Origination:	*03/2017*
Effective:	*12/2019*
Last Approved:	*12/2019*
Last Revised:	*12/2019*
Next Review:	*12/2020*
Owner:	*April Siebert: Director of Quality Improvement*
Policy Area:	*Quality Improvement*
References:	

Use of Behavior Treatment in Community Mental Health Settings

POLICY

It is the policy of the Detroit Wayne Integrated Health Network (DWIHN) that the use of behavioral treatment techniques comply with DWIHN, state and federal policy.

PURPOSE

This policy is intended to give direction to the required Behavioral Treatment Plan Review Committees to appropriately oversee access to and implementation of behavior treatment techniques.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWIHN Board, DWIHN Staff, Contractual Staff, Access Center,Service Providers, Crisis services vendor, Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adults, Children, I/DD, SMI/SEI, SED,SUD, Autism
3. This policy impacts the following **contracts/service lines** : MI-HEALTH LINK, Medicaid, SUD, Autism, Grants, General Fund

KEYWORDS

1. Aversive Techniques
2. Behavior Plans
3. Behavioral Treatment Plan Review Committee (Committee)
4. Crisis
5. Crisis Plans
6. Emergency Interventions
7. Expedited Behavior Treatment Plan Review
8. Functional Behavioral Assessment (FBA)
9. Imminent Risk

10. Individual Plan of Service/Person-Centered Planning (IPOS/PCP)
11. Intrusive Techniques
12. Peer Review Literature
13. Physical Management
14. Positive Behavior Support
15. Reactive Strategies in a Culture of Gentleness
16. Request for Law Enforcement intervention
17. Restraint
18. Restrictive Techniques
19. Seclusion
20. Special Consent

STANDARDS

STANDARDS FOR DWIHN SERVICE PROVIDERS' BEHAVIORAL TREATMENT PLAN REVIEW POLICY REQUIREMENT

1. DWIHN Service Providers shall monitor and ensure their implementation of behavioral treatment policies and procedures. At a minimum, the policies and procedures should include the following:
    a. The Committee review, approval, deferral, or disapproval of behavior plans;
    b. The Committee has written documentation on the approval, deferral, or disapproval of behavior plans;
    c. Describe the frequency of meetings;
    d. How minutes and notes of the meetings are to be used and safeguarded;
    e. How case record reviews of persons receiving behavior treatment services will be conducted;
    f. How it is determined when the behavior treatment program is concluded, monitored and referenced in the person's IPOS;
    g. Collect data on the number of referrals for a behavior treatment plan;
    h. Collect data on the number of behavior treatment plans approved, deferred, denied and/or terminated;
    i. Establish a mechanism for the expedited review of behavior treatment plans in emergent situations, whereby the plan is reviewed, deferred, denied and/or approved in a short time frame such as 24 or 48 hours;
    j. Conduct an annual evaluation of the committee'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 the individuals served. The results of the annual evaluation shall be forwarded to the DWIHN Behavioral Treatment Oversight Committee.

COMPOSITION OF THE BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE (BTPRC) AT DWIHN SERVICE PROVIDERS

1. Service Providers' Behavior Treatment Plan Review Committees shall, at a minimum, consist of three

members:

a. At least one individual shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c (10). The individual should be credentialed in the mental health field.

b. At least one individual shall be a licensed psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Chapter 3, with the specified training. The individual should be credentialed in the mental health field.

c. At least one individual shall be a representative of the Office of Recipient Rights is required to participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance.

d. Other non-voting members may be added at the committee'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 or I/DD Peer Mentor or Peer Recovery Coach or Youth Peer Specialist.

e. The Behavior Treatment Plan Review Committee and Committee Chair shall be appointed by the service provider for a term of not more than two years. Members may be re-appointed to consecutive terms. The Committee Chair and committee member names, professional license and length of appointment shall be submitted to DWIHN by the respective service providers. This documentation shall be kept current and available for review, upon request. Any changes to the committee or committee members shall be documented and the information submitted to DWIHN.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of DWIHN service providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff,Service Providers, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Federal Balanced Budget Act of 1997 (P.L. 105-33) 42 CFR 438.100
2. MCL 330.1712, Michigan Mental Health Code
3. MCL 330.1740, Michigan Mental Health Code
4. MCL 330.1742, Michigan Mental Health Code
5. Michigan Department of Health and Human Services Administrative (MDHHS) Rule 330.7199(2)(g)
6. MDHHS/CMHSP Managed Mental Health Supports and Services Contract:
7. MDHHS Medicaid Provider Manual, Chapter III, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Section 2.4 Staff Provider Qualifications (current version).
8. MDHHS Mental Health and Substance Abuse Administration, Technical Requirement for Behavior

Treatment Plan Review Committees, Revision FY17

9. NCQA Guidelines for Treatment Record Review (2017)

RELATED POLICIES

1. DWIHN Clinical Peer Review Policy
2. DWIHN Crisis Plan Policy
3. Procedures for Behavior Treatment Plans in Community Mental Health Settings

RELATED DEPARTMENTS

1. Clinical Practice Improvement
2. Customer Service
3. Integrated Health Care
4. Quality Improvement
5. Recipient Rights
6. Substance Use Disorders
7. Utilization Management

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments

DWIHN Behavior Treatment Plan Review Checklist FY 2020.docx
DWIHN Crisis Plan Template (FY 2019-20).docx
DWIHN Functional Behavioral Assessment Clinical Practice Standard Manual (FY2020).docx
DWIHN Monitoring Plan for Behavior Treatment Plan Review Committees (FY2019-20).docx
DWIHN-Behavior Treatment Plan Development (FY 2019-20).docx
DWIHN-Behavior Treatment Plan Review Committee Review Form (FY 2020).docx
Instructions for Completing CrisisPlan_SafetyPlan_AdvanceDirective (FY2019-20).docx
MDHHS Data Spreadsheet (FY 2019-20).xlsx

Approval Signatures

Approver	Date
Dana Lasenby: Chief Clinical Officer	12/2019

Approver	Date

Origination:	*01/2017*
Effective:	*12/2018*
Last Approved:	*12/2018*
Last Revised:	*12/2018*
Next Review:	*12/2019*
Owner:	*April Siebert: Director of Quality Improvement*
Policy Area:	*Quality Improvement*
References:	

Procedures for Behavior Treatment Plans in Community Mental Health Settings

PROCEDURE PURPOSE

The purpose of this procedure is to provide procedural and operational guidelines for Behavior Treatment Committees in the development, review, and approval of behavior treatment plans in community-based settings through the person-centered planning process.

EXPECTED OUTCOME

DWMHA, and Service Provider staff will understand the standardized process in the review, development, and approval of behavior treatment plans that are clinically warranted, meet medical necessity, and are not intrusive or restrictive for all consumers receiving services in the DWMHA provider network.

PROCEDURE

The person-centered planning process is used in the development of an individualized written plan of service will be utilized to identify when a behavior treatment plan will need to be developed. In order to ensure the development of a behavior treatment plan is clinically warranted, a functional behavioral assessment is conducted to rule out physical, medical and/or environmental causes of the behavior, and there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the behavior.

Behavior treatment plans that propose to use restrictive or intrusive techniques as defined in this policy must have the special written consent of the individual and/or legal guardian, the parent with legal custody of a minor child or a designated patient advocate, and shall be reviewed and approved or disapproved by the Behavioral Treatment Plan Review Committee (Committee). This approval or disapproval must be obtained prior to implementation of the plan. If consent is denied or withdrawn by the person legally designated to give consent, the respective treatment shall not be administered or continued.

Behavioral treatment plans that propose to use physical management in a community mental health setting are prohibited by law and shall not be approved by the Behavioral Treatment Plan Review Committees. However, approved physical management, is permitted for intervention in emergencies only, and is considered a critical/ sentinel event that must be reported verbally within 24 hours to the Detroit Wayne Mental Health Authority's Quality Management Critical/Sentinel Event Coordinator. After verbally reporting the incident, the service provider must follow up with a copy of the Incident Report and submission of the critical/sentinel event report

within three days. If it does meet the criteria for a sentinel event, the provider has two days from the date of the determination to start the root cause analysis of the incident and submit to the DWMHA Quality Management Unit.

Use of physical management or requesting the assistance of law enforcement may be evidence of treatment/ supports failure. Should the use of approved physical management and/or assistance from law enforcement occur more than three times in a 30-day period, the individual's written BTP must be revisited using the person-centered planning process and modified accordingly, if indicated. The DWMHA, MDHHS Behavior Treatment Guidelines and MDHHS Administrative Rules prohibit emergency interventions from inclusion as a component or step in any behavior plan. However, the BTP may be developed and approved on an emergency basis. The emergent BTP shall note the interventions to be used. Should interventions outlined in the BTP fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented.

Once a decision to approve a behavior treatment plan has been made by the Committee, it becomes part of the person's written IPOS. The individual or their designated advocate has the right, at any time, to request a review of the behavior treatment plan (BTP) written as part of the IPOS. A meeting to review the BTP using the IPOS process shall be re-convened as soon as possible. (MCL 330.1712[2]).

Any injury or death that occurs from the use of any behavior intervention is also considered a critical/sentinel event that must be reported verbally within 24-hours to the Detroit Wayne Mental Health Authority's Critical/ Sentinel Event Coordinator, followed up with submission of a written critical/sentinel event report within three days. If it does meet the criteria for a sentinel event, the provider has two days from the date of the determination to start the root cause analysis of the incident and submit to the DWMHA.

All staff that have direct physical contact with persons receiving behavioral treatment services shall have on-going education and training on the individual's BTP and in the proper and safe use of the approved techniques and methods identified in the BTP.

There shall be regular monitoring of in the consumer's BTP by the Behavioral Treatment Plan Committee and/ or the designated provider staff member.

FUNCTIONS of the BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE of SERVICE PROVIDERS

1. The committee shall maintain document and maintain all behavior treatment review committee meeting minutes clearly delineating the actions of Committee.
2. The committee shall provide decisions and instructions, in writing, to the responsible staff person with a copy to the file of the person receiving the services utilizing DWMHA approved forms and formats.
3. The committee shall advise and recommend the need for specific staff or home-specific training in a culture of gentleness, positive behavioral supports, and other individual specific non-violent interventions.
4. The committee shall advise and recommend 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 or harm.
5. The committee shall meet as often as needed under the direction of the chairperson who shall be appointed by the service provider's executive director.
6. The committee shall recommend to the executive director any specific changes to the current policy and procedures, minimum annual training in behavior assessment, treatment and behavior analysis for staff.

7. Provide specific case consultation as requested by professional staff.
8. Assist in assuring that other related standards are met, e.g., positive behavior supports.
9. Review at its discretion, other formally developed behavior treatment plans, including positive behavioral supports and interventions, if such reviews are consistent with the provider's needs.
10. May serve another service entity (e.g.,subcontractor) if agreeable between the involved parties.
11. Ensure plans forwarded to Service Provides' Behavioral Treatment Plan Review Committee shall be accompanied by:
    a. A comprehensive Functional Behavioral Assessment, which includes results of assessments performed to rule out relevant physical, medical and environmental causes of the problem behavior.
    b. A copy of the member's Crisis Plan.
    c. Results of inquiries about any medical, psychological 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 attempted to ameliorate the behavior and have proved to be unsuccessful.
    e. Evidence of continued efforts to find other options.
    f. References to the literature should be included, and where the intervention has limited or no support in the literature, why the plan is the best option available
12. Behavior Treatment Plan Review Committees of DWMHA Service Providers are responsible for tracking the use of all physical management for emergencies, and the use of intrusive techniques by each individual receiving the intervention, as well as:
    a. Dates and numbers of interventions used.
    b. The settings (e.g., individual's home or work) where behaviors and interventions occurred.
    c. Observations about any events, settings or factors that may have triggered the behavior.
    d. Behaviors that initiated the techniques.
    e. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
    f. Description of positive behavioral supports used.
    g. Behaviors that resulted in termination of the interventions.
    h. Length of time of each intervention.
    i. Staff development and training and supervisory guidance to reduce the use of these interventions.
    j. Review and modification or development, if needed, of the individual's behavior plan.
    k. Data on the use of intrusive and restrictive techniques shall be evaluated by the DWMHA Behavior Treatment Oversight Committee, which provides oversight, and will be made available for MDHHS reviews. Physical management and/or involvement of law enforcement, permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported to the DWMHA. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

PROCEDURE MONITORING & STEPS

Who monitors this procedure:	April Siebert/Fareeha Nadeem
Department:	Behavior Treatment Review Committee
Frequency of monitoring:	Quarterly
Reporting provided to:	Detroit Wayne Mental Health Authority Quality Improvement Unit

Attachments

No Attachments

Approval Signatures

Approver	Date
April Siebert: Director of Quality Improvement	12/2018
April Siebert: Director of Quality Improvement	12/2018

Name _____ MH-WIN ID# _____ DOB _____ BTPRC Review Date _____

BEHAVIOR TREATMENT PLAN (BTP) REVIEW CHECKLIST

Behavior Treatment Plan (BTP) Review Criteria Check List		Met	Not Met	N/A	Location in Plan (page, step#)
1.	The BTP has a copy of the Crisis Plan attached				
2.	A comprehensive Functional Behavioral Assessment is included in BTP.				
3.	The BTP identifies and describes specific target behaviors.				
4.	The BTP indicates the frequency of each identified target behavior.				
5.	The BTP indicates the severity of each identified target behavior.				
6.	The BTP identifies the antecedent(s) of each identified target behavior.				
7.	The BTP identifies consequences of each identified target behavior.				
8.	The BTP identifies the function(s) of each identified target behavior				
9.	Medical and/or physical conditions that could cause or exacerbate behavior(s) have been ruled out by a physician or specifically addressed in the BTP.				
10.	Environmental conditions that could cause or exacerbate behavior(s) have been ruled out or specifically addressed in the BTP.				
11.	The BTP documents that the potentially harmful effects of the restrictive/intrusive procedures outweigh the potentially harmful effects of the target behaviors.				
12.	The Goal(s) and Objective(s) in the BTP are measurable and time limited.				
13.	The BTP (utilizes/incorporates) procedures and interventions (that) are specific to the targeted behaviors.				
14.	The BTP identifies positive reinforcements.				
15.	When psychotropic medications that <u>are not</u> a standard treatment or dosage for the individual's diagnosed condition are prescribed to manage or control behaviors, BTP interventions and the medication treatment are interrelated.				
16.	When restrictive/intrusive interventions are included in BTP.				
17.	a) Justification for the restrictive/intrusive intervention is included in the BTP.				
18.	b) There are provisions for the removal, decrease and/or discontinuation of the restrictive or intrusive interventions based on specific criteria.				
19.	c) Special consent for the use of restrictive/intrusive intervention has been obtained from the person legally empowered to give consent.				
20.	Emergency situations are addressed in the BTP.				
21.	The BTP specifies the professional staff person responsible for implementing the BTP.				
22.	The BTP describes the responsibilities of the staff caregivers involved.				

List Restrictive/Intrusive Interventions Included In BTP (add more rows if needed)	Target Behavior Addressed By Intervention

BTP is ready for Behavior Treatment Plan Review Committee (BTPRC) Review (all above criteria met): No _____
Yes _____

_____
Preparer's Signature and Credentials Date

CRISIS PLAN AND ADVANCE DIRECTIVE

Provider/Clinically Responsible Service Provider_____Contact Information _____

IDENTI□YING IN□ORMATION				
Name	DOB	AGE	MH-WIN ID□	GENDER
Address				
Date				

Advanced Directive ☐ Yes ☐ No (if Yes, where can we find it□): _____

This form should be completed at the time of initial/annual treatment plan (or earlier) using the Person Centered Planning process. This is to be used when the consumer requires emergency medical or psychiatric care. There are times of crisis when the person may need help with some routine items until the crisis has passed.
Client chooses to participate in Crisis Planning ☐ Yes ☐ No (if No, then please sign below):

How do you □now when I am in crisis□
Don□t do □when I am in crisis
Don□t ta□e me to or Ta□e me to □note □oth and why□

SYMPTOMS□□EELINGS□OR TRIGGERS THAT MAY LEAD TO A CRISIS		
☐ Wanting to hurt myself or suicidal Why/How□	☐ Wanting to hurt others Why/How□	☐ Attempting suicide How?
☐ Feeling not heard How?	☐ Bullying How?	☐ Using drugs/alcohol to cope Why□
☐ Losing temper	☐ Fighting with other people	☐ Using drugs or alcohol
☐ Increase or decrease in sleep	☐ Not eating for several days	☐ Hearing voices
☐ Gambling loss What type?	☐ Being touched Why□	☐ Crying non-stop or off/on Why□
☐ Not paying my bills	☐ Becoming physically ill	☐ Feeling unsafe
☐ Potential loss of housing	☐ Change in hygiene	☐ Not keeping appointments
☐ Potential loss of children/family How/When□	☐ Arguments What type□	☐ Seeing a particular person Why□
☐ Loud noises	☐ Lack of privacy	☐ Being rude
☐ Time of year	☐ Time of day	☐ Other

IMMEDIATE RISK CONCERNS			
Access to Weapons ☐ Yes ☐ No	Types of Weapons	Current Location of Weapons:	Risk of Harm present: ☐ Yes ☐ No
Access to Medications/Illegal Drugs ☐ Yes ☐ No	Medications that are accessible:	Current Location of Medications:	Risk of Harm present: ☐ Yes ☐ No
Plan to address if current risk present:			

SUPPORT SYSTEM THAT CAN HELP BE□ORE OR DURING A CRISIS		
Name	Relationship	Contact Information

PRO□ESSIONAL RESOURCES THAT CAN HELP	
Name	**Contact Information**
Provider	Phone Number:
Case Management Team	Phone Number:
DWMHA Crisis Line	Phone Number:

CRISIS PLAN AND ADVANCE DIRECTIVE

STEPS TO TAKE TO MINIMI□E OR PREVENT MY CRISIS		
☐ Talking with my family (Name/Number)	☐ Talk to my therapist (Name/Number)	☐ Talking with friends (Name/Number)
☐ Time out in my room	☐ Use therapy/DBT skills	☐ Be around others
☐ Wrap up in a blanket	☐ Talking with an adult	☐ Be near my family
☐ Punch a pillow	☐ Talk with staff about my needs	☐ Go to the Drop-In Center/Social place
☐ Lie down with a cold face cloth	☐ Sitting with staff	☐ Use a male or female staff as support
☐ Take a shower/bath	☐ Watch TV	☐ Read (book/paper/magazine)
☐ Do deep breathing exercises	☐ Listening to music	☐ Write in a journal
☐ Drink a cup of warm tea	☐ Go for a walk	☐ Start artwork
☐ Hugging a stuffed animal	☐ Pace back/forth	☐ Play video games
☐ Get a hug	☐ Exercise	☐ Bounce a ball
☐ Do chores/jobs	☐ Coloring in a book/paper	☐ Molding clay
☐ Other	☐ Draw on my arm with a red marker	☐ Snap a rubber band on my wrist
☐ Other	☐ Other	☐ Other

Consumer Signature_____Print Name_____Date _____

Family / Guardian Signature_____Print Name_____Date _____

Family / Guardian Telephone Number: _____

Staff Signature/Credentials_____Print Name_____Date _____

Date of next review: _____

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DETROIT WAYNE INTEGRATED HEALTH NETWORK

□unctional Behavioral Assessment
Clinical Practice Standards Manual
□□Y □□□□□□□□

□unctional Behavioral Assessment

In order to ensure that a request for the development of an initial or updated Behavior Treatment Plan is clinically warranted, a request to conduct a Functional Behavioral Assessment (FBA) must first be submitted. Upon completion of the Functional Behavior Assessment, a determination will be made as to whether or not the development and implementation of a formal behavior treatment plan is clinically warranted.

If the exhibited behaviors place the individual and/or others at risk, an Emergency/Crisis Plan should be immediately developed and implemented in order to ensure safety while the Behavior Treatment Plan is being developed. The development and approval of the Behavior Treatment Plan are to be expedited.

Definition:

Functional Behavioral Assessment (FBA): 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 treatment plan. The focus of an FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain, or end a target behavior. A physical examination must be done by a MD or DO to identify biological or medical factors related to the target behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the target behavior itself so that a new behavior or skill will be developed to provide the same function or meet the identified need of the recipient. Functional assessments should also identify situations and events that precede positive adaptive behavior to provide more information for a positive behavior support plan.

Procedural Steps □or Re□uesting A □unctional Behavioral Assessment:

Initial Request:

1. The requesting party should first conduct a clinical assessment. In the case of a request for an initial Functional Behavioral Assessment, the clinical assessment should accurately describe the exhibited behaviors of concern, and the extent of the impact of the behaviors on the individual and/or others, as well as any environmental impact of the behaviors.

2. In addition, the clinical assessment should be accompanied by any relevant Incident Reports, previous psychological reports, the latest annual psychiatric evaluation and most recent psychiatric review which lists current medications, if psychiatric services are being delivered, and any other relevant evaluations and assessments that have been conducted.

3. The clinical assessment and additional paperwork will be submitted with the request for a Functional Behavioral Assessment. Upon completion of the Functional Behavior Assessment, a determination will be made as to whether or not the development and implementation of a formal behavior treatment plan is clinically warranted. The results of the functional behavior assessment may recommend that alternate clinical methods be employed to alleviate the reported difficulties.

Request for Updated FBA:

1. In regard to requests for updated assessments/plans, the requesting party should first conduct a clinical assessment update. The updated clinical assessment should clearly state the current level of progress on the goals established within the Individual Plan of Service (IPOS) for the existing behavior treatment plan.

2. The previous Functional Behavioral Assessment can be updated utilizing the updated clinical assessment, results of Behavior Treatment Plan Monitoring services provided throughout the course of the year, and review of psychiatric services provided throughout the course of the year, Incident Reports filed, and any other relevant evaluations and assessments that have been conducted. Upon completion of the updated Functional Behavior Assessment, a determination will be made as to whether or not the continued implementation of a formal behavior treatment plan is clinically warranted. If it is determined that continued implementation of a formal behavior treatment plan is clinically warranted, the results of the assessment will also indicate whether there is a need for modification of the initial behavior treatment plan.

□UNCTIONAL BEHAVIORAL ASSESSMENT/ POSITIVE BEHAVIOR SUPPORT PLAN

□□UNCTIONAL BEHAVIORAL ASSESSMENT/TREATMENT PLAN□

COMPONENTS/TEMPLATE O□ THE □UNCTIONAL BEHAVIORAL ANALYSIS:

IDENTI□YING IN□ORMATION:

Name, Case Number, Address, Date of Birth, Gender, Assessment/Plan Date.

DSM □/ICD□□□ DIAGNOSES:

Mental, Behavioral, Neurodevelopmental Disorders, and relevant Medical Diagnosis.

RELEVANT BACKGROUND IN□ORMATION:

Brief background history, current residential, medical status, vocational/program, and psychiatric information, and any other pertinent information.

CURRENT MEDICATIONS

Name, dosage/frequency, and the purpose.

PRESENTING CONCERNS:

Overview of current difficulties

DATE O□ ONSET:

Indicate when behavioral difficulties initially developed, and onset of current behavioral difficulties.

SPECI□IC TARGET BEHAVIORS:

Describe each behavior, for example: Physical Aggression: hitting, kicking, and biting; Potentially Self Injurious Behavior: banging head on hard surfaces, biting hands, etc.)

□REQUENCY/DURATION/SEVERITY O□ BEHAVIORS:

□re□uency: How often the behavior occurs

Duration: Average length or range of lengths of each behavior/episode

Severity: Mild: not resulting in injury to self or others; Moderate: has resulted in mild injuries to self or others and/or with potential for injury as a result of behavioral acceleration, periodic disruption of the ongoing activities of others, etc.; Severe: places self/others at imminent risk and/or has resulted in significant injuries or excessive property damage, exhibited behaviors incite or intimidate others, etc.

POSSIBLE CAUSES: all contributing factors need to be taken into consideration)

Medical/Physical/Environmental Issues:

Any medical and/or physical conditions that could cause or exacerbate behavior(s) need to be ruled out by a physician or specifically addressed in the plan. Any environmental factors that could cause or exacerbate behavior(s) need to be specifically addressed in the plan.

Antecedents:

The antecedents are factors or events present and/or occurring prior to the exhibition of a specific behavior. When, where, the persons involved/present, and during what activity/task, are behaviors most likely and least likely to occur. Antecedents can be singular, or a combination of multiple factors.
Antecedents may involve:

Health issues, physical limitations, sensory difficulties, emotional/psychiatric instability, poor frustration tolerance, impulsivity, difficulties maintaining focus an attention, mood fluctuations, motivational issues, sleep issues, hunger, etc.

Environmental factors (lighting, temperature, noise levels, persons, activity/task demands, etc.)

Specific antecedents may include not having demands immediately met, being told no, being given a directive the person chooses not to follow, a desire to establish a sense of control over their environment, to include over other persons, and/or a desire for attention. the perceived opportunity to successfully engage in the behavior.

Conse uences:

Consequences can either negatively or positively impact behaviors, and are responses and/or environmental changes that generally occur following the exhibition of specific behaviors. Problematic behaviors may also be inadvertently reinforced as a result of ineffective consequences.

ANALYSIS O BEHAVIORS:

unction s:

What is the purpose of the behavior, what perceived, desired or expected outcome is the behavior directed towards Examples of functions include having demands immediately met, escaping/avoiding demand or undesirable situations, immediate gratification, removal of an undesirable stimulus, and/or the responses elicited from others, such as receiving direct attention.

The function may be of an intrinsic nature, such as directed toward establishing a sense of control or reducing negative emotions, such as anxiety. The same behavior may also serve different functions, dependent on the antecedent conditions.

Behavioral Considerations:

What factors increase or decrease the potential for re-occurrence or elimination of the behavior. What strategies and interventions have been previously employed with success, or have been shown to be ineffective in regard to effectively addressing problematic behaviors.

Are behaviors inadvertently reinforced as a result of the response they elicit from others, such as successfully escaping demands, gaining immediate attention from others, manipulating others, as a result of ineffective consequences, and/or as a result of inconsistent implementation of interventions and supportive strategies

Potential Positive Reinforcers:

Reinforcers are what the individual considers to be rewarding, and can be utilized to reinforce or strengthen a desirable behavior. Reinforcers can be tangible items, access to preferred activities, or a positive response from others, such as positive feedback and encouragement. It is recommended that a variety of potential reinforcers be identified in order to avoid satiation, and also to ensure accessibility. For example, going for a walk following completion of a specific task may be very reinforcing, but accessibility is at times dependent on weather conditions.

An effective reinforcement delivery schedule will also have to be established. In some cases, it will be essential to deliver the reinforcer immediately following the exhibition of the desired behavior in order to be effective.

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DETROIT WAYNE INTEGRATED HEALTH NETWORK

MONITORING PLAN

□OR

BEHAVIOR TREATMENT PLAN REVIEW COMMITTEES

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Table of Contents

I EXECUTIVE SUMMARY

The purpose of this monitoring plan is to assure compliance of the Detroit Wayne Mental Health Authority's (DWIHN) service providers with the Michigan Department of Health and Human Services (MDHHS) Standards for Behavior Treatment Plan Review Committees (BTPRC).

Service providers within the Detroit Wayne Mental Health Authority Network of Care are delegated the responsibility for using a specially constituted committee to review and approve, disapprove, defer or discontinue Behavior Treatment Plans for consumers served by the public community mental health system of the DWIHN. Behavior Treatment Plans are those that propose to use restrictive or intrusive interventions for consumers who exhibit seriously aggressive, self-injurious or other behaviors that place the individual and/or others at risk of physical (or emotional) harm. Crisis Plans are for all consumers that do not require the use of restrictive or intrusive interventions in order to effectively address problematic behaviors.

The ***DWIHN's Behavior Treatment Oversight Committee*** is comprised of service provider representatives, DWIHN staff and **consumers**. The Committee evaluates the results of all behavior treatment plan review activities and ensures the implementation of improvement planning and corrective action as necessary. The functions of the DWIHN's Behavior Treatment Oversight Committee include:

- Review the implementation of the service providers' Behavior Treatment Plan Review Committees and evaluate each committee's overall effectiveness at least annually and documenting the evaluation of those functions.
- Review system-wide Behavior Treatment Plan Review Committee process issues, including but not limited to trends, behavior plan approvals, deferrals, disapprovals, expedited plans, and terminations.
- Review system-wide Behavior Treatment Plan Review Committee trends and patterns compared to key indicators such as psychiatric hospitalization, behavior stabilization, reductions or increases in use of interventions, crisis plans, and behavior treatment plans.
- Submit quarterly Behavior Treatment Plan Review Committee reports to MDHHS.
- Annually develop, update and approve the DWIHN's Behavior Treatment Oversight Committee goals and objectives, and periodically monitoring the attainment of these goals.
- Make recommendations for activities necessary to insure the delivery of clinically appropriate least restrictive behavior treatment services and supports.

This committee takes the lead for implementing a systematic approach to monitor service providers and DWIHN compliance with the Michigan Department of Health and Human Services (MDHHS) Standards for Behavior Treatment Plan Review Committees.

This is conducted by first focusing on monitoring the functions and roles that must exist and operate within each provider's Behavior Treatment Plan Review Committee. This includes reviewing the committee member composition and letters of appointment, as well as monitoring meeting schedules, and meeting notes.

The second effort is by focusing on the provider's compliance with Behavior Treatment Plan Standards listed in the DWIHN's policy on "Use of Behavior Treatment in Community Mental Health Settings". This is accomplished in part through the continuing development and implementation of standardized forms and formats for referrals for conducting functional behavioral assessments, referral and review forms for case presentation to the Behavior Treatment Committees, "Special Consent" forms, data collection spreadsheets, and other related formats and forms that are recommended for use by the DWIHN throughout the system.

The third effort is focusing on the on-going data collection as it is reported to the DWIHN by service providers.

The fourth is through analysis of the site review findings; analysis of data collected; and analysis of data submitted. This information will result in "cross network comparison" reports that will continually measure weaknesses, strengths, and need for improvement relative to use of Behavior Treatment Review processes within the DWIHN system. Report findings and recommendations are to be "aggregated upward" for inclusion in the DWIHN's Quality Improvement process. The annual evaluation of the effectiveness of the Behavior Treatment Plan process is to be submitted to the DWIHN Quality Improvement Steering Committee and to be addressed in the QAPIP Annual Evaluation. This information will also be utilized to identify and effectively address issues related to areas such as recidivism, Behavior Treatment Plan efficacy, expedited plan reviews, crisis plans, and other concerns.

II. Goals of Monitoring Plan

- To ensure compliance with the Standards throughout the DWIHN system;
- To determine if there is an increase or decrease in the use of restrictive and/or intrusive interventions throughout the DWIHN system;
- To determine if the use of Committee approved interventions results in more effective plans of service.
- To ensure the least restrictive behavior treatment interventions are properly employed and monitored in accordance with the Standards outlined in the MDHHS Contract Attachment and in the DWIHN Policy.
- To conduct ongoing assessment and evaluation of the implementation of the monitoring process to ensure continued quality improvement, adherence to Federal, State and DWIHN rules, regulations and policies, and compliance with all applicable laws.

III Monitoring Compliance with Data Submission

Relevant definitions for this section:

Behavior Plans: Behavior treatment plans that propose the use of intrusive and/or restrictive interventions with individuals served by the public mental health system in order to effectively address behaviors that are considered to be seriously aggressive, self-injurious or otherwise challenging and place the individual and/or others at risk of harm. These behavior plans and interventions must be presented to and approved by the Behavior Treatment Plan Review Committee prior to implementation. Behavior Plans are reviewed minimally on a quarterly basis.

Behavior Treatment: The development and implementation of a therapeutic treatment plan which utilizes positive behavioral supports, and is derived from the results of a Functional Behavior Assessment, with the purpose of modifying behavior in order to facilitate the development of alternate skills directed toward alleviating the potential for the exhibition of behaviors which place the individual and/or others at risk, or otherwise have a negative impact on self and/or others, in order to promote health and safety while enhancing quality of life.

Crisis Plans: Crisis plans do not require the use of restrictive or intrusive interventions as defined in the MDHHS Standards for Behavior Treatment Plan Review Committees, in order to effectively address problematic behaviors. Crisis Plans are to be completed by all consumers receiving services within the DWIHN service delivery area. The development of Crisis Plans are to begin during the first point of contact with the consumer. Crisis Plans are reviewed, at a minimum, as medically necessary.

Expedited Behavior Treatment Plan Review: Expedited plan reviews are requested in emergent situations when the plan requires immediate implementation. The Committee Chair receives, reviews and approves such plans on behalf of the Committee. **The Recipient Rights Office must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan.** Upon approval, generally within a short time frame such as 24 or 48 hours, the plan may be implemented. All plans approved in this manner must be subject to full review at the next regular meeting of the Committee.

Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used 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 the review and approval by the Committee.

Restrictive Techniques: Those 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. Examples of such techniques as limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting ordinary access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.

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 targeted behaviors that place the individual or others at risk of physical harm by conducting a functional assessment, and 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, and property destruction Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school work, and in the community.

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of an individual by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Physical management shall only be used on emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations. ***To ensure physical management techniques are appropriately utilized during emergency situations, the service providers must have on file, evidence of staff who have been appropriately trained and certified in the use of approved physical management and physical management techniques.*** The term "physical management" does not include briefly holding an individual in order to comfort him or to demonstrate affection, or holding his/her hand. Physical management involving prone immobilization of an individual, as well as any physical management that restricts a person's respiratory process, for behavioral control purposes is prohibited under any circumstances. The following are examples to further clarify the definition of physical management:

Manually guiding down the hand/fists of an individual who is striking his or her own face repeatedly causing risk of harm IS considered physical management if he or she resists the physical contact and continues to try and strike him or herself. However, it is NOT physical management if the individual stops the behavior without resistance.

When a caregiver places his hands on an individual's biceps to prevent him or her from running out the door and the individual resists and continues to try and get out the door, it

IS considered physical management. However, if the individual no longer attempts to run out the door, it is NOT considered physical management.

Physical management involving prone immobilization of an individual, as well as any physical management that restricts a person's respiratory process, for behavioral control purposes is **prohibited under any circumstances**.

Required data submission:

All behavior treatment data will be collected from the service providers. This data shall minimally include:

1) Cumulative listing, by ID numbers, of persons receiving behavior treatment interventions year-to-date.
2) Number of new persons during the reporting period receiving behavior treatment interventions.
3) Frequency of the exhibition of each target behavior during the reporting period.
4) Specific interventions used and dates.
5) Length of time of each intervention was implemented.
6) Behaviors that initiated the interventions.
7) Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
8) Attempts to use positive behavioral supports, but the positive behavior supports were not successful.
9) Number of physical management interventions used in emergency situations and the dates.
10) Number of requests for police intervention used in emergency situations and the dates.
11) All Critical/Sentinel events submitted as a result of Serious Challenging Behaviors, Inpatient Behavioral Hospitalizations, Injuries Requiring Hospitalization or ER/ED as a result of the behavior.

All behavior treatment data will indicate which plans were approved, disapproved, deferred, or discontinued.

What happens:

The data noted above will be collected by the service providers. From there, it is forwarded directly to the DWIHN's Behavior Treatment Oversight Committee for further review, analysis and recommendations.

How frequent:

Detailed Behavior Treatment Plan Review Committee data and committee notes are to be collected on a monthly basis, and submitted to the DWIHN on a monthly basis. This data is due to the DWIHN by the 15th of month following the end of each month (Jan 15th, February 15th, March 15th, etc.).

By whom:

The provider's Behavior Treatment Plan Review Committee is responsible for designating someone (e.g. Chair Behavior Treatment Plan Review Committee, case manager, psychologist or sub-committee member) the responsibility for capturing and documenting data available from the committees review activities. The committee member or assigned administrator must be designated to forward the detailed behavior treatment review data and committee notes to the DWIHN Behavior Treatment Oversight Committee.

What reports are produced at a minimum:

- Special data reports
- Notes from committee meetings
- Frequency and trend analysis reports
- Quality monitoring report to show degree of compliance with standards and processes.
- Encounter data reports
- Frequency of committee meetings
- Number of expedited behavior treatment plans

How are reports used at a minimum:

- To help determine effectiveness of behavioral plans that contain intrusive and/or restrictive techniques;
- To determine if there is an increase or decrease in the number of behavior treatment plans;
- To assure all behavior plans that use interventions are in compliance with the MDHHSs technical requirement and the DWIHN policy and guidelines on the use of behavior treatment committees in the community setting.
- To determine the clinical need for continuation of behavior treatment plans.

What forms are used:

The detailed Behavior Treatment Plan Data Form and other forms that will be standardized for use by the DWIHN. These documents and the related instructions sheet are attached as exhibits.

IV Monitoring Compliance with Behavior Treatment Plan Standards

Relevant Definitions in this section:

Desk audit:
Documentation review conducted to determine compliance with standards and policy guidelines.

Annual site visit:
Yearly site review conducted to determine a provider's compliance with contract expectations.

Program Monitors:
Staff who work in the DWIHN's Quality Improvement Unit.

Medicaid Verification Review:
A review conducted to determine if Medicaid covered services are properly documented and supported by encounter and claims data.

The DWIHN shall monitor behavior treatment standards by:

1) Conducting desk audits every quarter (January, April, July & October) on 5 of the total number of behavior treatment plan cases within service provider's data base. The service providers are responsible for collecting the data, and sending copies of behavior treatment plans (including the functional behavior assessment and all other relevant assessments and evaluations) and BTPRC meeting minutes and results to the DWIHN.

2) Annual site visits by DWIHN Quality Improvement Performance Monitors at the time site reviews are scheduled. One objective of this annual site visit will be to determine if the behavior treatment plan tie into the Individual Plan of Service (IPOS). Cases shall be chosen randomly by the DWIHN staff.

3) Identifying and tracking of all consumers who have intrusive and/or restrictive behavior treatment interventions as part of their plans, and all consumers who have Crisis plans. One method to accomplish this is to generate encounter data reports through the DWIHN's computer system. These reports will enable comparative reviews of the behavior treatment service plans approved by all behavior treatment committees in the system to the documented frequency those plans through the use of encounter code H2000 and are being monitored as tracked by the encounter code H2000 with TS modifiers. This monitoring method can be accomplished once per quarter, or as otherwise indicated, for submission to the DWIHN's Behavior Treatment Oversight Committee. This same quarterly data can be "rolled up" for use with the DWIHN's Medicaid Verification review which is conducted during the DWIHN Annual Review process.

4) Conducting reviews of critical/sentinel events reports submitted to the DWIHN where physical management, 911 calls for police intervention were used in emergency situations, crisis situations resulting in hospital ED/ER and/or inpatient psychiatric hospitalization.

What happens:

Desk audits, annual site reviews using Behavior Treatment Plan Review Committee checklists and a review of the IPOS and the behavior treatment plan and/or Crisis Plan, in addition to comparing findings of the Medicaid Verification review and review of critical/sentinel event cases to behavior treatment plan and Crisis Plan cases.

How frequent:

- Desk audits will be conducted by the DWIHN at least quarterly;
- Annual site visits as scheduled by the DWIHN's Quality Improvement Unit;
- Medicaid Verification Quarterly Review; as scheduled by the DWIHN's Quality Improvement Unit;
- Review of Critical/Sentinel Events cases of individuals with behavior plans and Crisis plans by the DWIHN as often as indicated.

By whom:

- The DWIHN's Quality Improvement Unit will participate in desk audits with assistance by the Contract Management Unit.
- Annual site visits conducted by the Quality Improvement Unit.
- Medicaid Verification Review will be conducted by the DWIHN's Quality Improvement Unit Performance Monitoring Section.
- Critical/Sentinel Event reviews with an eye on behavior treatment cases will be conducted by the DWIHN's Quality Improvement Unit.

What reports are produced at a minimum:

- Analysis and interpretation of desk audit findings will be conducted by the DWIHN Behavior Treatment Oversight Committee in conjunction with: Recipient Rights and Quality Divisions. Focus will be on compliance with behavior treatment plan standards.
- Annual Report on Medicaid and Contractual Compliance
- Medicaid Verification Report
- Special reports identifying Critical/Sentinel Event occurrences that either warrant behavior treatment plan review or special 30-day re-review.

How are reports used at a minimum:

- to determine effectiveness of the behavioral plans;
- to determine if there is an increase or decrease in the number of behavior treatment plans;
- to determine if restrictive and or intrusive interventions are being used according to the recommended MDHHS requirements and DWIHN policy guidelines.
- to determine what type of behaviors are being treated within DWIHN system.
- to determine the length of time and frequency of use of interventions.

What forms are used to monitor compliance with behavior treatment plan review standards:

The Aggregate Behavior Treatment Plan Data Form is currently being utilized to collect and analyze data pursuant to monitoring compliance with behavior treatment plan review standards.

The DWIHN's Quality Improvement Unit is also currently engaged in the ongoing process of development of standardized forms and formats for referrals, for conducting functional behavioral assessments, referral and review forms for case presentation to the Behavior Treatment Committees, Special Consent forms, data collection spreadsheets, and other related formats and forms that are to be implemented for use throughout the system. These standardized forms will assist in the ongoing assessment and evaluation of the monitoring process to ensure continued quality improvement

V Monitoring the unctions of the Behavior Treatment Plan Review Committees

The DWIHN's Behavior Treatment Oversight Committee shall participate in monitoring the operational functions of the providers Behavior Treatment Plan Review Committee via randomly scheduled plan reviews. Internal DWIHN reviewers will use specially designed review checklists to focus on the following key areas:

1) Does the Committee review and defer or approve or disapprove Behavior Treatment Plans utilizing intrusive and/or restrictive techniques and any other behavior techniques that require special consent, and Crisis Plans that do not require the use of restrictive or intrusive interventions to in order to effectively address problematic behaviors
2) Is the Committee reviewing and making recommendations, on all behavior treatment plans, which involve the use of psychoactive medications when it is applied for behavior control purposes and the prescribed medication is <u>not</u> a standard treatment or dosage for the individual's diagnosed condition
3) Does the Committee maintain all behavior treatment review committee meeting notes clearly delineating the actions of the Committee
4) Does the Committee meet as often as needed under the direction of the chairperson

5) Are the Committee members and the Committee Chair appointed by the service provider Executive Director for a term of not more than two years
6) Does the Committee advise the Executive Director regarding administrative and other policies affecting behavior treatment practices
7) Is there a copy of the approved behavior treatment plan in the person s record showing evidence of committee review and approval
8) Is there evidence of an evaluation of the committee s effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates
9) Is the Committee comprised of at least the three required voting individuals: one a licensed psychologist with training and experience in applied behavior analysis; and one a physician/psychiatrist, and is there also a representative of the Office of Recipient Rights participating who is an ex-officio non-voting member.
10) When proposed behavior treatment plans are forwarded to the Committee, are they accompanied by:

- A comprehensive functional behavioral assessment.
- Results of assessments performed to rule out relevant physical, medical and environmental causes of the problem behavior.
- Results of inquiries about any medical, psychological or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma.
- Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been attempted to ameliorate the behavior and have proved to be unsuccessful.
- Evidence of continued efforts to identify and utilize the least restrictive options.
- Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
- References to the literature should be included, and where the intervention has limited or no support in the literature, why the plan is the best option available.

What happens:

DWIHN staff will use various review and monitoring activities to enforce provider compliance with Behavior Treatment Plan Review Committee Standards that have been distributed by the DWIHN and the Michigan Department of Health and Human Services (MDHHS).

How fre uent:

Minimum once per year, and for cause as indicated.

By whom:

The DWIHN Quality Improvement, Contract Management and Recipient Rights staff will be assigned responsibilities to assist with the activities described above.

What reports are produced:

Compliance reports will be generated and plan of correction reports be produced with specific timelines to correct deficits.

How are reports used:

To determine the need for staff training; additional resources, areas of systemic weaknesses and strengths.

To ensure the behavior treatment processes are implemented and operating according to MDHHS standards.

To ensure active and current monitoring of the interventions to manage behaviors within the DWIHN system.

What forms are used:

Review checklist form to capture the site review findings that focuses on the areas identified above under section IV, 1-10 of this document.

VI Monitoring Compliance with Standard DWIHN Behavior Treatment Plan Review Committee orms

Issues relative to compliance and use of methods for data collection are discussed at the monthly meetings of the DWIHN s Behavior Treatment Oversight Committee.

The DWIHN s Behavior Treatment Oversight Committee will assist in determining the need for revision to and implementation of behavior treatment forms, across the system, based on the quality and usefulness of the data retrieved for analysis. The ease with which this data is extracted using various forms will help determine the need to generate new and or additional data collection methods.

What happens:

Electronic data collection methods are currently in place. Additional methods of data collection are also being explored in order to further enhance the monitoring process.

How frequent:

Behavior Treatment Plan Review Committee data is to be collected from the manual and electronic methods on a monthly basis and reviewed quarterly.

By whom:

The provider's Behavior Treatment Plan Review Committee is responsible for designating someone (e.g. Committee Chair of the Behavior Treatment Plan Review Committee, case manager, psychologist or sub-committee member) to complete and submit any Behavior Data Forms used throughout the year, utilizing the designated electronic Excel spreadsheet, and other methods of data collection required by the DWIHN. The provider committee member or assigned administrator must forward the data to the DWIHN's Behavior Treatment Oversight Committee. The committee will designate someone to forward copies to the DWIHN's Quality Improvement Unit.

What reports are produced:

- Behavior data reports (manually and/or electronically) that capture intervention usage information and compliance with processes.
- Frequency and trend analysis reports

How are report forms used:

- To determine effectiveness of Behavioral Treatment Plans (with intrusive and/or restrictive interventions) and Crisis plans being used in DWIHN system;
- To determine if there is an increase or decrease in the number of Behavior Treatment Plans;
- To determine if restrictive and/or intrusive interventions are being used in accordance to the MDHHS Standards and the DWIHN policy guidelines.
- To determine what type of behaviors are being treated with interventions within the DWIHN system.
- To determine the length of time and frequency of use of interventions.
- To capture demographic information on consumers who have intrusive and/ or restrictive interventions in their Behavior Treatment Plans.

VII Analysis and Handling of Data

Analysis of the internal and external site review findings conducted on the behavior treatment plan review processes within this system; analysis of behavior committee data collected from the monthly detailed behavior treatment data; quarterly encounter data focusing on the H2000 and the H2000 with TS modifier encounter codes; and the roll-up of that this data to supplement Medicaid Verification reviews will all result in cross network comparison reports that will continually measure system weaknesses, strengths and need for improvement, relative to use of Behavior Treatment Review processes within the DWIHN system.

Members of the DWIHN's Behavior Treatment Oversight Committee will participate in the review and analysis of all behavior treatment data and additional DWIHN internal review committees will provide recommendations.

VIII Expedited Review of Proposed Behavior Treatment Plans

The service providers with Behavior Treatment Plan Review Committees must establish a mechanism for the expedited review of proposed behavior treatment plan in emergent situations. Expedited means the plan is reviewed and approved in a short time frame such as 24 or 48 hours by service provider's BTPRC/contracted BTPRC.

Expedited plan reviews may be requested when, based on data presented by the professional staff (Psychologist, RN, Supports Coordinator, Case Manager), the plan requires immediate implementation. The Committee Chair may receive, review and approve such plans on behalf of the Committee. The Recipient Rights Office must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan. Upon approval, the plan may be implemented. All plans approved in this manner must be subject to full review at the next regular meeting of the Committee

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IX LEGAL AUTHORITY AND REFERENCES:

A. Federal Balanced Budget Act of 1997 (P.L. 105-33) 42 CFR 438.100
B. MCL 330. 1712, Michigan Mental Health Code
C. MCL 330. 1740, Michigan Mental Health Code
D. MCL 330. 1742, Michigan Mental Health Code
E. Michigan Department of Health and Human Services Administrative (MDHHS) Rule 330.7199(2)(g)
F. MDHHS/CMHSP Managed Mental Health Supports and Services Contract FY 18
G. MDHHS Medicaid Provider Manual, Chapter III, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Section 2.4 Staff Provider Qualifications.
H. MDHHS Mental Health and Substance Abuse Administration, Technical Requirement for Behavior Treatment Plan Review Committees, Revision FY 18.
I. NCQA Guidelines for Treatment Record Review (2017)

X EXHIBITS:

A. Behavior Treatment Plan Review Committee Referral Checklist Form

B. Behavior Treatment Plan Review Committee Review Form

C. Behavior Treatment Plan Development Guidelines

D. Functional Behavioral Assessment Guidelines

E. Crisis Plan Template

F. Instructions for Completing Crisis Plan Template

G. Crisis Plan Procedures

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DETROIT WAYNE INTEGRATED HEALTH NETWORK

Behavior Treatment Plan
Clinical Practice Standards Manual
□□Y □□□□□□□□

BEHAVIOR TREATMENT PLAN DEVELOPMENT

Behavior Treatment:

The development and implementation of a therapeutic treatment plan based on the principles of Applied Behavior Analysis, which utilizes positive behavioral supports, and is derived from the results of a Functional Behavior Assessment, with the purpose of modifying behavior in order to facilitate the development of alternate skills directed toward alleviating the potential for the exhibition of behaviors which place the individual and/or others at risk, or otherwise have a negative impact on self and/or others, in order to promote health and safety while enhancing quality of life.

Goals and O□□ectives:

Progress toward the established goals and objectives must be observable and measurable. Goals and objectives should also be time limited, and realistic in regard to the expectation that success will be progressively achieved. The interventions must be supported by peer-reviewed literature or practice guidelines.

Proposed Restrictive/Intrusive Interventions:

In order to justify the use of intrusive and/or restrictive interventions with individuals served by the public mental health system in order to effectively address behaviors that are considered to be seriously aggressive, self-injurious or otherwise challenging and place the individual and/or others at risk of physical harm, present evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been attempted to ameliorate the behavior and have proved to be unsuccessful.

Provide the results of consideration of any medical, psychological or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma, and documentation that the potentially harmful effects of the restrictive/intrusive procedures outweigh the potentially harmful effects of the target behaviors.

Describe the proposed intrusive and/or restrictive interventions. If medications are considered to be restrictive/intrusive, provide verification that the prescribed medications are not a standard treatment or dosage for the individual□s diagnosed condition. List the specific medications and the behaviors the medications are prescribed to address, and the name of the person prescribing the medication. Also include information from the latest medication review, stating the specific purpose for which the medication is being prescribed. If the manner in which staffing is being utilized is considered to be restrictive/intrusive, indicate the specific purpose of limiting freedom of movement or encroaching upon personal space. List the behaviors exhibited, the days and hours during which staffing is being utilized, the setting(s) in which staffing is utilized, and the specific interventions being employed by the assigned staff.

Include the provisions for the removal, decrease and/or discontinuation of the restrictive or intrusive interventions based on achieving specific criteria.

Behavior treatment plans that propose to use restrictive or intrusive techniques as defined in this policy must have the special written consent of the individual and/or legal guardian, the parent with legal custody of a minor child or a designated patient advocate prior to implementation.

Methodology and Interventions:

Program strategies and interventions are to be developed pursuant to established evidence based, best practice guidelines, while incorporating positive behavior supports in order to facilitate the development of alternate skills directed toward alleviating the potential for the exhibition of problematic behaviors. Proactive strategies are to be employed to prevent seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm from occurring or for reducing the frequency, intensity or duration.

Programming Considerations:

Most persons respond best to a structured environment, with an established predictable daily routine which provides access to a wide variety of positive tasks and activities and the opportunity to make individual choices. Prescribed interventions should also include structuring the environment to minimize the opportunity for the exhibition of problematic behaviors, while also providing contingent positive reinforcement for the exhibition of desirable behaviors.

Many problematic behaviors are exhibited due to a lack of stimulation, boredom, the inability to remain independently focused and attentive in regard to sustained participation in structured activities, frustration in regard to lack of skills related to task completion and/or participating in activities, poor communication skills, impulsivity, failure to have needs, wants, and concerns appropriately addressed, and/or as a result of control issues.

Psychiatric and/or behavioral difficulties are more likely to occur when a person is not engaged in activities which keep them focused and attentive. The exhibited inability to self initiate positive tasks and/or activities which will maintain interest and focus often results in the exhibition of undesirable behaviors.

Many behaviors are inadvertently reinforced as a result of the response they elicit from others, such as successfully escaping demands, gaining immediate attention from others, and/or manipulating others. Providing ongoing positive reinforcement of the exhibition of desired and/or socially acceptable behaviors, while minimizing the direct attention given to undesirable behaviors will encourage individuals to make reasonable choices in regard to their behavioral options. Although the **direct** attention given to problematic behaviors should be minimized, **safety** is to always remain a primary focus and concern. In order to minimize inadvertent reinforcement when immediate intervention is required to prevent

escalation of behaviors and/or to ensure safety, persons intervening should always maintain a calm composure without exhibiting an emotional response (exhibiting an absence of facial expression, while maintaining normal volume and tone of speech, and a nonaggressive posture).

Data Collection:

All behavior treatment programs must also include a data collection procedure in order to measure progress toward the established goals and objectives, and to identify the need to implement additional intervention strategies and/or make program modifications.

BEHAVIOR TREATMENT COMMITTEE RE□ERRAL AND REVIEW □ORMS:

Prior to submitting an initial, expedited, or annual Behavior Treatment Plan to the Behavior Treatment Plan Review Committee for review, The Behavior Treatment Plan Review Committee Referral Form must be completed and attached to the plan.

The Behavior Treatment Plan Review Committee Review Form will be completed and utilized during each review by the Behavior Treatment Committee to document the recommendations and decisions of the committee.

In emergent situations when the plan requires immediate implementation, it will be submitted for an expedited behavior treatment plan review, whereby the plan can be reviewed, or denied, or deferred, or approved in a short time frame such as 24 or 48 hours. All plans approved in this manner must be subject to full review at the next regular meeting of the Committee.

IMPLEMENTATION:

Once a behavior treatment plan has been approved for implementation by the Behavior Treatment Plan Review Committee and all required consents have been obtained, it will need to be in-serviced. All persons directly involved in implementation of the of the plan, staff, family members, and other caregivers, need to trained on program implementation, data collection, and any other related reporting requirements. Documentation of trainings must be maintained in the individual□s record.

Name:
Member ID :
Date of Birth:
Residence:
BTPRC Review

BEHAVIOR TREATMENT PLAN REVIEWCOMMITTEE BTPRC REVIEW ORM

Date of Plan:_____Author:_____BTPRCC Approval Date:_____

DSM 5/ICD-10 DIAGNOSES:

I/DD Dx	
Other DSM/ICD Dx	
Relevant Medical Dx	
Current Stressors	
Current GAF/GAS	

Treatment Team: Psychiatrist:_____Psychologist:_____
Therapist:_____SC/CM:_____

Is consumer involved in school, day or work program Yes ___ No___
Name/Location:_____

MEDICATIONS include Over the Counter:

Current Medication	Dosage	Frequency	Purpose

Prescribing Physician:_____
Last date of medication titration/decrease:_____
AIMS Screening date:_____ Results:_____

TARGET BEHAVIORS (describe):
1.

2.

3.

4.

5.

Name:
Member ID □:
Date of Birth:
Residence:
BTPRC Review

Cumulative Summary of Frequency Data
Months

Behavior										Severity
1										
2										
3										
4										
5										

Severity: *□il□ □not re□ultin□ in in□ury to □elf or ot□er□□□ o□erate □re□ultin□ in mil□ in□urie□ to □elf/ot□er□ □it□ □i□□ potential for □i□nificant □arm a□ a re□ult of be□avioral acceleration an□/or ne□ative/y impact□ or incite□ ot□er□□□ Severe □place□ □elf/ot□er□ at imminent ri□□ an□/or re□ult□ in □i□nificant □arm or in□urie□□*

Duration: □Average length or range of lengths of each behavior/episode)

Indicate how many times any of the following issues have been reported during the current reporting period.

Injury to self:_____Injury to others:_____Physical Management:_____911 Calls:_____

Progress since last review: Improved:____ Stable:____ Regression:____

Psychologist□s Recommendations:

Proposed restrictive or intrusive intervention(s): ***(Medications:*** *provi□e verification t□at t□e me□ication□□□ are not a □tan□ar□ treatment or □o□a□e for t□e in□vi□ual□ □ia□no□e□ con□ition□□ i□t t□e □pecific me□ication□□□ an□ t□e be□avior□ t□e me□ication□ a□□re□□□ an□ t□e name of t□e per□on pre□cribin□ t□e me□ication□Al□o attac□ t□e report of t□e late□t me□ication revie□□□tatin□ t□e □pecific purpo□e for □□ic□ t□e me□ication i□ bein□ pre□cribe□□* ***Staffing:*** *In□icate t□e □pecific purpo□e of limitin□ free□om of movement or encroac□in□ upon per□onal □pace□□ i□t t□e be□avior□ e□□ibite□□ t□e □ay□ an□ □our□ □urin□ □□ic□ □taffin□ i□ bein□ utili□e□□t□e □pecific □ettin□□□□in □□ic□ □taff i□ utili□e□□an□ t□e □pecific intervention□ bein□ employe□ by t□e a□□i□ne□ □□S □taff□□*

Is there a less restrictive/intrusive intervention that could be used to address the challenging behavior□

Criteria for discontinuation of restrictive/intrusive intervention:

Behavior Treatment Plan Review Committee □indings:

_____ Plan approved/continued as presented
_____ Plan not approved/discontinued
_____ Plan approved/continued with noted changes/revisions/comments:
_____ Plan discontinued

Name:
Member ID □:
Date of Birth:
Residence:
BTPRC Review

Notes:

_____
_____
_____
_____
_____
_____

Review: 30 days_____Quarterly_____Annually_____Other _____

Next Review Date: _____

SIGNATURES O□ COMMITTEE MEMBERS	DATE	Approve	Disapprove	Approve with Revisions	A□stain

INSTRUCTIONS FOR COMPLETING CRISIS PLAN AND ADVANCE DIRECTIVE

SECTION	STEPS
Provider/Clinically Responsible Service Provider (CRSP)	
	Identify the name of the Provider or the Clinically Responsible Service Provider (CRSP) and the contact telephone number
Identifying information	
	Write the following: • Member's name • Current Address with city and zip code • Date of Birth • Age • MH-WIN ID number • Gender • Date the section was completed
Advance Directive - Check the box	
	If yes, identify where the document can be found If no, leave blank
Client's Choice to participate in Crisis Planning – Check the box	
	If yes, complete the remaining sections of the form. If no, do not complete the remaining sections of the form. The member must sign the bottom of the form stating he/she has declined to option to complete a Crisis Plan.
How do you know when I am in crisis?	
	Provide the key elements that identify when the member is in crisis
Don't do when I am in crisis	
	Provide the negative key elements that will increase the member's behavior when they are in crisis.
Don't take me to or take me to (note both and why)	
	Document where the member does not want to go to (i.e., hospital, shelter, etc.) Document where the member who like to go when (i.e., need hospitalization, shelter, etc.)
Symptoms, Feelings or Triggers that may lead to crisis – Check the box	
	Review each of the symptoms, feelings or triggers. Check each of the boxes that meet one of the symptoms, feelings or triggers. Add additional information for those symptoms, feelings or triggers that require more explanation than a check box.
Immediate Risk Concerns – Check the box	
	Review each of the risk concerns. Check each of the boxes that meet one of the risk concerns. Add additional information for those risk concerns that require more explanation than a check box.
Support System that can help before or during a crisis	
	Include: Name Relationship

INSTRUCTIONS □OR COMPLETING CRISIS PLAN AND ADVANCE DIRECTIVE

SECTION	STEPS
	Contact Information
Professional Resources that can help	
	Identify, at a minimum, Name and Contact Information Provider Name and Contact Information Case Management Team and Contact Information
Steps to take to minimize or prevent my crisis – Check the box	
	Review the check boxes Check the boxes that are appropriate
Signatures and Date	
	Sign, print and date, as appropriate on the form: Member Family/Guardian Staff completing the form with credentials
MAKE SURE THIS DOCUMENT IS AVAILABLE IN MH-WIN AND A COPY IS GIVEN TO EACH MEMBER UPON COMPLETION	

FY 2015 Behavior Treatment Plan Review Committee (BTPRC) Data Spreadsheet for Waivers

PIHP: **CMH:**

Program	Medicaid ID	Last Name	First Name	Date of Review	Frequency for Review (Monthly, Quarterly etc.)	Issue Being Reviewed (Specify) *Use abbreviations listed on tab titled "ISSUES". May have multiple issues related to one restrictive or intrusive intervention (e.g., medication for HS, HO, PD and would be recorded on one row)*	Physical, Medical Environmental Causes Ruled Out	Interventions What Approaches are used?				Since last BTPRC review has there been an incident of: *Please enter date(s) under the applicable column(s)*					Outcome	
								Positive Behavior Support	Restrictive/Intrusive/Emergency Interventions	Medications Number of Anti-psychotics	Medications Number of Psychotropics	Harm to Self	Harm to Others	Physical Management	911 calls	Critical/Sentinel Event	Analysis	Recommendations

Comments

Issues Being Reviewed	Abbreviation
Harm to self	HS
Harm to others	HO
Property destruction	PD
Emergency use Physical Management	EMPM
Emergency use Law Enforcement	EMLE

Please add to the tab if you have additional abbreviations.

	Definition
Restrictive	Per FY 18 MDHHS CMHSP contract Attachment C6.8.3.1 Standards for Behavior Treatment Review Committees (Revision FY17) the definition is as follows: Those 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. Examples of such techniques as limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee
Intrusive	Per FY 18 MDHHS CMHSP contract Attachment C6.8.3.1 Standards for Behavior Treatment Review Committees (Revision FY17) the definition is as follows: Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control 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 the review and approval by the Committee.
Positive Behavior Support	Per FY 18 MDHHS CMHSP contract Attachment C6.8.3.1 Standards for Behavior Treatment Review Committees (Revision FY17)s: 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 risk of physical harm by conducting a functional assessment, and 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.
Emergency Interventions:	Per FY 18 MDHHS CMHSP contract Attachment C6.8.3.1 Standards for Behavior Treatment Review Committees (Revision FY17) the definition is as follows: There are only two emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement intervention. Each agency shall have protocols specifying what physical management techniques are approved for use.

Physical Management	Per FY 18 MDHHS CMHSP contract Attachment C6.8.3.1 Standards for Behavior Treatment Review Committees (Revision FY17) the definition is as follows: A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: 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. To ensure the safety of each consumer and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations.
Request for Law Enforcement Intervention	Per FY 18 MDHHS CMHSP contract Attachment C6.8.3.1 Standards for Behavior Treatment Review Committees (Revision FY17) the definition is as follows: Calling 911 and requesting law enforcement assistance as a result of an individual exhibiting seriously aggressive, self-injurious or other behavior that places the individual or others at 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 eliminatin the imminent risk of harm to the individual or others.

COLUMN	A	B	C	D	E
Why is this Information required on this spreadsheet?	**Program -** MDCH utilize this as the identifier to sort data by 1915(c) waiver programs (CWP, HSW, or SEDW) so one spreadsheet can be used for all waiver enrollees.	**Medicaid ID**- MDCH utilizes this as the identifier with regard to waiver enrollment.	**Last Name** - Self-explanatory	**First Name** - Self-explanatory	**Date of review -** The date the Committee reviewed this plan. Its purpose is to monitor that the BTPR is completed timely and in accordance Section III.I which outlines the functions of the Committee.

COLUMN	F	G	H	J	K
Why is this Information required on this spreadsheet?	**Frequency for Review –** How often the Committee reviews this plan. Its purpose is to monitor that the BTPR is completed timely and in accordance with Section III.I which outlines the functions of the Committee.	**Issue being reviewed** - What issues are related to the intervention used in the BTP that the Committee is reviewing? Please use abbreviations listed on tab titled "ISSUES". The Committee may add as many issues (and create abbreviations) as necessary. After two quarters of data, MDCH will analyze the various reasons and begin standardizing the issues and abbreviations for use state-wide. This assists in data collection and analysis.	**Physical, Medical, Environmental Causes Ruled Out -** It is important to be sure the treatment team is following up on any issues which could be contributing to the changes in behavior. Things that need to be considered, at a minimum, are health concerns (illness, injury, allergy, dental issues, etc.) Also, other things to consider - was there a change in support staff, clinicians, medications, loss of family member, etc. Or, does this person have sensory issues which are unaddressed? - This is needed in accordance with Section II. Definitions under Functional Behavioral Assessment. In addition, see Section II.I which outlines the functions of the Committee.	**Positive Behavior Support -** This is needed in accordance with Section III.H in order to determine whether positive behavioral supports and interventions have been adequately pursued.	**Restrictive/ Intrusive/ Emergency Interventions-** This is needed in accordance with Section III.I which requires the Committee, on a quarterly basis, to track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention.

COLUMN	L	M	O	P	Q
Why is this Information required on this spreadsheet?	**Medications - Number of Anti-Psychotics** - The use of these medications for behavioral control and which is not standard treatment for the person's condition is defined in MDCH Technical Requirement as "intrusive"; however, CMS defines these as "chemical restraint" for purposes of c-waiver applications. CMS has recently added sub-assurances within Participant Safeguards that will require additional oversight & monitoring by the State for waiver enrollees around use of medications for behavioral control, as well as polypharmacy for diagnosed conditions. By asking the Committee to track these, it will help MDCH prepare for the upcoming waiver renewals. See the list of medications under the tab labeled "MEDICATIONS-Anti-Psychotic".	**Medications- Number of Psychotropics** - Same explanation as Anti-Psychotics in column L. See the list of medications under the tab labeled "MEDICATION-Other Psychotropic".	**Since last BTPRC review has there been an incident of:** Harm To Self – Committee would enter date of any incidents. Suggested definition of "harm to self" is an injury that resulted in emergency medical treatment or hospitalization (this is a reportable population within Critical Incident Reporting System -CIRS). Monitoring "harm to self" is required by Attachment P.7.1.1 Section VIII F Risk Events Management for the QAPIP but the Committees also need to be aware of these events as they may have an impact on analysis and recommendations.	**Since last BTPRC review has there been an incident of: Harm To Others** – Committee would enter date of any incidents. Suggested definition of "harm to others" is an injury, that IF the other party were in a reportable population, would have been reported in CIRS because of an injury that resulted in emergency medical treatment or hospitalization. Monitoring "harm to others" is required by Attachment P.7.1.1 Section VIII F Risk Events Management for the QAPIP but the Committees also need to be aware of these events as they may have an impact on analysis and recommendations.	**Since last BTPRC review has there been an incident of emergency use of physical management** – This column is included as a double-check in case the Committee did not capture the event in Column K.

COLUMN	R	T	U	V
Why is this Information required on this spreadsheet?	**<u>Since last BTPRC review has there been an incident of 911 calls</u>** -This column is included as a double-check in case the Committee did not capture the event in Column K.	**<u>Analysis</u>** - This is needed as outlined in BTPRC Technical Requirement P1.4.1 Section III.J. which outlines the additional responsibilities of the Committee and the allows the BTPRC the opportunity to provide advice/ consultation to the treatment team and/ or the agency to be able to provide individualized & appropriate care.	**<u>Recommendations</u>** - This is needed as outlined in BTPRC Technical Requirement P1.4.1 Section III.J. which outlines the additional responsibilities of the Committee and the allows the BTPRC the opportunity to provide advice/consultation to the treatment team and/ or the agency to be able to provide individualized & appropriate care.	**<u>Comments</u>** - This is for the Committee to enter in any very specific issues to the individual which are not covered within the other sections.

Anti-Psychotic Medications:

If the individual is prescribed any of the following anti-psychotic medications, count them in DD proxy measure 51.1. Note: brand names begin with a capital letter, while generic names begin with small letters. If both the brand name and generic name for a medication are listed, the generic name is in parentheses ( ).

Abilify (aripiprazole)	Relprevv
Clozaril (clozapine)	Risperdal (risperidone)
Fanapt (iloperidone)	Seroquel (quetiapine)
Geodon (ziprasidone)	Saphris (asenapine)
Haldol (haloperidol)	Symbyax (contains both antipsychotic [olanzapine] and antidepressant [fluoxetine])
Invega (paliperidone)	
Invega Sustenna	Thorazine (chlorpromazine)
Latuda (lurasidone)	Trilafon (perphenazine)
Mellaril (thioridazine)	Zydis (olanzapine)
Prolixin (fluphenazine)	Zyprexa (olanzapine)

"Other" Psychotropic Medications:

depressants, ADHD, anti-anxiety, manic, or other), count in DD proxy measure 51.2. Note: brand names begin with a capital letter, while generic names begin with small letters. If both the brand name and generic name for a medication are listed, the generic name is in parentheses ( ).

Anticonvulsants:

Some of the anticonvulsants listed are seldom prescribed by psychiatrists. However, for our purposes, all should be counted, even though these may not be technically psychotropics.

Carbatrol	Lyrica (pregabalin)
Depakote (divalproex)	Mysoline (primidone)
Diastat (diazepam)	Neurontin (gabapentin)
Diamox (acetazolamide)	phenobarbital
diazepam (rectal, intramuscular, or intravenous)	Tegretol (carbamazepine)
Dilantin (phenytoin)	Topamax (topiramate)
diphenylhydantoin	Trileptal (oxcarbazepine)
divalproate	valproic acid
Felbatol (felbamate)	Vimpat (lacosamide)
Keppra (levetiracetam)	Zarontin (ethosuximide)
Klonopin (clonazepam) —in psychiatry, this is more commonly used for anxiety	Zonegran (zonisamide)
Lamictal (lamotrigine)	

Anti-Depressant:

Celexa (citalopram)	Effexor (venlafaxine)
Cymbalta (duloxetine)	Elavil (amitriptyline)
Desyrel (trazodone)	Lexapro (escitalopram)
Norpramin (desipramine)	Serzone (nefazodone)
Oleptro	Symbyax (contains both antipsychotic
Paxil (paroxetine)	[olanzapine] and antidepressant [fluoxetine])
Prozac (fluoxetine)	Tofranil (imipramine)
Remeron (mirtazapine)	Wellbutrin (bupropion)
Sarafem (fluoxetine)	Zoloft (sertraline)

ADHD Medications:

Adderal (amphetamine and dextroamphetamine)	Focalin (dexmethylphenidate)
Concerta (methylphenidate)	Metadate (methylphenidate)
d-amphetamine	Methylin (methylphenidate)
Daytrana (patch)	Ritalin (methylphenidate)
Dexedrine (dextroamphetamine)	Straterra (atomoxepine)
	Vyvanse (lisdexamfetamine)

Anti-Anxiety:

Atarax (hydroxyzine)	Valium (diazepam) (oral, intramuscular)
Ativan (lorazepam)	Vistaril (hydroxyzine)
Buspirone	Xanax (alprazolam)
Klonopin (clonazepam)	

Bi-Polar Medications:

Eskalith (lithium)	Lithobid (lithium)

Other Psychotropic Medications:

Ambien (zolpidem)	melatonin
Benadryl (diphenhydramine)	temazepam
Halcion (triazolam)	