Illinois Department of Public Health
Office of Health Care Regulation

Developmentally Disabled Facilities Advisory Board Meeting

MINUTES
August 20, 2014

Video Conference locations
122 S. Michigan Avenue, Conference room 711, Chicago
525 W. Jefferson, 4th floor Conference room, Springfield

Call to Order

The meeting was called to order at 10 a.m.

Approval of Meeting Minutes:

A motion to approve the May 21, 2014 meeting minutes was unanimously approved.

Part 350: Intermediate Care for the Developmentally Disabled Facilities Code

Mike Bibo stated some high risk not appropriate for DD. Mike Bibo also mentioned that the involuntary transfer form on the Department website is not appropriate for DD facilities and needs to be changed. He also stated that deficiency notices are not being sent to the licensee, only faxed to the facilities.

Susan Meister's notes on modifications:

1. Page 26 – change Mental Health to Developmental Disabilities and end the sentence after program.
2. Page 66 – revisit the definition of physical abuse. They don't like the new one or the old one. Does not need to result in injury and the things in parenthesis should not be considered part of a treatment program, which is how it could be read. Also suggested look at how the feds define it.
3. Page 67 – see how feds define active treatment.
4. Page 69 – see how feds define behavior management plan and behavior modification.
5. Page 71 –did not like the new language in definition of DD. Also discussion of why we are adding intellectual disability to the rules – it is not the same as developmental disability and the statute doesn't use it.
6. Page 79 – definition of IEP – add "or IPP" after IHP and add 'or Individual Program Plan to the definition of IHP.
7. Page 82 definition of nursing care – change "nursing procedures" to 'nursing activities or nursing related tasks" to more closely match Nurse P. Act.
8. Page 84 –check definition of psychiatrist – number of years (3) may not be correct.
9. Page 84 – check with staff attorney—can we add "working" in front of "3 days"?
10. Mike Bibo is going to review the citations for the high risk designations – he thinks that some of them are not appropriate for DD and were just copied from the nursing home rules.
11. Page 130—Check the mental Health Code to see if a psychologist or a QMRP can order the use of physical restraints.
12. Page 131 – Why was the existing text taken out in (b) and (c)?
13. Page 135 (d) Check the mental health code and guidelines to see how long the period of time is for the use of the restraint to be reviewed. They thought it was less than 30 minutes.
14. Page 158 (c0(3) – needs more explanation – what if the facility knows that the resident will return after more than 10 days? Why do involuntary discharge? Make it optional?
15. Page 160 – check whether this is PASRR or PASS.
16. Page 168 – (a) – check the statute to see if this language is stricken out and if not, why is it stricken in the rule?

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Dr. Pyo referred to the Mental Health Code and DHS guidelines, with her suggested proposed changes to the "Draft Notice of Proposed Amendments" as follows:

- P69, Definition of Autism

  DSM-V definition.

  Autism is a neurodevelopmental disorder characterized by impaired social interaction, verbal and non-verbal communication, and by restricted and repetitive behavior (WIKIPEDIA).

  The essential features of autistic disorder are the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests (DSM-IV).

  Autism spectrum disorder is characterized by persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communicative behaviors used for social interaction, and skills in developing maintaining, and understanding relationships. In addition to the social communication deficits, the diagnosis of autism spectrum disorder requires the presence of restricted, repetitive patterns of behavior, interests, or activities. (DSM-V)

  P69 Definition of Behavior Management Plan: a comprehensive plan, developed by a qualified member of the interdisciplinary team, …

  Suggestion: "The BMP is developed by a behavior specialist/psychologist and approved by the IDT…"

  P69 Definition of Behavior Modification—specific programs and practices used to manage behaviors, consistent with written policies and procedures…

  Dr. Pyo is not sure why we need this definition, since the Behavior Management Plan is used throughout the document and basically both are same.

- P71 Definition "Developmental Disability"

  Suggestion; why not follow the MH Code definition??

  (405 ILCS 5/1-106) (from Ch. 91 1/2, par. 1-106)
  Sec. 1-106. "Developmental disability" means a disability which is attributable to: (a) mental retardation, cerebral palsy, epilepsy or autism; or to (b) any other condition which results in impairment similar to that caused by *mental retardation* (an Intellectual Disability?) and which requires services similar to those required by *mentally retarded (intellectually disabled?)* persons. Such disability must originate before *the age of 18 years (or 22?)*, be expected to continue indefinitely, and constitute a substantial handicap. (Source: P.A. 80-1414.)

- P130 Section 350.1082 Nonemergency use of physical restraints

  a) Physical restraints shall be used only when required and as recommended by the interdisciplinary team and approved by the resident's personal physician. …..

  based on the PD Restraint Use and the MH Code, when an individual requires a programmatic restraint, a behavior specialist/psychologist changes individual's behavior intervention program incorporating the use of restraint, which will be approved by an interdisciplinary team meeting. When it is approved, an authorized person writes an order when a situation requires a physical restraint.

  Suggestion is; "Physical restraints shall be used only when approved by the interdisciplinary team and obtained a written order by an authorized person.

  Programmatic Restraint." Use of restraint as a component of an individual's behavior intervention program. When unplanned restraint is used three times in six months the IDT must plan for the potential future use of restraint by incorporating the use of restraint into the individual's behavior intervention program unless an exemption is obtained for specific clinical/programmatic reasons.

  Should it be determined that a change in the Behavior Intervention Program that incorporates the use of restraint is warranted, then an Interdisciplinary Team meeting and team approval process must be accomplished prior to the program change occurring.

  MH Code (405 ILCS 5/2-108) (from Ch. 91 1/2, par. 2-108)
  (a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others.

- P133 j) physical restraints may be used as a health-related protection or as a medical immobilizer, as identified by the interdisciplinary team and approved by the physician. …

  Suggestion; ..as identified by the physician and approved by the IDT

- P134 m) 4) the written approval from resident's personal physician (regarding documentation in the record)

  written approval from IDT

- P135 C) If a resident needs emergency care and other less restrictive interventions have proven ineffective, a physical restraint may be used briefly to permit treatment to proceed. The attending physician shall be contacted immediately for orders. If the attending physician is not available, the facility's advisory physician or Medical Director shall be contacted. If a physician is not immediately

available, a nurse or QIDP with supervisory responsibility may approve, in writing, the use of physical restraints. ….

This is regarding a "Temporary Order" and the PD 02.03.03.010 Restraint Use in SODCs and Programs dictates that only a qualified staff member can issue a temporary order which should be confirmed by an authorized person within 2 hours after the restraint application.

1. Only authorized persons may order restraint.
2. Only a physician may order a chemical restraint.
3. Only qualified staff members may apply restraint.

"Qualified Staff Member." A qualified staff member is an employee who has successfully completed the SODC Operations and Center's mandated competency based restraint training which includes application of the restraint device and/or physical holding restraint being used, the restraint policy and procedures and restraint documentation requirements. (Refer to Section (V)(D))

There is a situation that requires the immediate use of a physical holding restraint or a restraint device and an authorized person is not immediately available, a qualified staff member may initiate the temporary use of restraint.

Suggestions from the IDPH, OHCR - Division of Administrative Rules and Procedures:

- The DD Board met to approve the rule changes the Department has been working to update since the passage of PA 96339 which created the ID/DD Community Care Act effective July 1, 2010. The rule changes were first presented to the Board at the May 2014 meeting. The Board made numerous changes to the rule, with the goal of coming back at the December meeting with more revisions. The Board declined to vote on the rules at the previous meeting because they had not had enough time to look at them. At the 12/5/14 meeting, the rule changes will be distributed to the Board.

- Changes will be incorporated by the December 2014 meeting and the intent at that meeting is to approve, or the department will move forward for first notice.

New business

Overview by John Absher, Public Service Administrator/Northern Supervisor, IDPH Office of Health Care Regulation, LTC FO ICF/IID Section:

Federal ICF/IID Definitions of Abuse and Neglect/Active Treatment

- "Threat," as used in this guideline, is any condition/situation which could cause or result in severe, temporary or permanent injury or harm to the mental or physical condition of individuals, or in their death.

- "Abuse" refers to the ill-treatment, violation, revilement, malignment, exploitation and/or otherwise disregard of an individual, whether purposeful, or due to carelessness, inattentiveness, or omission of the perpetrator.

- "Physical abuse" refers to any physical motion or action, (e.g., hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs. It includes use of corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment.

- "Verbal abuse" refers to any use of oral, written or gestured language by which abuse occurs. This includes pejorative and derogatory terms to describe persons with disabilities.

- "Psychological abuse" includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma.

- Neglect means failure to provide goods or services necessary to avoid physical or psychological harm.

- Active treatment is the aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. This program is directed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible, while preventing or decelerating the regression or loss of current optimal functional status.

Restraint info from ICF/IID regulations:

- Physical restraint" is defined as any manual method or physical or mechanical device that the individual cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body. Examples of manual methods include therapeutic or basket holds and prone or supine containment. Examples of mechanical devices include arm splints, posey mittens, helmets, and strait jackets. Physical restraint is used only in response to a specific type and/or severity of behavior and only for the amount of time specified in the individual program plan.

- Emergency physical restraint for an unanticipated type or severity of behavior is used only to prevent injury to the individual or others.

- In effect no longer than 12 consecutive hours; and a client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints, released from the restraint as quickly as possible, (As quickly as possible" means as soon as the individual is calm or no longer a danger to self or others.) and a record of these checks and usage must be kept.

- Restraints must be designed and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.

- Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed and a record of such activity must be kept.

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John discussed a committee he is on with CMS and other state representatives on a Proposed Focused survey. This focused survey would focus on a more observational survey process. Changes that are being looked at include:

1. Changes to the sample process
2. Changes to Task 2 (incident Review)
3. Med Pass observations
4. More observational based

To be qualified facilities would have to meet certain guidelines. This is in the beginning stages and more information will go out as these meetings continue.

Next meeting
December 5, 2014 - 10 a.m.
122 S. Michigan Avenue, Conference room 711, Chicago
525 W. Jefferson, 4th floor Conference room, Springfield

There being no further business, the meeting was adjourned.