Person Centered Plan. When a living situation is identified as a possibility, the individual and the support team as appropriate will have multiple opportunities to visit, meet potential house-mates, interview the staff and provider, spend time in the situation, and be given the opportunity to make a choice about the living situation, request program enhancements or adjustments, or decline the option. When a discharge into an alternative living situation is agreed upon, the Transition Plan will be further developed and finalized. The Program will work with counties, and tribal governments, who shall have a system of locally available and affordable services to serve persons with developmental disabilities, to assure the development and availability of a community home and services to meet the individual's needs. The Program administration will also send a letter to the county case manager and legal representative/guardian confirming the development and/or availability of the home and services prior to the individual's transition to the community setting.

THE PROGRAM'S MOBILE SUPPORT SERVICES

The Program, in addition to offering residential placement, offers mobile support services to serve individuals in their current setting. The Program can provide augmentative service supports, consultation, mobile teams, and training to the individual and those supporting the individual in his or her own home, family home, group home, work place and throughout the community as quickly as possible to provide a safety network, as needed, to help prevent re-institutionalization and other transfers to a more restrictive setting, and to maintain the individual in the most integrated setting. These services will be provided in collaboration with the Community Support Services (CSS) and other crisis services.

QUESTIONS

Questions regarding admission should be directed to the Transition Coordinator at (763) 689-7326.

Americans with Disabilities Act (ADA) Advisory

This information is available in alternative formats to individuals with disabilities by calling (651) 431-3676 (voice). TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.