Chapter: **QUALITY IMPROVEMENT**
Title: **BEHAVIOR TREATMENT PLANS**

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Proposed by: _____ 08/01/2022
Chief Executive Officer Date

Approved by: Al Lorenzo 08/02/2022
County Executive Office Date

I. ABSTRACT

This policy establishes the standards and procedures of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, on the use of Behavior Treatment Interventions.

II. APPLICATION

This policy shall apply to all directly-operated and contract network providers of MCCMH.

III. POLICY

It is the policy of MCCMH that a centralized Behavior Treatment Plan Review Committee (hereinafter "the BTPRC") be established and maintained for the purposes of review and approval (or disapproval) of behavior treatment plans that propose to use restrictive or intrusive interventions, as defined here, with MCCMH persons served who exhibit predictable or continuing aggressive, self-injurious, or other behaviors that place the individual or others at imminent risk of physical harm. Any limitation shall be justified, time-limited, and clearly documented in the behavior treatment plan and the plan of service. Documentation shall describe attempts that have been made to avoid limitations, as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the limitations in the future. MCCMH's BTPRC shall monitor and track the use of intrusive and restrictive techniques for purposes of quality improvement and may advise the MCCMH Quality Council regarding policy and procedures related to the use of positive behavioral supports and other interventions. The review of behavior treatment plans is not a function to be delegated. All MCCMH providers shall utilize the MCCMH BTPRC as established under this policy for the review of behavior treatment plans for MCCMH persons served.

IV. DEFINITIONS

A. Aversive Techniques
Techniques that require the deliberate infliction of unpleasant stimulation (stimuli which

would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control, or termination of seriously aggressive, self-injurious, or other behaviors that place the individual or others at imminent risk of physical harm. Examples of such techniques include use of mouthwash, water mist, or other noxious substance to consequate behavior or to accomplish a negative association with target behavior, and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating target behavior. Clinical techniques and practices established in the peer-reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g., exposure therapy for anxiety) are not considered aversive for purposes of this policy. Otherwise, use of aversive techniques is prohibited**.**

B. Emergency Interventions

The following emergency interventions are the only approved emergency interventions for implementation in crisis situations and may only be implemented when all other supports and interventions fail to reduce the imminent risk of harm:

1. Physical Management

A technique used as an emergency intervention to restrict the movement of an individual by continued direct physical contact despite the individual's resistance to prevent him or her from physically harming him/herself or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. The term "physical management" does not include briefly holding an individual to comfort him or her or to demonstrate affection or holding his/her hand. Physical contact with an individual that continues after the point when the individual begins to resist the physical contact is considered physical management and is not permitted except as an emergency intervention technique.

Physical management involving prone immobilization of an individual for behavioral control purposes is prohibited under any circumstances, **even in an emergency.** Prone immobilization is extended physical management of an individual in a prone (face down) position, usually on the floor, where force is applied to the person's body in a manner that prevents him or her from moving out of the prone position.

2. Request for Law Enforcement Intervention

A technique used by staff as an emergency intervention by calling 911 and requesting law enforcement assistance as a result of an individual exhibiting a seriously aggressive, self-injurious, or other behavior that places the individual or others at imminent risk of physical harm. Law enforcement should be called for assistance only when caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.

C. Functional Behavioral Assessment

An approach that incorporates a variety of techniques and strategies to determine the pattern and purpose or "function" of a particular behavior and guide the development of

an effective and efficient behavior plan. A functional behavioral assessment should identify social, affective, environmental, and trauma-based factors or events that initiate, sustain, or end a behavior. A physical examination should be done by a MD or DO to identify biological or medical factors related to the behavior, and the functional behavioral assessment should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the behavior itself so that a new behavior or skill can be substituted to provide the same function or meet the identified need. Functional assessments should also identify situations and events that precede positive behavior to provide more information for a positive behavior support plan. The content of the Functional Assessment Interview Form (Exhibit A) must be incorporated into the Functional Behavior Assessment. A trauma screening must be completed with all behavior treatment plans. If any trauma is identified, a trauma assessment should be completed. (Suggested trauma assessment: Weathers, F.W., Blake, D.D., Schnurr, P.P. Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013), The Life Events Checklist for DSM-5).

D. Intrusive Techniques

Those techniques that encroach upon the bodily integrity or the personal space of the person served for the purpose of achieving management or control of a seriously aggressive, self-injurious, or other behavior that places the individual or others at imminent risk of physical harm. Examples of such techniques include the use of a medication to manage, control, or extinguish an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires review and approval by the BTPRC.

Note: Plans of Service documenting any intrusive techniques that do not require the intervention of a behaviorist or written behavior treatment plan must submit documentation (as applicable) through the non-emergent expedited review process.

E. Peer-Reviewed Literature

Professional journals and similar scholarly works, published after review by a representative panel of professional peers, that typically represent the latest original research in the field, and includes research that has been generally accepted by academic and professional peers for dissemination and discussion. Publication in peer-reviewed literature does not necessarily mean the research findings are true, but the findings are considered authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

F. Positive Behavior Support

A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious, or other behaviors that place the individual or others at imminent risk of physical harm by teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral and biomedical science, validated procedures, and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, property destruction, and pica. Positive behavior supports are most effective when they are implemented across all environments such as home, school, work, and in the community.

G. Practice or Treatment Guidelines

Guidelines published by professional organizations such as the American Psychiatric Association (APA) or the federal government.

H. Proactive Strategies in a Culture of Gentleness

Strategies within a positive behavior support plan used to prevent seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of the occurrence of physical harm or for reducing their frequency, intensity, or duration. Supporting individuals in a culture of gentleness is an ongoing process that requires patience and consistency. As such, no precise strategy can be applied to all situations. Some examples of proactive strategies include unconditional valuing, precursor behaviors, redirection, stimulus control, and validating feelings.

I. Reactive Strategies in a Culture of Gentleness

Strategies within a positive behavior support plan used to respond when individuals begin feeling unsafe, insecure, anxious, or frustrated. Some examples of reactive strategies include reducing demanding interactions, increasing warm interactions, redirection, giving space, and blocking. Blocking does not mean using one's body to prevent egress. Blocking may lead to physical management if the physical contact with the individual continues after the point when the individual begins to resist the physical contact. Physical management is not permitted except as an emergency intervention technique.

J. Restraint

The use of a physical or mechanical device to restrict an individual's movement at the order of a physician. The use of physical or mechanical devices used as restraint is prohibited, except in a state-operated facility or a licensed hospital under contract with MCCMH.

This definition excludes:

1. Anatomical or physical supports that are ordered by a physician, physical therapist, or occupational therapist for the purpose of maintaining or improving an individual's physical functioning.

2. Protective devices which are defined as devices or physical barriers to prevent the individual from causing serious self-injury associated with documented and frequent incidents of the behavior and which are incorporated in the written Individual Plan of service through a Behavior Treatment Plan which has been reviewed and approved by the BTPRC and received special consent from the individual or his/her legal representative.

3. Medical restraint, i.e., the use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the individual written plan of service for medical or dental procedures.

4. Safety devices required by law, such as car seat belts or child car seats used while riding in vehicles, when used in a manner that is consistent with its intended purpose.

K. Restrictive Techniques

Techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the Federal Balanced Budget Act. Use of restrictive techniques requires the review and approval of the BTPRC. Examples of

such techniques used for the purposes of management, control, or extinction of seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of physical harm, include:

1. Limiting or prohibiting communication with others when that communication would be harmful to the individual;

2. Prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); and

3. Using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual.

Note: Plans of Service documenting any restrictive techniques that do not require the intervention of a behaviorist or written behavior treatment plan must submit documentation (as applicable) through the non-emergent expedited review process.

L. Seclusion

The placement of an individual in a room alone where egress is prevented by any means. Seclusion is prohibited except in a hospital or center operated by Michigan Department of Health and Human Services (MDHHS), a hospital licensed by MDHHS, or a child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.

M. Serious Physical Harm

Physical damage suffered by a person served that a physician or registered nurse determines caused or could have caused the death of a person served, the impairment of his or her bodily functions, or permanent disfigurement.

N. Special Consent for Behavioral Treatment Intervention

Obtaining the written consent of the person served, the legal guardian, the parent with legal custody of a minor child or a designated patient advocate prior to the implementation of any behavior treatment intervention, including those that include the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. The special consent needs to be signed by the person/guardian after BTPRC approval and prior to the implementation of the behavior plan.

Note: Special consent is always required prior to implementation of a behavior treatment intervention unless the person has been adjudicated pursuant to the provisions of section 469a (treatment as alternative to hospitalization), 472a (involuntary treatment), 473 (continuing involuntary treatment), 515 (State Center admission), 518 (State Center admission), or 519 (care and treatment other than admission) of the Mental Health Code.

O. Presenter

The individual who represents the person's served treating program and presents the case / proposed behavior treatment plan to the BTPRC. The individual is preferably the author of the behavior treatment plan but may be the person's case manager, supports coordinator, therapist, psychologist, social worker, occupational therapist, or nurse. In certain circumstances, the individual may be a member of the BTPRC, but may not vote on cases / proposals for which he / she has been a presenter.

V. STANDARDS

A. MCCMH shall have one sole BTPRC that reviews all behavior treatment plans of MCCMH persons served.

B. MCCMH providers shall conduct appropriate functional behavioral assessments (see definition) and evaluations of individuals to rule out physical, medical, environmental (e.g., interpersonal relationships), and trauma-based conditions prior to considering interventions to be used for the purpose of treating, managing, controlling, or extinguishing a person's predictable or continuing seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of physical harm.

C. Where physical, medical, and environmental conditions have been ruled out as the cause of a person's predictable or continuing seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of physical harm, MCCMH providers shall develop an individual behavior treatment plan that proposes interventions to be used for the purpose of treating, managing, controlling, or extinguishing those behaviors.

D. Behavior treatment plans shall adhere to any psychiatric advance directive that is present for an adult with serious mental illness.

E. The initial or ongoing presentation worksheet shall be completed by the individual completing the behavior treatment plan.

F. The behavior treatment plan shall first employ positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, training, redirection, extinction, or similar techniques, as the first and preferred approaches.

G. MCCMH providers may consider other kinds of behavior treatment or interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions only after positive behavior supports and interventions are documented to be unsuccessful.

H. MCCMH providers may, as a last resort, propose restrictive or intrusive techniques, as defined herein, that shall be reviewed and approved by the BTPRC prior to implementation, when there is documentation that neither positive behavior supports nor other kinds of interventions supported by peer-reviewed literature or practice guidelines were successful.

I. When restrictive or intrusive interventions are approved as part of a behavior treatment plan, the plan shall include the methodology that will be used to ameliorate or eliminate the need for the interventions in the future.

J. Applied Behavior Analysis (ABA) Intervention Plans developed through the Autism Benefit Program requesting the use of 2:1 treatment (2 staff to 1 person served) must present the plan to the full BTPRC.

K. Any plans utilizing the Parent Child Interaction Therapy model shall be reviewed through the BTPRC's expedited, non-emergent review process prior to plan implementation to determine if the plan contains restrictive or intrusive interventions or limitations of person

served rights. After initial approval, such plans must be reviewed at least quarterly. The clinical packet should, at a minimum, contain the following documents: initial or ongoing presentation worksheet, initial or updated behavior treatment plan, trauma assessment (if applicable), medications, lab results, behavior daily data tracking sheet, and a behavior monthly tracking sheet.

L. Conditional approvals are given for 30-45 days with another review scheduled within that timeframe.

M. Neither restraint nor seclusion (where permissible) nor any other behavioral or physical intervention, shall be used as a means of coercion, discipline, convenience, or retaliation.

N. The exhibits in this policy must be used for documentation. Any other clinical templates must be approved by the BTPRC Chair prior to implementation. It is the expectation that those templates contain all content in current policy exhibits.

O. BTPRC Membership

1. Except for the MCCMH Recipient Rights Representative, members must be appropriately privileged prior to appointment to the BTPRC pursuant to MCCMH MCO Policy 10-070, "Credentialing and Re-Credentialing."

2. The BTPRC members and the BTPRC Chair shall be formally appointed by the MCCMH Chief Executive Officer, or designee, for a term of not more than two (2) years. Members may be re-appointed for consecutive terms. Letters of appointment shall be maintained for each appointed member.

3. The BTPRC shall be comprised of at least three voting members.

   a. At least one member shall be a board-certified behavior analyst or licensed behavior analyst, and/or a licensed psychologist, as defined in the MDHHS Medicaid Provider Manual.

   b. At least one member shall be a licensed physician or psychiatrist as defined in the Michigan Mental Health Code, MCL 330.1100c (10).

   c. At least one other member who is a master's trained and licensed professional in the State of Michigan and credentialed and privileged as defined in MCCMH Policy 10-070 (nurse, social worker, counselor, psychologist, etc.) shall be included.

4. A representative of the Office of Recipient Rights shall participate on the BTPRC as anex-officio, non-voting member to provide consultation and technical assistance. Other non-voting members may be added at the BTPRC's discretion, and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or certified peer support specialist.

5. The Chairperson shall have responsibility for assuring committee activity, documentation management, and other committee functions as designated.

6. A BTPRC member who has prepared a Behavior Treatment Plan to be reviewed

by the BTPRC must recuse him/herself from the final decision-making on the behavior treatment plan.

P. Expedited Review of Proposed Behavior Treatment Plan

1. In urgent situations, professional staff may request the BTPRC Chair, on behalf of the Committee, perform an expedited review and approval of a proposed behavior treatment plan within 1 to 2 business days. Non-urgent expedited reviews will be reviewed within 14 business days by the BTPRC Chair.

2. Urgent is defined as needing immediate action to prevent harm or injury. Examples of an urgent situation requiring an expedited behavior treatment plan review include:

    a. When emergency interventions (e.g., use of physical management or requesting law enforcement) occur more than three (3) times in a thirty (30) day period for an individual;

    b. When emergency interventions occur or are used on a prolonged basis.

3. The MCCMH Office of Recipient Rights must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan. Upon approval and consent from the person served or the person's legal representative, the plan may be implemented.

4. All plans approved in an expedited manner are subject to a full review at the next regular meeting of the BTPRC.

5. The MCCMH Quality Department shall provide information to the BTPRC on individuals whose provider has submitted an Incident Report documenting the use of emergency physical management.

Q. The BTPRC shall:

1. Determine whether an appropriate functional behavioral assessment has been performed identifying factors and events, including biological or medical, related to the behavior; whether positive behavioral supports and interventions have been adequately pursued; and where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.

2. Assure that inquiry has been made about any known medical, psychological, or other factors that the individual has which might put him/her at high risk of death, injury, or trauma if subjected to intrusive or restrictive techniques.

3. Expeditiously review, considering current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques.

4. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulation.

5. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The BTPRC, at its discretion, may review behavior treatment plans more often than the minimal quarterly review.

6. As part of the Quality Assessment and Performance Improvement Program (QAPIP), arrange for an evaluation of the BTPRC's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of persons served.

7. Monitor and analyze on a quarterly basis, the use of all emergency interventions (physical management and involvement of law enforcement for emergencies) and the use of intrusive and restrictive techniques for everyone receiving the intervention.

R. The BTPRC may:

1. As part of the QAPIP, advise and recommend to the Clinical Division the need for specific staff or site-specific training in a culture of gentleness, positive behavioral supports, and other individual-specific interventions.

2. As part of the QAPIP, advise and recommend to the Clinical Division acceptable interventions to be used in emergency or crisis situations when a behavior treatment plan does not exist for an individual who has never displayed or been predicted to display seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of harm.

3. At its discretion, review behavioral assessments to determine the need for a behavior treatment plan, and review other formally developed behavior treatment plans, including positive behavioral supports and interventions.

4. At its discretion, review medications prescribed for persons with developmental disabilities to ensure that prescribed medications are not being used for purposes of behavior control. This will be done through the non-emergent review process and signed by the BTPRC Chair and BTPRC Physician.

5. As part of the QAPIP, advise the MCCMH Quality Council on policies affecting behavior treatment and modification practices.

6. Provide specific case consultation as requested by MCCMH provider network staff.

7. Assist in assuring that other related standards are met, e.g., positive behavioral supports.

S. <u>Behavior Treatment Plans</u>

1. The person-centered planning process used in the development of an individualized written plan of services will identify when a behavior treatment plan needs to be developed and where there is documentation that functional behavioral assessments

have been conducted to rule out physical, medical, or environmental causes of the behavior; and that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or ameliorate the behavior.

2. Behavior treatment plans must incorporate the results of the functional behavioral assessments.

3. Written special consent must be given by the person served or his/her guardian on the individual's behalf if one has been appointed, or the parent with legal custody of a minor, or a designated patient advocate prior to the implementation of any behavior treatment plan, but particularly those that include intrusive or restrictive interventions. The general consent to the individualized plan of service and/or supports is not sufficient to authorize implementation of a behavior treatment intervention. The special consent needs to be signed by the person served/guardian after BTPRC approval and prior to implementation of the plan.

   Note: Special consent is always required prior to implementation of a behavior treatment intervention unless the person served has been adjudicated pursuant to the provisions of section 469a (treatment as alternative to hospitalization), 472a (involuntary treatment), 473 (continuing involuntary treatment), 515 (State Center admission), 518 (State Center admission), or 519 (care and treatment other than admission) of the Mental Health Code.

4. Consent shall be re-obtained when substantial changes to the behavior treatment plan are proposed, or at least annually. The completed, signed special consent form shall be scanned into the individual's electronic medical record.

5. Behavior treatment plans that propose use of physical management and/or involvement of law enforcement in a non-emergent situation, aversive techniques, or seclusion or restraint in a setting where it is prohibited by law shall be disapproved by the BTPRC. Utilization of physical management or requesting law enforcement may be evidence of treatment/supports failure. Should use occur more than 3 times within a 30-day period, the individual's plan of service must be revisited through the person-centered planning process and modified accordingly.

6. Plans forwarded to the BTPRC for review shall be accompanied by:

   a. Results of assessments performed to rule out relevant physical, medical, traumatic, and environmental causes (causal analysis) of the challenging behavior;

   b. A functional behavioral assessment, trauma screening, and a trauma assessment, as needed;

   c. Results of inquiries about any medical, psychological, traumatic experiences, or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury, or trauma;

   d. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope, and duration that have been used to ameliorate the behavior that have proved to be unsuccessful;

e. Evidence of continued efforts to find other options;

f. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention;

g. References to the literature should be included on new procedures and where the intervention has limited or no support in the literature, the reason(s) why the plan is the best option available. Citing for common procedures that are well researched and utilized within most behavior treatment plans is not required; and

h. Plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s). Note: Behaviorist is directly responsible for training all staff on implementing the behavior treatment plan interventions.

7. Persons served, guardians, or parents with legal custody of minor persons served, as applicable, as well as others at the request of persons served, may attend BTPRC meetings for observation and understanding of the plan approval / disapproval rationale.

8. Once a decision to approve a behavior treatment plan has been made by the BTPRC and written special consent to the plan been obtained from the person served, the legal guardian, the parent with legal custody of a minor or a designated patient advocate, it becomes part of the person's individual plan of service (IPOS). The individual, legal guardian, parent with legal custody of a minor child, or designated patient advocate has the right to request a review of the IPOS, including the right to request that person-centered planning be re-convened, to revisit the behavior treatment plan.

T. Emergency Use

1. Emergency interventions may be utilized only in a crisis situation when positive behavior supports such as de-escalation, changes to physical environment, redirection, active listening, etc., have been unsuccessful, and the situation places the person served or others at imminent risk of serious or non-serious physical harm.

2. Physical management shall be employed only by individuals who have received documented training in the use/skill of safe and approved physical management. Such physical management training curriculum must have been approved by the MCCMH BTPRC.

3. Requests for emergency physical management must be pre-approved by MCCMH's BTPRC using the Request for Emergency Physical Management Form. The form must accompany a trauma screen and medical clearance for the use of emergency physical management.

    a. In the rare event that an emergency intervention must be used prior to the approval of a request for emergency physical management, a trained individual must complete an Incident Report and a Use of Physical Management and/or Police Contact Form by the end of the shift in which

the occurrence took place.

i. Individuals served must still have a completed trauma screen and medical clearance on file prior to the use of emergency physical management. The recommendation is for providers to adopt this as standard practice upon intake.

ii. The agency supervisor must contact MCCMH's BTPRC, by emailing btprcinquiry@mccmh.net, within 1 business day of the initial incident to request approval for additional use of emergency physical management, if needed.

b. When there are no individuals who have received documented training in safe physical management, provider staff are to follow the provider's emergency protocols, unless such protocols indicate the use of physical management by untrained staff. The option to contact law enforcement is then to be utilized.

c. If a person served requires the repeated or prolonged use of emergency intervention procedures, the MCCMH provider must initiate a review process according to the provisions of this policy to evaluate positive alternatives or the need for a specialized intervention plan.

4. Physical management or the use of restraint or seclusion cannot be authorized in a behavior treatment plan or crisis plan. The plan may note that should all other less restrictive measures fail, staff should implement the least restrictive techniques necessary according to MCCMH's approved behavior treatment plan policy to maintain safety and avoid injury. Specific techniques that may be most appropriate or prohibited in an emergency, may be included based upon the individual's medical condition or trauma history.

U. Evaluation and Review

1. The MCCMH Quality Council shall evaluate the data from the BTPRC on the use of intrusive or restrictive techniques and shall make this data available for MDHHS review.

2. Physical management and requesting law enforcement intervention, permitted in emergencies only, are considered critical incidents that must be managed and reported according to the QAPIP standards. Any injury or death that was caused by or could have been caused using any behavior intervention is considered a sentinel event.

V. Confidentiality

Documents and information pertaining to BTPRC activities that are reported pursuant to the QAPIP (i.e., de-identified data evaluating BTPRC's effectiveness and the uses of intrusive or restrictive techniques; quarterly reports with observations of patterns and trends; recommendations and advisements regarding acceptable interventions to be used in emergency or crisis situations, etc.) remain confidential quality improvement documents, and are not subject to discovery under the U.S. Department of State Freedom of Information Act (FOIA) or Michigan's FOIA. No copies of such documents shall be maintained in the clinical records of persons served but shall be kept in MCCMH administrative files.

VI. PROCEDURES

A. The BTPRC Chairperson shall coordinate review meetings, the frequency of which will be based upon the number and urgency of cases to be reviewed but occurring no less than quarterly from the last review for plans with intrusive or restrictive techniques, or more frequently if clinically indicated for the person's condition, or when requested through the person-centered planning process.

B. At a minimum, the psychiatrist or the psychologist and one other BTPRC member must be present. When this is not possible, the Chair of the BTPRC may grant interim, short term approval of the Behavior Treatment Plan, with review by the BTPRC at a subsequently arranged meeting.

C. The BTPRC review may be conducted via telephone conference call, or other means of electronic communication, where the process can be expedited via this methodology.

D. BTPRC case presentation packets shall contain:

1. Initial or Ongoing Presentation Worksheet
2. Functional Assessment (if not included in behavior plan)
3. Initial or Updated Behavior Treatment Plan
4. Trauma Assessment (if applicable)
5. Medications and Lab results (if applicable)
6. Behavior Daily Data Tracking sheets
7. Behavior Monthly Tracking sheet

E. The BTPRC Initial or Ongoing Presentation Worksheet Form must be completed by the individual completing the behavior treatment plan. Assistance may be sought through consultation with a BTPRC member during this process if the presenter or team has questions regarding completion of the form.

F. The BTPRC Chairperson, program supervisor, or the presenter / directly-operated or contract provider representative may request:

1. An expedited BTPRC meeting or telephone conference call to consider an "emergency" plan. Provisions for prior distribution of review materials may be waived for expedited meetings.
2. An expedited review of a previously approved behavior treatment plan if presenting circumstances warrant immediate consideration of implementation of alternative techniques to provide interventions which may be required to prevent injury or protect the rights of other persons served or staff.

G. Completion of the Special Consent for Behavior Treatment Plan, (Exhibit A), shall adhere to the guidelines as set forth in MCCMH MCO Policy MCO 9-600, "Informed Consent," including making special accommodations to explain the meaning of the consent where

necessary, and documenting the record appropriately.

H. The presenter / directly-operated program or contract provider representative shall prepare a case presentation packet and submit the packet to the BTPRC Chairperson or identified representative within three (3) days of the scheduled review date.

I. The BTPRC Chairperson, or identified representative, shall review the case presentation packet for completeness of preparation, place the case on the agenda for the next meeting, and assure distribution of packet materials to members of the BTPRC for review prior to the presentation.

J. If the presentation packet is not complete, the BTPRC Chairperson or identified representative shall notify the presenter of the deficiency and may make recommendations regarding corrections or additional materials needed to assure a timely review.

K. The presenter shall:

1. Present the person's descriptive information, target behavior(s), proposed approach, alternatives tried or considered, risks and benefits of the recommended approach, expected outcome(s), measures for assessment of progress toward attainment of planned objective(s), and criteria for discontinuation.

2. When there is a review of a previously approved behavior treatment plan, present a summary of activity during the reporting period and proposed modifications to plan / objectives / criteria, if any.

3. Respond to inquiries from BTPRC members regarding the case presentation.

L. BTPRC members shall:

1. Review the Initial or Ongoing Presentation Worksheet Form and the proposed behavior treatment plan with accompanying documentation; and

2. Formulate recommendations (if any) for modification of the plan, including approaches, measures for assessment of progress toward attainment of planned objective(s), and criteria for discontinuation.

M. The BTPRC Chairperson shall:

1. Poll the members for consensus regarding approval / disapproval / modification of the plan presented.

2. If the members approve the plan, establish a date not to exceed 90 days for review of the outcome and/or continuing need for the approved procedures.

3. If the members do not approve the plan, summarize deficiencies in the plan / presentation and indicate conditions or actions required for resubmission, if applicable.

4. Prepare the written report of the findings of the BTPRC for the case reviewed by completing the BTPRC Action form (Exhibit G).

5. Sign the behavior treatment plan, if applicable, and forward it with the BTPRC action form to the supervisor for filing in the individual clinical record.

6. Assure that minutes of the BTPRC meeting are recorded. Upon approval of the minutes by the BTPRC, assure that the minutes are distributed to the BTPRC members.

N. Monitoring and Review

1. On a quarterly basis, the BTPRC shall track and analyze the following:

   a. The use of all physical management for emergencies;

   b. The involvement of law enforcement for emergencies;

   c. The use and effects of intrusive and restrictive techniques on each person receiving the intervention;

   d. Dates and numbers of interventions used;

   e. The settings (e.g., person's home or work) where behaviors and interventions occurred;

   f. Observations about any events, settings, or factors that may have triggered the behavior;

   g. Behaviors that initiated the techniques;

   h. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention;

   i. Description of positive behavioral supports used;

   j. Behaviors that resulted in termination of the interventions;

   k. Length of time of each intervention;

   l. Staff development and training and supervisory guidance to reduce the use of these interventions; and

   m. Review and modification or development, if needed, of behavior plans.

2. The BTPRC shall forward data on the use of intrusive and restrictive techniques to the MCCMH Quality Council at least semi-annually.

3. The BTPRC shall submit its quarterly report to the MCCMH Quality Council, with observations of patterns and trends that can be analyzed to identify ways to reduce the use of these techniques. The MCCMH Quality Council may channel pertinent information to appropriate individuals or departments as necessary (i.e., MCCMH Chief Executive Officer, Division Director(s), the Recipient Rights Advisory Committee, etc.), and may make recommendations for further action.

4. The use of emergency interventions as defined in this policy shall be routinely reported to the MCCMH Office of Recipient Rights and shall be reported quarterly to the MCCMH Clinical Risk Management Committee. This information shall be made available for MDHHS review.

5. Any injury or death that was caused by or could have been caused by the use of any behavior intervention shall be reported to MDHHS as a sentinel event according to the standards and procedures of MCCMH MCO Policy 8-003, "Sentinel Events, Root Cause Analysis, and Mortality Review."

VII. REFERENCES / LEGAL AUTHORITY

A. Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual

B. Commission on Accreditation of Rehabilitation Facilities (CARF) Standards Manual

C. MDHHS / MCCMH Medicaid Managed Specialty Supports and Services Concurrent Contract

D. MDHHS / MCCMH Managed Mental Health Supports and Services Contract

E. MCL 330.1712(2), 330.1740, 330.1742

F. MDHHS Administrative Rule 330.7199(2)(g); 330. 7001(r)

VIII. EXHIBITS

A. Functional Assessment Interview Form

B. Initial Presentation Worksheet

C. Ongoing Presentation Worksheet

D. Behavior Daily Data Tracking Sheet

E. Behavior Monthly Data Tracking Sheet

F. Emergency Physical Management Form

G. BTPRC Action Form

H. Special Consent for Behavior Treatment Plan