

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES**



PROCEDURE	
Subject: Behavior Support Plan Requirements	Procedure No.: 2013-DDA-H&W-PR016
Responsible Program or Office: Developmental Disabilities Administration	Effective Date: September 3, 2013
	Number of Pages: 9
Supersedes Procedure Dated: August 1, 2011	
Cross References and Related Policies and Procedures: Behavior Support policy; Behavior Support Plan Safeguards and Oversight procedure; Human Rights policy; Human Rights Definitions; Human Rights Advisory Committee procedure; Restrictive Control Review Committee procedure; Health and Wellness Standards; Individual Support Plan policy; Imposition of Sanctions policy; Enhanced Monitoring procedure; Watch List procedure.	

1. PURPOSE

This purpose of this procedure is to establish the standards and guidelines to be used in providing behavior support to people with intellectual and developmental disabilities in the District of Columbia. Behavior support is an appropriate service for a person who displays a pattern or patterns of behavior which are likely to seriously limit his or her ability to engage in activities or relationships that are meaningful to the person; or which threaten the physical safety of the person or those around them. These procedures will govern how Department on Disability Services (“DDS”), Developmental Disabilities Administration (“DDA”) providers develop behavior support plans for the people they support.

2. APPLICABILITY

This procedure applies to all DDS employees, subcontractors, providers, vendors, consultants, volunteers, and governmental agencies that provide services and supports on behalf of people with intellectual and developmental disabilities who are receiving services as part of the DDA Service Delivery System funded by DDA or the Department of Health Care Finance (“DCHF”).

3. PROCEDURES

The following sections establish procedures and protocols for implementation of the DDS Behavior Support Policy.

A. Implementation

As Behavior Support Plans (BSPs) are developed or updated in accordance with a person's needs, the BSP shall meet the requirements described below. Pre-existing BSPs must meet the requirements in the DDS Behavior Support Plan procedure, dated August 2011.

B. General Provisions for Behavior Support Plans ("BSP")

1. BSPs shall adhere to the principles of Positive Behavior Support (PBS). PBS is an evidence-based, person-centered approach to preventing challenging behavior that is based on a functional assessment of the behavior to determine the purpose of the behavior and the circumstances under which it occurs. PBS strengthens existing skills and teaches new behaviors that accomplish the same functional purpose as the challenging behavior, making the challenging behavior unnecessary. Through positive reinforcement strategies and modifications to the environment, PBS facilitates behavioral changes that promote independence and community integration.
2. BSPs shall adhere to a person-centered approach and be developed in collaboration with the person and the person's support team. The BSP must be consistent and compatible with the person's Individual Support Plan ("ISP").
3. The person, or his or her substitute decision-maker, must give written informed consent to any restrictive control and any BSP.
4. The provider of behavioral supports is responsible for the person's support needs across settings (residential and day). This specifically includes training, tracking services and supports and evaluating the effectiveness of the services and supports.

C. Required Components of Behavior Support Plans

All BSPs must contain the following information:

1. Identifying Information

BSPs should include the person's name, age, and residential and day service providers. They should also include the name and credentials of the author of the plan, and be dated (including the original plan date, BSP expiration date, and the date of any revisions). BSPs should not contain people's Social Security numbers,

Medicaid numbers, or other unnecessary pieces of personal information.

2. Purpose of the BSP

Describe the reasons for the necessity of the BSP.

3. Relevant History

This section should provide historical background information that is relevant to the current target behavior(s). For a person who already has a BSP in effect, new plans should include information on each recommended restrictive control and whether they have faded or been decreased from the prior plan; are the same; have changed but are not substantially more or less restrictive (for example, changing psychotropic medications within the same class without a comparable change in dosage); or whether restrictive controls have increased. This section should not include a review of the person's developmental history.

4. Diagnostic Information

List all current mental health diagnoses, intellectual/ developmental diagnoses, and medical diagnoses. Refer to the most recent version of the Diagnostic and Statistical Manual.

5. Medication Treatment

Include a list of all medications, dosages, and their intended purpose. Separate out the list by psychotropic and non-psychotropic medications.

6. Target Behaviors

Target behaviors must be consistent with the person's diagnoses. For each target behavior provide a clear, measurable definition and data about the frequency of the target behavior in both the day and residential setting, over the last 12 months, if possible.

7. Functional Assessment

Based upon the author's knowledge of the person, direct observation, interviews with the person for whom the plan is being developed (if possible), interviews with the people who know the subject best, , and record reviews, the functional assessment must describe the antecedents and maintaining consequences for each target behavior. It should also provide a hypothesized function for each target behavior in the setting(s) where it occurs.

The functional assessment should describe the setting events that may predict the target behavior. Setting events are contextual events that may include mood,

psychiatric status, illness, sleeplessness, time of day, absence of medication, emotional events, and staffing changes that make target behaviors more or less likely to occur. In contrast to setting events, which occur an hour, day, or week prior to the behavior, antecedents represent more immediate influences on target behavior and occur in closer proximity to the target behavior. The BSP should include a statement about the setting events that make the target behavior more likely to occur and the setting events that make the target behavior less likely to occur.

Functional assessments must:

- a. List the sources of information used to conduct the functional assessment. At a minimum, procedures must include meeting and getting to know the person, direct observation, interviews with the people who know the person best, review of records, and must incorporate into the BSP the results of any assessment tool used;
- b. Be performed in both the residence and day setting, if applicable. For example a functional assessment would not be appropriate at a person's job site.
- c. Provide a clear, measurable, operational definition of each target behavior, which includes (as applicable) frequency, duration, and intensity of the behavior.
- d. Be based on data showing the frequency of occurrence for each target behavior (over the last 12 months if possible);
- e. Identify the antecedents to the target behavior and the maintaining consequences, or outcomes, that follow the behavior; and
- f. Propose the specific function of the target behavior in each setting where it occurs.

8. Behavioral Goals

For each target behavior, describe goals for changing or reducing the behavior that can likely be accomplished within one (1) ISP year.

9. Proactive Strategies

For each target behavior describe the positive proactive strategies that will be used to prevent the behavior from occurring. Proactive strategies are defined as:

- a. Environmental modifications or attempts to identify and change those features of the person's physical environment, interpersonal environment or service environment that might contribute to target behavior.
- b. Positive Programming strategies for teaching new replacement skills and new competencies that provide a more effective/appropriate way of achieving the same function as the target behaviors. New skills are taught through direct instruction shaping, prompting, chaining, role play, or modeling/ imitation, etc.
- c. Focused Support strategies that use differential reinforcement strategies to increase the use of alternative behaviors the person currently has in his or her repertoire and decrease the frequency of target behaviors.

10. Goals for Behaviors Targeted for Increase

List specific behavioral goals for increasing replacement skills, functional communication skills and alternative behaviors. Include measurement criteria and propose a time frame over which the skill increases are projected to occur.

11. Staff Responses and Crisis Intervention Plan

Describe how staff will respond to target behaviors when they occur. Describe the specific, person-centered procedures for supporting the person in the event of a crisis aimed at ensuring the person's safety and dignity.

12. Staffing Supports

- a. Describe the staffing supports, including the staffing ratio, needed to implement the BSP as written.
- b. If an approved emergency restraint is included in a person's BSP, only staff that have been trained in a crisis intervention curriculum approved by DDS may use a physical restraint and may only do so as specified in the curriculum.
- c. Annual training in crisis prevention and restrictive procedures is required of all staff who deliver direct support services, including program supervisors, managers, coordinators and/or Qualified Intellectual Developmental Disability Professionals to people who have a BSP that includes the use of restraint (emergency or non-emergency).
- d. Individualized staffing support may only be recommended based on a person-centered planning process, in collaboration with the person and his or her Support team, which balances the person's rights to privacy, to refuse, and to least restrictive interventions with his or her need for support. When individualized

staffing is recommended, the team must develop a specific list of duties and instructions for the 1:1 staff (and how staff breaks should work), that will include at least the following:

- i. Explicit description of the proximity of the staff to the person in different situations/conditions (i.e. arm's length; line of sight);
- ii. Number of hours of individualized staffing per day and specific staffing schedule
- iii. Exceptions to the individualized staffing (i.e. when using the restroom; sleeping; private conversations);
- iv. Whether individualized staffing is recommended for the day setting, residence, or both;
- v. Responsibility to monitor and manage the environment (i.e. removal of specific items from the environment; closer proximity in the presence of people with certain characteristics);
- vi. Expectations for enriched activities (i.e. increase in training; activities);
- vii. Responsibility for data collection and reporting;
- viii. Identification of required competencies, skills, characteristics and experience;
- ix. Description of training requirements; and
- x. A fade plan for reducing the person's need for individualized staffing support.

12. Restrictive Components

- a. Any plan with restrictive control procedures must include an explanation of the necessity for each restrictive control and specific criteria and plan for reducing, fading, or eliminating the restriction. Restrictive components (also called restrictive interventions and restrictive controls) include, but are not limited to any device, procedure, protocol or action that restricts, limits or otherwise negatively impacts a person's freedom of movement, control over his or her own body; or access to anything that would typically be available to people in the community, including privacy.
- b. BSPs must include documentation that adequate behavioral data was collected and considered before determining that restrictive control procedures are warranted to address the target behavior(s).
- c. BSPs must include documentation that the plan was developed in collaboration with the person's Support team and determined to include the least restrictive measures to address the specific target behaviors.
- d. For BSPs that contain restrictive controls, target behaviors that relate to the use of restrictive controls must be likely to seriously limit a person's ability to engage in meaningful activities or relationships; or threaten the physical safety

of the person or those around them. Whether or not a target behavior is linked to the use of a restrictive control must be clearly marked on the BSP. The fade plan for use of the restrictive controls must only be tied to those behaviors that are linked to a restrictive control.

- e. The criteria for reducing, fading or eliminating the restrictive control procedures must be weighed against the dangerousness of the behavior and the restrictiveness of the control, and may not be punitive.
- f. Criteria for possible medication titration shall be developed jointly between the prescribing psychiatrist and the BSP developer and shall be included in both the BSP and the medication plan. Titration plans for medication must be developed unless it is clinically determined that titration is contraindicated (e.g. documented evidence from previous titration attempts that titration was ineffective).
- g. There must be written informed consent for the use of any BSP that incorporates the use of restrictive interventions. If a person has been legally certified to not have the capacity to consent for the use of psychotropic medications, and there is no substitute health care decision-maker available, the DDS Psychotropic Review Panel may authorize the use of psychotropic medications for up to nine consecutive months.
- h. In an emergency in which a person is experiencing a mental health crisis and in which the immediate provision of mental health treatment, including medication, is, in the documented opinion of the attending physician, necessary to prevent serious injury to the person or others, a provider may administer medication without seeking informed consent, only to the extent necessary to terminate the emergency.

13. Medical Sedation Orders

- a. Sedation orders for medical appointments must be accompanied by a desensitization plan which describes the positive, proactive approaches that will be utilized to reduce the person's need for sedation, unless desensitization strategies have been clinically determined to be ineffective.
- b. Desensitization strategies are not required when they have been clinically determined to be ineffective. In those cases, there must be documentation of that clinical determination. However, the person must still have a BSP containing positive proactive strategies to support a person to succeed with his or her medical appointment and reduce the need for sedation.
- c. Sedation orders must comply with the relevant DDS Health and Wellness Standards, including review by a physician every 30 days.

14. Data Collection and Monitoring

The BSP developer must provide a clear plan for tracking and collecting behavior data to review progress on behavioral developments. This must include a description of how behavioral changes will be monitored and data will be used to assess the effectiveness of the BSP.

- a. The BSP must specify the professional who will review the data on a monthly basis (or more frequently if necessary) and provide quarterly progress reports to the Support team.
- b. The BSP must specify how often the BSP developer will participate in medication reviews to share behavioral data with the prescribing physician so the physician can make data informed prescribing decisions.
- c. Include data on the use of all intervention techniques used, by whom, the duration, and the reason. For physical restraints and any hands-on intervention, staff shall document each use of physical restraint or other hands-on interventions in a person's record. For restraints, this should include the type of restraint, the time it was initiated and concluded, and the reason for its use. Restraints may only be used in an emergency basis to prevent the person or others from imminent harm. Restraints must be removed as soon as it is safe to do so.

15. Staff Training

The BSP shall describe how any staff who work with the person will be trained to competency by the BSP developer or his/her designee on the implementation of the BSP and data collection protocols, and how the BSP developer or his/her designee will verify that staff demonstrate competency to implement the plan as written.

The BSP developer may train the Qualified Intellectual and Developmental Disabilities Professional or Program Specialist on the specifics of plan implementation, who may then in turn train Direct Support Professionals who were not present at the training, or who are hired at a later date. This applies to both the residential and day settings.

Regardless of setting, every provider is responsible for ensuring staff are trained and records are kept in accordance with DDS's Direct Support Training policy and procedures.

16. Signatures of BSP Developer(s)

BSPs must be signed and dated by the BSP developer and supervisory professional (if any). Include a typewritten version of each person's name and credentials.

17. Informed Consent

BSPs must also be signed by the person for whom the plan was developed, or his or her substitute decision maker, indicating that he or she consents to the BSP. The BSP developer is responsible for securing informed consent, which specifically includes verifying that the following information is explained in a manner which can be understood by the person or the person's decision maker: the purpose, intended outcome, and procedures involved in the BSP; the risks and benefits of behavior support procedures; the risks of not having behavior support; and that consent can be withheld or withdrawn at any time with no punitive actions taken against the person.

18. Addendum of Changes Since Last Restrictive Controls Review

List the updates to diagnoses, changes in psychotropic medication, and modifications in other restrictions that occurred since the last restrictive review but prior to the BSP expiration date.

19. Best Practices Guide

The BSP must provide a Best Practices Guide that serves as a quick reference for staff members who have been trained to competency on the BSP. The Best Practices Guide should follow the approved DDS template.

D. Sanctions

DDS may impose sanctions on providers who do not comply with the DDS Behavior Support policy, DDS Human Rights policy, or this procedure, including those who demonstrate deficient performance, as indicated by BSPs that are rejected by the DDS RCRC.