PROCEDURE	
Behavior Support Plan Oversite and Requirements Procedure	Procedure No.: 2026-QAPMA-PRXXX
Responsible Program or Office: Quality Assurance and Performance Management Administration	Effective Date:
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Supersedes: Behavior Support Plan Safeguards and Oversight Procedure (9/3/2013) and Behavior Support Plan Requirements (9/2/2013).	
Cross References, Related Policies and Procedures: Behavior Support policy; Human Rights policy; Human Rights Definitions; Human Rights Advisory Committee procedure; Person-centered Thinking Tools procedure; Restrictive Control Review Committee procedure; Health and Wellness Standards; Individual Support Plan policy; Provider Training policy and procedure; Imposition of Sanctions policy; and Enhanced Monitoring 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 the person's ability to engage in meaningful activities or relationships; or which threaten the physical safety of the person or those around them. These procedures will govern how the Department on Disability Services ("DDS"), Developmental Disabilities Administration ("DDA") providers develop, implement, and monitor 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. Responsible Provider

1. When a person receives residential support, the residential provider is responsible for ensuring that the person, or his substitute decision-maker, if applicable, has provided informed consent for any restrictive controls, and for any Behavior Support Plan ("BSP"). The residential provider is responsible for ensuring review and approval by its Provider Human Rights Committee (HRC), before implementation of any new restrictive controls. (Psychotropic medications shall be implemented immediately when prescribed by a licensed physician pending review by the Provider HRC.) The residential provider is also responsible for uploading and committing the BSP and all required supporting documents to MCIS.

2. When the person does not receive residential supports, the day services provider is responsible for obtaining informed consent, HRC review and approval, uploading and committing the BSP and all required documents to MCIS. The day provider is also responsible for participating in the residential provider's HRC reviews of BSPs for each person that the day provider supports.

3. For persons who live in a natural home setting and do not receive day services, the in-home support provider is responsible for all aspects of implementing the BSP.

4. In the event that a person does not have a residential provider, day services provider, or an in-home support provider (including when the person is enrolled in Participant Directed Services), the Service Coordinator will be responsible for obtaining informed consent, requesting a review by the DDS Human Rights Advisory Committee, and uploading the person's BSP and supporting documents to MCIS for review by the DDS RCRC in accordance with the RCRC procedure.

5. Regardless of setting, every provider is responsible for ensuring staff are trained and records are kept in accordance with DDS's Provider Training policy and procedures. If the person does not have a provider, the BSP clinician is responsible for the initial training and subsequent training of the person(s) who will be implementing the BSP.

B. BSP Informed Consent

1. The responsible provider or Service Coordinator must ensure the person or the person's substitute decision maker, or guardian has given written informed consent for the use of all restrictive interventions and for the BSP itself, regardless of whether it contains restrictive controls. The provider must maintain documentation of informed consent by using the informed consent section of the BSP template and upload this information into MCIS along with the other required supporting documents.

2. If psychotropic medications are prescribed, a separate psychotropic medication consent form is needed. 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 Medication Review Panel may authorize the use of psychotropic medications for up to nine consecutive months.

3. Psychotropic Medication Review Panel

    a. The panel shall be comprised of 3 members. The member of the panel shall not be affiliated with the person, the provider, or the physician seeking to administer the medication, but shall include:
        1. A board-certified psychiatrist or an advanced practice registered nurse;
        2. A licensed professional; and
        3. A person, or if unavailable, an advocate for a person with an intellectual or developmental disability or other person advocate.

    b. The panel shall convene within seven (7) calendar days of a request being made if all required documentation is available, including documentation of a mental health diagnosis, the proposed psychotropic medications for treatment, the symptoms targeted by the medications, and a description of their risks, potential side effects and benefits.

    c. If the psychotropic medication review panel is convened the person has the right to request that the DDS Human Rights Advisory Committee ("HRAC") review the decision of the panel. If the person requests a review by the HRAC, the decision shall not be implemented until after the HRAC responds to the requested review. HRAC must review the decision at its next meeting or no later than 30 days after the request, whichever is earlier, and issue a response promptly.

    d. The HRAC's decision may be appealed in writing to the DDS Deputy Director for Quality Assurance and Performance Management Administration (QAPMA)

within 3 business days of receiving the decision. The DDS Deputy Director for QAPMA must review and provide a response with 10 business days of receipt.

e. For people for whom the DDS Psychotropic Medication Review Panel has provided consent for three or more consecutive months and for whom there is a reasonable likelihood that, during the next six months, the person would not achieve capacity and a decision-maker would not become available, DDS shall petition for appointment of the most limited form of guardianship that would meet the person's needs.

C. General Provisions for the Behavior Support Plans ("BSP")

1. BSPs shall adhere to the principles of Positive Behavior Support (PBS), 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. The purpose of the BSP is to describe specific strategies for programming, skill building, and modifications to the environment that lead to behavioral changes and improve the person's quality of life.

2. BSPs shall adhere to person-centered and trauma-informed approaches 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. BSPs shall consider the person's need for technological or supervisory assistance to adapt or cope with day-to-day activities.

4. The provider of behavior supports is responsible for the person's support needs across settings (residential, day, and in-home support) to include training, tracking services and supports, and evaluating the effectiveness of the services and supports on an ongoing basis.

D. Required Components of Behavior Support Plans

1. Purpose of the BSP

   Describe the goals that are important to the person and important for the person and how challenging behaviors present barriers to achieving those goals. The description should explain what the person will be able to accomplish if the challenging behaviors were reduced and how quality of life would be better for the person.

2. Relevant History

   Briefly summarize historical information that is relevant to current challenging behaviors, including but not limited to: major life events, previous challenging behaviors and interventions, mental health history, legal involvement, trauma, and relevant medical conditions that impact on the person's behavior. Describe any diagnosed psychiatric conditions that currently impact behavior. This section should not include a review of the person's developmental history.

3. Diagnostic Information

   List all *current* mental health diagnoses, intellectual/ developmental diagnoses, and medical diagnoses. Utilize the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD). Historical diagnoses and diagnoses that need to be ruled out should not be included on the BSP.

4. Medication Treatment

   Include a table listing all current medications, dosages, symptom or behavior targeted by the medication and the mental health condition for which it is prescribed. Separate out the list by psychotropic and non-psychotropic medications. A psychotropic medication is any medication that alters thought processes, mood, sleep, or behavior. Non-psychotropic medications are somatic medications used to treat health conditions.

5. Target Behaviors

   Provide an operational definition for each target behavior to decrease, and each target behavior to increase, describing observable elements that can be measured. Target behaviors to decrease should be limited to behaviors that pose a danger to the health or safety of the person or to those around them or property.

   Target behaviors to increase should provide more adaptive responses than resorting to challenging behaviors. The identified behaviors to increase should be related to goals that are important to/for the person and will improve quality of life. As necessary, interventions to increase behaviors should address relevant replacement skills, positive reinforcement, knowledge (i.e. understanding or comprehension) and attitudes (i.e. ways of thinking about someone or something).

6. Data
   Include tables showing data for behaviors to increase and behaviors to decrease in the residence and day setting (if any) over the last 12 months.

7. Goals for Behaviors to Decrease

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

8. Goals for Behaviors to Increase

   For each behavior targeted for increase, describe goals for changing or increasing the behavior that can likely be accomplished within one (1) ISP year using SMART goal format (Specific, Measurable, Achievable, Realistic, and Time-limited).

9. Functional Assessment

   a. The functional assessment is only required for behaviors to decrease. Information used to complete the functional assessment will be gathered from record reviews, direct observation, interview of the person, interviews with the people who know the person best, and any relevant assessment tools. The functional assessment must describe the antecedents and maintaining consequences for each target behavior. It should also provide a working hypothesis about why the target behavior occurs (i.e. the BSP should describe the primary function of the behavior) and use the working hypothesis as the basis for selected interventions.

   b. 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. The BSP intervention strategies must be related to the setting events, antecedents, consequences and the detailed hypothesis about why the behavior occurs as identified in the functional assessment.

c. Functional assessments must:

1. List the sources of information used to conduct the functional assessment. Be performed in both the residence and day setting, if applicable. A functional assessment would not be appropriate at a person's job site.
2. Provide a clear, measurable, operational definition of each target behavior, which includes (as applicable) frequency, duration, and intensity of the behavior.
3. Identify the antecedents to the target behavior and the maintaining consequences, or outcomes, that follow the behavior; and
4. Propose a clear hypothesis about why the behavior occurs, in each setting where it occurs.

10. Proactive Strategies

a. Describe the positive proactive strategies that will be used to prevent challenging behavior from occurring. As it pertains to person-centered thinking, the BSP should incorporate positive proactive strategies that need to be present for the person to feel content, satisfied, comforted, fulfilled and happy. The BSP also incorporates strategies necessary for the person's health and safety.

b. Proactive strategies include environmental modifications that identify and change those features of the person's physical environment, interpersonal interactions, or daily programming to reduce challenging behaviors.

1. Modification to Physical Environment:
List changes that need to be made in the person's physical environment (i.e. strategies to limit noise, crowding, access to sharp objects, etc.) to make the target behavior less likely to occur.

2. Modification to Interpersonal Interactions:
List changes that need to be made in social interactions (i.e. access to peers and family, quality of interactions with staff) to make target behaviors less likely to occur Describe the interpersonal exchanges and preferred activities that must happen in order for the person to feel content and safe.

3. Modifications to Programming:
Describe the actions other people can do on a daily basis to help the person be successful in what is important to and important for them. Include specific

rituals and daily routines that must happen in order for the person to feel happy, satisfied, fulfilled and safe. Describe what a good day looks like for the person and what needs to happen to make it a good day. Describe what a bad day looks like and what happens to make a day bad for the person. Describe what staff should do to make a good day more likely to occur and a bad day less likely to occur, Describe how to support the person during a difficult day at home, work, or in the community

c. Trauma Informed Responses:
List any known triggers for trauma related responses and describe factors required for the person to feel safe, valued and respected. Describe how the person will be provided with opportunities for choice, predictability and control in their day-to-day life.

d. Communication Strategies:
Describe how the person communicates through words or actions when they are content and when they are distressed. Describe what staff can do or say to support the person in those situations.

e. Skill Building Strategies:
Skill building strategies strengthen existing skills and teach new behaviors that make challenging behavior unnecessary. Describe in observable terms, the skills the person is expected to use (e.g. functional skills, coping skills, social skills). Provide specific instructions and strategies for how to teach new skills (e.g. modeling, positive reinforcement, role play, direct instruction). Describe how the person will be supported to use the skills and how the skills will help achieve goals that are important to or for the person. Additionally, skill building interventions must also describe the resources and locations and other elements needed to teach the person the skill.

11. Staff Response and Crisis Intervention Plan

Describe how staff will respond to challenging 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. Staff responses and crisis interventions must include input from the person and those who know the person well.

12. Staffing Supports

a. Describe the staffing patterns, 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 to people who have a BSP that includes the use of physical restraint including program supervisors, managers, coordinators and/or Qualified Intellectual Developmental Disability Professionals.

d. Individualized staffing support may only be recommended based on a person-centered planning process, in collaboration with the person and the person's support team, which balances the person's rights to privacy, to refuse, and to least restrictive interventions with the 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:

1. Explicit description of the proximity of the staff to the person in different situations/conditions (i.e. arm's length; line of sight);
2. Number of hours of individualized staffing per day and specific staffing schedule
3. Exceptions to the individualized staffing (i.e. when using the restroom; sleeping; private conversations);
4. Whether individualized staffing is recommended for the day setting, residence, or both;
5. 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);
6. Responsibilities when supporting a person during a behavioral crisis including responsibilities when the person is taken to an emergency room for a behavioral crisis.
7. Expectations for enriched activities (i.e. increase in training; activities);
8. Responsibility for data collection and reporting;
9. Identification of required competencies, skills, experience, and characteristics of the person(s) who might support the person best (aligned with ISP section "People who support me best");
10. Description of training requirements; and
11. A fade plan for reducing the person's need for individualized staffing support.

13. Restrictive Components (If applicable.)

a. Any plan with restrictive control procedures, including individualized housing and an increased staffing ratio, must include an explanation of how the restrictive control will be used to reduce challenging behavior.

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 BSP must indicate the specific criteria and plan for reducing, fading, or eliminating the restriction. 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, the person, and the person's support team 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.

g. Restitution Plans may be considered for persons who engage in property destruction. Restitution can be applied to the cost of replacing damaged or destroyed items and should reasonably be thought to minimize future destructive behavior. Restitution Plans cannot be applied to items damaged/destroyed prior to the implementation of the plan.

14. Medical Sedation Plans (Required as applicable)

a. A BSP is required when sedation is used on a regular basis for medical appointments. It is not required for one-time use of sedation as defined in the Incident Management and Enforcement Policy, or when sedation is a routine part of the medical procedure (e.g. colonoscopy).

b. Behavior support plans that incorporate the use of sedation for medical appointments must include 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.

c. 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 the medical appointment and reduce the need for sedation.

d. The BSP for medical sedation must include a table that lists the type of medical appointment, the name of the sedating medication and dosage used, and whether or not the appointment was successfully completed.

e. Medical sedation orders must comply with the relevant DDS Health and Wellness Standards.

15. 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 who, at the provider agency or agencies, will review the data on a monthly basis (or more frequently if necessary) and forward the data to the BSP clinician.

b. The BSP must specify how the BSP developer will share behavior data with the prescribing physician so the physician can make data informed prescribing decisions.

c. For data collected using electronic data collection methods the BSP must specify how the data will be shared with the BSP clinician. If electronic databases cannot accurately record data in the format prescribed in the BSP then the provider that implements the BSP is required to use a data collection format that can accurately record the data.

16. Staff Training

a. 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.

b. At his or her discretion, 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.

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

17. Signature(s) of BSP Developer(s)

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

18. Addendum of Changes Since Last Restrictive Controls Review

List any updates to diagnoses, changes in psychotropic medication, modifications in other restrictions, and responses to RCRC recommendations that occurred since the last restrictive control review.

19. Best Practices Guide

The BSP must provide a Best Practices Guide for crisis de-escalation 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.

E. Required Oversight and Review of BSPs Containing Restrictive Controls or Involving the Use of Psychotropic Medications

1. BSP's that involve the use of psychotropic medications as the only restriction must be reviewed and approved by:

   a. The person or, if the person does not have capacity to consent, the person's substitute healthcare decision-maker;

   b. The person's support team, and;

   c. The provider's Human Rights Committee, in accordance with Section 3.A., above.

2. BSPs that contain restrictive controls used in conjunction with psychotropic medications must be reviewed and approved by:

   a. The person or, if the person does not have capacity to consent for him or herself, the person's substitute healthcare decision-maker;

   b. The person's support team;

   c. The provider's Human Rights Committee, in accordance with Section A, above, and;

   d. The DDS Restrictive Control Review Committee ("RCRC").

3. QAPMA will be responsible for performing a quarterly audit of BSPs approved by the provider HRCs where medication is the only restriction. These audits will consist of both a technical and quality review of the plan. Samples will be randomized with additional targeted reviews as needed.

F. Required Oversight and Review of BSP Exemptions

Initial exemption requests and all subsequent exemption requests shall be uploaded to MCIS 60 days prior to the ISP effective date along with the two most recent Psychotropic Medication Review Forms, Provider HRC minutes and exemption form. All documents shall be committed to MCIS for review by the Office of Rights and Advocacy (ORA). If

there are any technical errors noted during this review, an issue will be automatically generated.

G. Implementation of Behavior Supports

1. Physician's orders, including those for psychotropic medications and sedation, must be implemented as ordered and without delay to ensure people's health and safety. The use of psychotropic medications and sedation requires informed consent prior to initiation.

2. Approved BSPs that include restrictive controls may continue to be implemented during the time in which a new BSP containing a revised or new restrictive control is pending approval.

3. DDS has provisions for emergency use of restrictive controls and for emergency approval of restrictive controls, set forth in DDS' Human Rights Policy and Restrictive Control Review Committee Procedures.

H. Required Data Monitoring

Collection of behavioral data is required to monitor the person's progress toward achieving his or her positive behavioral goals.

1. All provider staff responsible for implementing the BSP, regardless of setting, are required to regularly and routinely record the frequency of each target behavior as indicated in the BSP.

2. Provider staff are responsible for forwarding the behavioral data to the BSP developer on a regular basis, and no less than monthly, by the 5th of the month or in accordance with the BSP instructions. Regardless of data reporting schedules, staff must inform the BSP developer of significant changes in behavioral functioning – including but not limited to, an unusual high or low frequency of behaviors, behavioral crisis, medication side effects, if new challenging behaviors emerge that cannot be addressed by the BSP, or when staff believes that restrictive procedures may no longer be necessary or could be faded.

3. The BSP developer is responsible for a quarterly report that includes notes on the person's progress, review of the data, and clinical justification for continued use of all restrictive interventions. This data must be provided to the prescribing psychiatrist during medication reviews.

I. Required Documentation

1. Providers responsible for implementation of the BSP must maintain the record and upload to MCIS, where indicated, the following documentation:

    a. Evidence that the plan was developed through a person-centered planning process that included the person and his or her support team.

    b. Evidence that the person, guardian, or his or her substitute healthcare decision-maker, if he or she has one, provided informed consent for the BSP and the use of psychotropic medications prior to initiation of the restrictive intervention. This documentation must be uploaded into MCIS along with the BSP.

    c. The person's last two quarterly psychotropic medication review forms, if the person is prescribed psychotropic medication. This documentation must be uploaded into MCIS along with the BSP.

    d. Evidence that staff who work with a person, are trained by the BSP developer or his/her designee on the implementation of the BSP and data collection protocols, in accordance with the DDS Direct Support Training policy and procedure. This documentation must be uploaded into MCIS along with the BSP.

    e. Evidence that the provider's HRC reviewed and approved the BSP's implementation. This documentation must be uploaded into MCIS along with the BSP.

    f. The last three months of behavior data across all settings, as applicable.

    g. Any of the following as applicable:
        1. Copy of the court order for restrictions that are court-ordered
        2. Proof of current certification in the use of CPI, Mandt or other DDS approved physical restraint training
        3. Physician's sedation orders
        4. Medical clearance for physical restraint
        5. Supporting documentation for CPI/Mandt or other DDS approved physical restraint training including medical clearance and description(s) of specific holds/techniques to be used as well as proof of staff training on the use of those holds/techniques.

2. 60 days prior to the effective date of the ISP, the provider or the SC, when there isn't a provider, must ensure that all documentation has been uploaded and/ or updated and committed into MCIS.

J. 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.