



**WISCONSIN DEPARTMENT
of HEALTH SERVICES**

Restrictive Measures Guidelines and Standards

A collaborative effort of:

Bureau of Assisted Living
Division of Quality Assurance

and

Bureau of Adult Quality and Oversight
Bureau of Adult Programs and Policy
Division of Medicaid Services

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Section 1: Who is Covered by These Requirements?

These requirements apply to requests for use of restrictive measures for individuals who live in community settings in all Medicaid-funded adult long-term care programs. Medicaid funded adult long-term care programs include: Family Care, Family Care Partnership, IRIS (Include, Respect, I Self-Direct) and PACE (Program of All-Inclusive Care for the Elderly). Community settings include individuals residing in their owned or rented home, in other supported living arrangements, adult family homes (AFHs), community-based residential facilities (CBRFs), and residential care apartment complexes (RCACs). Community-based vocational settings and day service programs are also community settings.

These requirements are not applicable to individuals not enrolled in the above-referenced Medicaid waiver programs. Use of restrictive measures in a Division of Quality Assurance (DQA) licensed setting to a non-Medicaid waiver individual, must follow the DQA process and requirements for approval found in the DQA guidance memo: www.dhs.wisconsin.gov/dqa/memos/15-003.pdf.

In instances where the requested measure does not meet the definition of a restrictive measure as outlined in these guidelines and standards, the licensed provider must follow the process outlined in the above-referenced DQA guidance memo. The licensed provider should consult Wis. Admin. Code chs. DHS 83, DHS 88, or DHS 89 licensing requirements regarding the need to assure waiver participant health and safety and least restrictive treatment.

These requirements apply to any individual who receives payment from a Medicaid-funded long-term support program to provide direct support services to an individual. Common examples are providers, provider agency staff, and participant-hired workers (PHWs).

These requirements and the rule governing the approval and use of restrictive measures do not apply to unpaid caregivers. Unpaid caregivers working in conjunction with a service provider may have limitations in their use of unapproved restrictive measures if the team identifies risks inherent in their use. The inappropriate use of restrictive measures by unpaid caregivers may be considered to be abuse or neglect under elders and adults-at-risk laws outlined in Wis. Stat. §§ 46.90(1)(a) and 55.043(1)(m) and should be reported to the appropriate local elder-at-risk, adult-at-risk, or county adult protective services agency. For additional information on how to address such situations, please go to www.dhs.wisconsin.gov/aps/index.htm.

Failure to obtain approval for the use of restrictive measures according to the process and criteria contained in these guidelines and standards will be considered a violation of the individual's rights under Wis. Stat. §§ 51.61 or 50.09 and Wis. Admin. Code chs. DHS 94 or DHS 83, DHS 88, or DHS 89 as applicable, by the Wisconsin Department of Health Services (DHS). For individuals enrolled in Family Care, Family Care Partnership, or PACE such failure will also be considered a violation of the terms and conditions of the DHS and managed care organization (MCO) contract and may result in a disallowance for some or all costs associated with serving the individual. Individuals enrolled in IRIS who fail to obtain approval for use of

restrictive measures may be subject to involuntary disenrollment due to health and safety risks that participants are unwilling or unable to resolve.

Section 2: Authority

Individuals enrolled in IRIS must adhere to the guidelines and standards outlined in this document in accordance with the IRIS Policy Manual. Per the IRIS Policy Manual, “The approved 1915(c) Home and Community-Based Services waiver states the following regarding the required approval process for the use of restrictive measures: ‘For a community placement, the use of isolation, seclusion, or physical restraint shall be specifically approved by the department on a case-by-case basis.’”

The MCO and its providers must comply with the guidelines and standards contained in this document. Per the DHS-MCO contract, “[t]he MCO and its providers shall follow the Department’s written guidelines and procedures on the use of isolation, seclusion and restrictive measures in community settings, and follow the required process for the approval of such measures.”

Section 3: Prohibited Practices

Providers **may not** use the following maneuvers, techniques, or procedures under any circumstances:

- Any maneuver or technique that does not give adequate attention and care to protection of the individual’s head.
- Any maneuver, technique, or device that places pressure or weight on the chest, lungs, sternum, diaphragm, back, or abdomen.
- Any maneuver or technique that places pressure, weight, or leverage on the neck or throat, on any artery, on the back of the head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway, such as straddling or sitting on the torso, or any type of chokehold.
- Any maneuver or technique that involves pushing into an individual’s mouth, nose, or eyes.
- Any maneuver or technique that utilizes pain to obtain compliance or control, including punching, hitting, hyperextension of joints, or extended use of pressure points.
- Any maneuver or technique that forcibly takes an individual from a standing position to the floor or ground. This includes taking an individual from a standing position to a horizontal (prone or supine) position or to a seated position on the floor.
- Any maneuver or technique that creates a motion causing forcible impact on the individual’s head or body or forcibly pushes an individual against a hard surface.
- Any use of seclusion where the door to the room would remain locked without someone having to remain present to apply constant pressure or control to the locking mechanism.

Section 4: Emergency Use of Restrictive Measures

MCOs and IRIS Consultant Agencies (ICAs) are required to obtain prior approval for use of restrictive measures from DHS. DHS will make an exception to the requirement for prior approval if the situation meets the definition of an emergency use of restrictive measures.

An emergency use of restrictive measures only applies to situations that either have not occurred before or have not occurred more than two times in a six-month period and the team does not anticipate will occur again. If the team anticipates this type of situation is likely to occur again or it has occurred more than twice in a six-month timeframe, the situation does not meet the definition of an emergency use of a restrictive measure. Once the provider anticipates an ongoing need for a restrictive measure, the team must request approval for its use. All future interventions to respond to such a situation require the team to go through the planning and approval process contained in these guidelines and standards.

Restrictive measures may be used in emergency situations only to protect the individual or others from harm, must be the least restrictive approach possible, and must be used for the shortest time possible. Each instance of emergency use of a restrictive measure warrants completion of a critical incident report.

All of the following conditions must be present for an emergency use of a restrictive measure:

- An individual's behavior poses an immediate threat of harm to self or others.
- There is no approved behavior plan for the individual dealing with the planned use of restraint, isolation, or protective equipment intended to address this behavior, or there is an approved plan but it failed to anticipate a significant escalation in intensity or severity of the behavior.
- The behavior in question has either not occurred previously or could not have been reasonably foreseen to occur based on observations of the individual's behavior.

In the emergency situation, the provider or provider agency staff should implement de-escalation strategies to the extent possible. De-escalation strategies are a series of steps including techniques such as response blocking, response interruption and redirection, and graduated physical guidance.

If all alternative measures tried prove to be ineffective, the emergency situation continues, and is placing the individual or others at imminent risk of harm, the provider may use emergency manual restraint, isolation, or protective equipment to protect the person or others from harm. The restrictive measure chosen should be the least intrusive option likely to be effective. If the initial measure is ineffective, the provider may use other measures involving greater restriction. Providers should document in the individual's file the use of each measure, the reasons the provider selected the measure, and a description of why any measure was not effective. Providers may reference documentation of these explanations in preparation for future applications for restrictive measures.

The provider must address the following requirements to be able to use emergency restrictive measures:

1. **Written policy:** Each provider agency must have a written policy describing the process used in the event staff need to use an emergency restrictive measure. The policy must identify the specific person or type of position that is authorized to select and initiate the emergency use of the restrictive measure and is responsible for related procedures when an emergency situation is present. At minimum, the policy must require those using the measure to obtain eventual authorization by the agency director or designee as quickly after its use, as is feasible. Such authorization must be limited to the specific current emergency episode. The provider is required to document the date, time, and method of all attempts at notification.

Individuals who utilize PHWs may outline emergency use of restrictive measures specific to the individual by completing a Risk Agreement, F-01558:

www.dhs.wisconsin.gov/forms/f0/f01558.docx.

2. **Release criteria:** The team ensures the provider agency staff person, director, or the director's designee has established individual-specific release criteria for the specific situation. Release criteria documentation must include a description of any conditions that must be present prior to releasing the individual. The criteria for release should also identify cues that are unique to the individual for determining if he or she appears to be calm and is no longer a danger. Any threats to an individual's health or well-being caused by the measure during its application require the immediate release from the restrictive measure and notification of supervisory personnel or medical personnel (if the individual requires immediate medical care).
3. **Reauthorization of use:** Direct support staff using the measure must obtain reauthorization for the use of the measure from the agency director or designee if an emergency recurs after release from restraint.
4. **Time limits and physician orders:** The agency director or designee may initially authorize use of restraint or isolation in emergencies for up to one hour. After an hour, the provider must attempt to contact the individual's physician to obtain a written authorization from the physician for continued use of the measure. The physician's initial authorization is limited to a maximum of two additional hours. The physician may reauthorize the use of the measure selected, if needed. The provider must document physician authorization in the individual's file.
5. **Training of staff:** The provider must ensure direct support staff applying or using the restraints or protective equipment is adequately trained and able to use the techniques competently. The provider should proactively seek the assistance of external professionals when needed to assist staff in responding to the emergency. The provider should outline the training curriculum in the written emergency procedure policy.
6. **Measure employed must be monitored:** The use of the emergency restrictive measure must be monitored in a manner that conforms to the requirements in these guidelines and standards including collecting data on the frequency per incident and the duration (number of minutes), each restrictive measure was utilized.

7. **Involve law enforcement when necessary:** If the dangerous behavior during the emergency reaches a point where staff believes they are not able to manage the situation effectively or safely and that harm to the individual, staff, or others is likely to result, staff should call appropriate law enforcement authorities for assistance. DHS recommends proactive discussions occur with local law enforcement and the team develops a plan that details the desired outcome for situations involving law enforcement.

Section 5: Training Information and Submission of Restrictive Measures Requests

Training of Involved Staff

All staff involved in the administration of restrictive measures must receive adequate training. Training must occur prior to implementing any restrictive measure and, at minimum, annually. Assurance of training of all individuals involved in the administration of restrictive measures is the responsibility of the team. Training must include proactive strategies to intervene at the first signs of tension to prevent further escalation, information about how to use specific restrictive measure techniques or devices properly, and how to inspect the device or equipment. DHS is not requiring a specific training curriculum for direct support staff on techniques of restrictive measures, but DHS may request information from teams on the training curriculum used and on the qualifications of the individuals conducting direct support staff training to determine how teams are addressing this need.

Preparing the Restrictive Measure Request

Providers are strongly encouraged to work with representatives of MCOs or ICAs early in the process to ensure they are aware of the expectations related to the application process. MCOs and ICAs are encouraged to be sensitive to the fact that many providers will be working with different agencies. MCO and ICA differences will make the process more difficult and frustrating for providers; therefore, MCOs and ICAs must try to work with one another to create a consistent process. DHS staff will attempt to facilitate this to the extent possible.

The information the provider submits to the MCO or ICA should conform to the requirements and expectations in these guidelines and standards, plus any additional requirements required by the MCO or ICA. DHS expects provider agency managers to review and approve the application internally before it is submitted.

The ICA or MCO must submit restrictive measures requests, along with all additionally required or supplemental documentation, electronically through the DHS restrictive measures online application.

Authorized users may access the online application through the LTC Information Exchange System (IES): <https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html>.

Behavioral Requests: The team must submit a behavioral request if a restrictive measure is necessary to ensure safety during a situation when the individual's behavior will put themselves or others at imminent risk of serious harm. If the measure is necessary to act as a form of behavioral control during a medical procedure or while a medical condition exists, the team

must also submit this information as a behavioral request. All behavioral requests must include a behavior support plan.

Medical Requests: The team must submit a medical request if a restrictive measure is necessary to ensure the safety of an individual due to a medical procedure or condition. The individual's medical condition must not be related to a challenging or dangerous behavior, such as, the medical condition is not caused by an intentional behavior or an intentional behavior is not occurring because of a medical condition. Restrictive measures used to complete medical procedures in a medical or dental professional's office do not require DHS approval.

The team must assess the use of any mechanical support to determine if it is a medical restrictive measure. Such devices can become restrictive measures requiring DHS approval for use if the method of use prevents or limits functional access by the individual to parts of their body or limits intentional, controlled, and purposeful movements or mobility **and** the individual cannot easily remove the device. If the team determines the device is acting as a medical restraint, the MCO or ICA must submit a request to DHS for approval.

When a device is acting as a medical restraint, a service plan addressing how to respond to the existing medical condition is required and all medical requests must include a plan or protocol for use of the measure(s).

Restrictive Measure Request Drafts

MCOs and ICAs may revise an application until submission to DHS. Upon submission to DHS, the system locks the request and MCOs and ICAs cannot edit it until DHS logs a response in the IES online application.

Section 6: MCO Restrictive Measures Oversight

MCOs are required to have an internal restrictive measures oversight committee. The MCO oversight committee must review restrictive measures proposals and either approve the proposal as submitted, approve the proposal with conditions, request additional information, or deny the proposal. All MCO decisions must be in writing, identify each measure reviewed separately, describe reasons for the return or denial, include any conditions of approval along with adequate descriptions of these conditions, and someone in a management position designated by the director of the MCO must sign the notification. Denials must also offer information for both the provider and individual or legal decision maker to grieve the decision. DHS recommends the communication provide guidance on what revisions the provider can make to remedy the defects in the returned or denied application. **The MCO must approve the provider's request before the MCO submits the request to DHS.** Provider requests to DHS for input, advice, or technical assistance regarding restrictive measures must also come through the MCO.

DHS recommends the MCO approval process parallel the process used by DHS. MCOs must have a written and easy to understand description of the review and decision-making process for providers to reference. The process must describe:

- All of the elements of the review, including the identification and description of the established point of contact for applications.
- The method used to review the application and who will participate (type of position, not necessarily a specific person) in the review.
- The method of communication used to communicate the results of the review to the provider.
- The grievance process made available to providers if a provider wishes to contest the MCO decision.

Section 7: IRIS Participant Restrictive Measures Assistance

Individuals enrolled in IRIS may choose who they would like to be involved in the development of their behavior support plan and restrictive measures request. The IRIS consultant can be a great resource to assist during this process. IRIS participants and those they have selected to develop their behavior support plan will gather the necessary documents listed in these guidelines and standards. The ICA must review the information and ensure all required components of the restrictive measures request are complete prior to submission to DHS. The ICA may delegate this duty to either their internal quality assurance staff or manager within the ICA. The ICA will initiate the DHS review process by ensuring the request is complete in the restrictive measures online application. Provider requests to DHS for input, advice, or technical assistance regarding restrictive measures must come through the ICA.

Section 8: Review and Approval Process for Restrictive Measures

Obtaining Approval Prior to Intermittent Treatment Program (ITP) Discharge

The MCO or ICA **must** have DHS approval for all use of restrictive measures prior to an individual's discharge from an ITP. Upon an individual's admission to an ITP, the team and the ITP staff should discuss possible restrictive measures recommendations for community as an agenda item starting with the first update meeting. DHS recognizes the ITP staff may not have recommendations during the first few meetings as they get to know the individual and support needs. However, it is important to consider whether there will be a need for restrictive measures in the community as soon as possible after admission. These quality discussions around the need for restrictive measures in the community setting will give MCOs or ICAs necessary information to adequately plan for provider needs, as well as planning time for the restrictive measures application process.

Obtaining Approval Prior to a Provider Change

It is necessary for MCOs or ICAs to resubmit a restrictive measures request when an individual will be transitioning to a new provider.

Until DHS grants approval for the use of the measure, the provider must complete a critical incident report for each use of the unapproved restrictive measure in the new setting.

Expedited Review

When urgent and unanticipated events occur, the MCO or ICA may request an expedited review from DHS.

A request for expedited review must contain the usual submission information, including required attachments, but DHS will accelerate the review timeframe. All expedited approvals will expire after no more than six months. A renewal submission is required 45 business days prior to expiration. If DHS approves an expedited request without the required physician's authorization, the MCO or ICA will have 30 business days to submit the physician's authorization to DHS once the individual has moved into the home with the new provider.

Division of Medicaid Services Review and Approval

MCOs and ICAs will submit restrictive measures requests to DHS. The DHS restrictive measures review panel will be comprised of staff from the Bureau of Adult Quality and Oversight, Bureau of Adult Programs and Policy, and DQA (as applicable to the request).

DHS will base approval of restrictive measures requests on all of the following:

- The team must cooperate to develop and approve the submission, which includes authorization by the MCO or acknowledgment by the ICA, providers, and the individual (or legal decision maker, if applicable).
- An authorization or approval from a medical practitioner is required for all restrictive measure requests. The team must obtain a physician's authorization annually, must list the requested restraints, and must include any contraindications for the use of the restraint.
- Documentation that the provider has tried less restrictive strategies and interventions that were ineffective.
- The plan details use of the measure only when the individual's behavioral response presents an immediate danger to self or other people. This does not include property damage, yelling, throwing objects, verbal threats, etc.
- The restrictive measure proposed is the least restrictive approach available to achieve an acceptable level of safety for the individual. This applies to each measure proposed and to the interactive effects, if any, of all such measures.
- There is a detailed description or images of each requested restrictive measure. Images are required for new requests, but renewal requests may include detailed written descriptions of the measures instead of images.
- When requesting initial approval and upon renewal of isolation or seclusion rooms, photos of the room and seclusion room locking mechanism must be included with the request.
- The plan specifies frequencies and intervals for monitoring an individual during use of a restrictive measure for signs and symptoms of adverse effects on their health and well-being specified. The selection of the frequency of monitoring depends on the individual and the measure used, but must not be less than once every 30 minutes and in the plan must clearly indicate the frequency. When plans include the use of isolation or seclusion, staff must ensure continuous visual monitoring.
- The plan outlines the maximum duration of continuous application of the measure for each instance of use.

- The plan outlines the release criteria from the measure. Staff must release the individual from the measure when the criterion identified in the plan is met.
- The provider does not use restrictive measures in lieu of adequate staffing or for staff convenience.
- The staff adequately ensures the health, safety, welfare, dignity, and other rights while the restrictive measure is in use.
- All staff involved in the use or monitoring of the restrictive measure must receive training prior to implementing it to ensure staff uses the measure properly. Staff must receive ongoing training on the use of the measure, at minimum, annually.
- The team's supervision, monitoring plan, and backup arrangements are adequate to ensure effective responses to unanticipated reactions to the measure that might arise.
- The request contains a reasonable plan for reducing or eliminating the need for using the measure as soon as possible. Teams should not think of restrictive measures as the solution for addressing the dangerous or challenging behavior but should instead think of them as a temporary strategy used to maintain safety.
- The plan includes a measurable benchmark that would lead the team to consider eliminating the use of the measure in an effort to determine whether the plan is effective.
- The request includes information related to how, protective equipment or other types of devices are checked regularly to ensure they remain in good working condition.
- The request includes information about how often the team will meet to engage in a formal review of the use of the restrictive measure to ensure it remains the most effective method to meet the individual's support needs.

Requirements for Denial - Pending Additional Items Notices

If DHS requires more information or clarification from the team prior to approving or denying a request, DHS will send a denial pending additional items, also known as DHS feedback, notice to the MCO or ICA via IES. The team will be required to respond to the questions and requests for additional information in the notice within two weeks. The MCO or ICA must request an extension from the DHS RM Coordinator if the team needs additional time to gather the requested information. If DHS does not receive a response within 45 business days of the date of denial - pending notice, the request closes. If the team wishes to pursue approval after that point, the MCO or ICA must submit a new request.

Section 9: Use and Continuous Monitoring of Restrictive Measures

The approval process for restrictive measures is a continuous process that does not end with the approval decision by DHS. The team must continually monitor the use of any approved restrictive measure according to an individual-specific plan that must accompany each submission. Continuous monitoring should address whether or not less restrictive supports are available as an alternative to use of the restrictive measure.

Restrictive Measure Data

Data collection is a requirement for all approved restrictive measures, including for those supported in self-directed settings. The provider must collect data, which includes the

frequency per incident and the duration (length of time) each restrictive measure was utilized. The data must also indicate which specific restrictive measure staff utilized. Teams must include a summary and analysis of the data with the application. DHS will not accept raw data sheets. The provider must submit a blank data collection form with any request that did not receive previous approval by DHS.

Permanent Revocation or Temporary Suspension of Approval

DHS may revoke approval at any time upon a determination there has been a negative impact on the individual. This may be either temporary or permanent. Cause for such an action may include a finding that there has been a substantial deviation in some aspect of the plan for using the measure or failure to adequately meet the conditions of approval. DHS or the MCO may also amend approval by imposing new or additional conditions, if the need is determined. The MCO must submit new imposed conditions of approval to DHS and the conditions are subject to DHS review and approval.

ICA, MCO, or DHS staff may impose suspensions on-site without written notification. The entity imposing the on-site suspension verbally must follow up with a written notification confirming the suspension, explaining the reasons for the suspension, and describing the action the provider needs to take in order to remove the suspension in a timely fashion. The entity imposing the suspension must send the written follow-up to the provider (with copies to the other approval bodies) within five business days of the ICA, MCO, or DHS verbal order suspending approval, even if DHS, the MCO, or ICA has lifted the suspension before the notification is delivered.

On-site suspensions take effect immediately. Continued use of the restrictive measure is a violation of the individual's rights. The MCO or ICA must maintain the written notification of suspension and the associated provider notes in the individual's file. Approval authorities will not accept grievances of suspensions; if the entity imposing the suspension does not find sufficient evidence to lift the suspension, the provider will have to resubmit an application in order to use the measure.

DHS intends suspensions of approval to be temporary pending further fact-finding and review. MCOs and ICAs should consider suspensions an interim step toward either restoration of the approval or towards revocation. DHS, MCOs, and ICAs must remove suspensions if the provider corrects the problem situation.

After the suspension, the MCO or ICA will conduct a fact-finding investigation to determine if the reasons for the suspension have merit. If the results of the fact-finding investigation indicate that the restrictive measure is not effective, is being misused, or is having unanticipated harmful effects, approval of the use of the measure will be revoked. The MCO or ICA must complete fact-finding for a suspension within 30 business days of the initial notice of suspension.

If the results of the fact-finding investigation substantiate the suspension, the MCO or ICA must notify DHS. DHS will communicate revocation of the approval of the measure in writing. Notices will provide the reasons for the revocation and include grievance rights for all parties involved. **DHS prohibits the provider from using the measure when approval has been suspended or**

revoked. If the provider continues intent to use the same restrictive measure, the process for obtaining approval must start over.

Discontinuing the Use of the Restrictive Measure

Providers will be required to discontinue the use of a restrictive measure if the team determines the use of the restrictive measure is not effective or no longer necessary. The provider must also remove discontinued restrictive measures from the individual's support plan. If the provider intends to use a previously discontinued measure in an emergency, criteria in section 4 of these guidelines must be met. Following the decision to discontinue the use of a measure, the MCO or ICA is responsible for entering the discontinuation date, the discontinue reason, and a letter of discontinuation into the previously approved request in the IES.

Section 10: Renewing Requests for Restrictive Measures

Approval for all restrictive measures, other than requests submitted for expedited review, will expire no later than one year from the date of approval. As stated previously, restrictive measure requests submitted for expedited review will expire no later than six months after the date of approval. In some instances, the review panel may approve a request for less than one year.

The MCO or ICA must submit a renewal request if the need to use a restrictive measure continues after the initial approval period. The MCO or ICA must submit the renewal via the IES 45 business days prior to the previous approval expiration date.

If an individual has approved restrictive measures and changes from one Medicaid-funded adult long-term care program to another or enrolls in a different ICA or MCO, the current plan may remain in place temporarily. The new MCO or ICA must submit a restrictive measures request to DHS within 90 business days of the enrollment change.

Data Analysis

When the team enters restrictive measure use data into the IES, the system will provide a graphical summary to demonstrate use and patterns. Teams are required to review this summary and provide an individualized analysis prior to requesting a restrictive measures renewal. For behavioral requests, the data analysis should outline if there are any patterns, trends, or correlations to when target behaviors are more or less likely to occur and what intervention strategies have been most effective. Analysis should also describe changes to the plan, if any, the team made because of the data analysis. The team may provide additional data collection, graphs, and analysis as attachments to applications, as needed.

Section 11: Incident Reporting for Restrictive Measures

The MCO or ICA must complete a critical incident report for each use of an unapproved restrictive measure.

The MCO or ICA must also complete a critical incident report upon discovering the provider used an approved restrictive measure in a manner outside of the approved plan.

Section 12: Contesting Restrictive Measures Related Decisions

All decisions made with respect to restrictive measures are subject to grievance, other than suspension of use, if there is disagreement with the decision. A grievance may come from an individual, their legal decision maker, a provider on behalf of the individual, or any person filing on behalf of an individual.

Individuals who receive treatment for mental health, substance abuse, or developmental disability may also follow the grievance process outlined in **Wis. Admin. Code Ch. DHS 94** to grieve decisions related to the use of a restrictive measure. The individual, their legal decision maker, a provider acting on behalf of the individual or their legal decision maker, or any person filing on behalf of an individual, who wishes to contest or grieve decisions of DHS or an MCO, related to the use of restrictive measures, should follow this clients rights complaint process: <https://www.dhs.wisconsin.gov/clientrights/complaints.htm>.

Grievance by IRIS Participants

IRIS participants have the right to complain, grieve, or voice their opinion about any IRIS matter, including the use of restrictive measures. The overall system for appeals and grievances in the IRIS program offers participants various options to resolve differences. IRIS participants may make complaints verbally, in person, or in writing, in an attempt to resolve the complaint before filing a grievance. DHS encourages participants to talk with their IRIS consultant agency or IRIS consultant if they disagree with a decision or are not happy. Working with the ICA or consultant directly is usually the fastest and easiest way to address concerns. Participants may file complaints with their IRIS consultant, IRIS consultant agency, MetaStar, or DHS.

If the participant does not want to, or was unable to resolve the complaint, he or she can choose to file a grievance so that an IRIS ombudsman or mediator can help.

Participants may file a grievance in any of the following ways:

- Calling MetaStar at 1-888-203-8338
- Calling Disability Rights Wisconsin at 1-800-928-8778 (for participants who are between ages 18-59)
- Calling the Board on Aging and Long Term Care at 1-800-815-0015 (for participants who are age 60 or above)
- Completing and submitting an IRIS grievance form: www.dhs.wisconsin.gov/forms/f0/f01212.docx .

IRIS participant may find additional information in the IRIS Participant Education Manual: www.dhs.wisconsin.gov/publications/p01704.pdf.

Grievance by Family Care, Partnership, and PACE Members of the MCO Decision

Family Care, Family Care Partnership, and PACE program members have the right to file a grievance regarding the MCO's decisions related to the use of a restrictive measure. The existing MCO grievance process applies to all member grievances related to the use of or denial of use of restrictive measures, other than the decision to suspend use. Each MCO has a written description of their grievance process and written protocols for explaining member rights, including the right to be free from restrictive measures and the right to prompt and adequate treatment. Members or their legal decision makers who wish to contest or grieve MCO decisions related to the use of restrictive measures should follow this process.

Members may file a grievance in any of the following ways:

- Contacting the individual's MCO care management staff or an MCO member rights specialist
- Calling MetaStar at 1-888-203-8338

Grievance of DHS Decisions

DHS assumes in cases such as these that the individual or legal decision maker, provider, and MCO or ICA agree about the need for the measure. If the team agrees about the use of a restrictive measure and DHS either denies or imposes unacceptable conditions on approval, the MCO or ICA may contact the Bureau of Adult Quality and Oversight restrictive measures coordinator directly or by general email at dhsbmcrm@dhs.wisconsin.gov to discuss the denial or imposed conditions of approval. The ICA or MCO may work with the provider to update documents and submit an updated or new restrictive measure request based on the feedback DHS provided prior to the original decision to deny the measure or impose conditions of approval. DHS's restrictive measures review panel will review the updated or new request and proceed with the approval or denial process.

Appendix A: Definitions

Behavior Supports: Behavior supports refer to the components of an individual's environment intended to encourage behaviors that replace challenging or dangerous behaviors and help the individual attain their desired quality of life. Behavior supports may include, but are not limited to, teaching the individual methods to communicate better with others, expanding the opportunities for developing relationships, improving the quality of living environments, or other clinical interventions.

Behavior Support Plan: A behavior support plan is a written document, specific to the individual, intended to inform direct support staff how to assist the individual in building pro-social and adaptive behaviors. Behavior plans also include direction on how to utilize other supports, strategies, and interventions in order to ensure safety and to decrease the individual's challenging behavior. For individuals with restrictive measures, the behavior support plan must include information about the use of the restrictive interventions. The plan must include a description of the proposed step-by-step procedures for applying or implementing the restrictive measure, along with a description of how it will be monitored and the criteria that govern release of the individual from the measure. The plan should also identify the maximum duration for the use of the measure. In addition, the plan must address the methods or strategies the team will employ to attempt to reduce or eliminate the restrictive measure. For individuals who have a behavior support plan, the ICA or MCO must attach the plan to the individual service and support plan or member-centered plan as an addendum.

Challenging or Dangerous Behavior: Challenging or dangerous behaviors refer to the individual's behavioral response during an incident that place the individual or others at risk of serious harm. Teams must only incorporate restrictive measures into an individual's support plan for use when the individual's behavior puts themselves or others at imminent risk of serious physical harm.

De-escalation Strategies: Strategies direct support staff use to help an individual return to a baseline, adaptive, or calm state. Strategies may include:

- Staff adopting a caring but neutral position.
- Remaining calm and using a calm tone of voice.
- Paying attention to the individual; listening, focusing on feelings, and validating them; empathizing; being nonjudgmental (in both body and verbal language).
- Reminding the individual of potential consequences to their behaviors and that he or she is in control.
- Staff working to reduce environmental stressors.
- Trying to determine what he or she wants and offering solutions or alternatives.
- Drawing the individual into a more pleasant, positive, and grounded state.

Emergency: An emergency, as it relates to restrictive measures, means an unanticipated situation has occurred where an individual suddenly engages in dangerous behavior, placing themselves or others at imminent, significant risk of physical injury, or exhibits signs known to

be precursors of such behavior for the individual. This may include the appearance of a behavior that has not happened for years or has not been known to occur before or it could include current behaviors that suddenly and unexpectedly escalate to an intensity the team has not seen before.

IRIS Consultant Agency: The IRIS consultant agency (ICA) is the entity DHS has certified to provide flexible and specialized support that is responsive to an IRIS participant's needs and preferences for long-term care services. The ICA's roles and responsibilities focus on supporting the participant in self-direction, which includes enrollment, service planning, and continued eligibility. Additional information may be found in the IRIS Participant Education Manual: www.dhs.wisconsin.gov/publications/p01704.pdf

Isolation: See Appendix B.

Isolation by Staff Withdrawal: See Appendix B.

Managed Care Organization: A managed care organization (MCO) is the entity DHS has certified as having capacity for financial solvency and stability and which has agreed to make services in the benefit package available to individuals enrolled in Family Care, Family Care Partnership, and PACE. Additional information regarding services and the benefit package is available in the DHS-MCO contract: www.dhs.wisconsin.gov/familycare/mcos/contract.htm.

Manual Restraint: A manual restraint, including physical holds and escorts, involves one or more people holding the limbs or other parts of the body of the individual in order to restrict or prevent their movement. DHS does not consider the following actions to be manual restraints or restrictive measures:

- Holding an individual's limbs or body to provide support for the achievement of functional body positions and equilibrium, such as supporting someone to walk or achieving a sitting or standing position.
- Holding an individual's limbs or body to prevent him or her from accidentally falling.
- Use of self-protection and blocking techniques in response to aggressive behaviors.
- Use of graduated guidance, assisting the individual to move, but not restricting body movement or forcing body movement, as part of an approved intervention.

Mechanical Support: A mechanical support is any apparatus used to provide proper alignment of an individual's body or to help an individual maintain their balance. Mechanical supports include but are not limited to, postural supports, position devices, and orthopedic devices. The team must utilize a qualified professional to design a plan for use of mechanical supports in accordance with principles of good body mechanics, with concern for circulation, and with allowance for change in position. Mechanical supports must not impair or inhibit visual or auditory capabilities or prevent or impair speech or other methods of communication.

Medical Procedure Restraint: Medical procedure restraints utilized while under the care of medical professionals in a medical or dental office or while receiving treatment in a clinic or hospital, do not need to be approved by DHS as long as the medical provider is directing staff who accompanies the individual.

MCOs or ICAs must submit a request to DHS for approval of a medical procedure restraint when the procedure is occurring in the individual's home, day program, or other nonmedical setting. Staff may only use medical procedure restraints when necessary to accomplish a specific diagnostic or therapeutic procedure ordered by a medical professional. The use of the restraint must only occur for the minimum duration necessary to complete the procedure. As stated earlier in this document, if the medical procedure restraint is necessary as a form of behavioral control, the MCO or ICA must submit a behavioral request.

Protective Equipment: Protective equipment includes devices that restrict movement or limit access to areas of one's body. Protective equipment refers to devices applied to any part of an individual's body to prevent tissue damage or other physical harm **and** the individual cannot easily remove the device. Protective equipment must not impair or inhibit visual or auditory capabilities or prevent or impair speech or other methods of communication. Protective equipment includes, but is not limited to:

- Helmets, with or without face guards
- Gloves or mitts
- Wheelchair seatbelts
- Shower chair seatbelts
- Bedrails
- Wrist cuffs
- Ankle straps
- Goggles
- Pads worn on the body
- Clothing or adaptive equipment specially designed or modified to restrict access to a body part

DHS does not consider the following protective equipment devices to be restrictive measures:

- Mechanical supports as defined in these guidelines.
- Wheelchair seat belts or foot straps, bed rails, and other transportation safety devices such as stretcher belts intended to prevent an individual from accidentally falling or slipping during transport.
- Motor vehicle seat belts or harnesses with buckle guards or similar devices in place to ensure a passenger is unable to remove the safety belt in a moving vehicle.
- Professionally designed therapeutic devices to promote optimal motor functioning.

Provider: An individual or agency that receives payment from a Medicaid funded long-term support program to provide direct support services to an individual.

Release Criteria: Criteria specified in the behavior plan, which, once met, would result in the termination of the use of the specific restrictive measure for that incident. The criteria for release should identify cues that are unique to the individual for determining if he or she appears to be calm and is no longer exhibiting behavior that puts someone at imminent risk of harm. Upon release, staff must offer the individual the opportunity to move about. If

appropriate to the situation, the staff should also give the individual the opportunity to have food and drink and to attend to their other needs.

The individual must be released:

- When the criteria outlined in the plan is met.
- If the criteria for releasing the individual from isolation, seclusion, or protective equipment have not been met within 60 minutes of the first use of the restraint.
- When the use of an approved manual restraint has lasted 15 continuous minutes.
- When the individual's behavior has not been dangerous and he or she has been calm for five full minutes.
- If there are any threats to the individual's health or well-being from use of the measure.

Restraint: A restraint is any device, garment, or physical hold that restricts the voluntary movement of, or access to, any part of an individual's body **and** the individual cannot easily remove it.

Restraint to Allow Healing: The treatment of acute medical conditions such as lacerations, fractures, post-surgical wounds, skin ulcers, or infections may require the use of a restrictive measure to allow healing. The use of a restraint to allow healing must include a protocol for use. The protocol must be for the specific device or procedure, include the rationale for its use, and specify the limited period of time it may be used. The MCO or ICA must submit a restrictive measures request to DHS if the restraint to allow healing will be utilized for more than three months.

Restrictive Measure: The term used to encompass any type of manual restraint, isolation, seclusion, protective equipment, medical procedure restraint, or restraint to allow healing as defined in these guidelines.

Restrictive Measure Oversight Committee: This refers to the group of people, developed by the MCO, who are responsible for the review and approval of any requests for the use of a restrictive measure prior to submittal to DHS.

Seclusion: See Appendix B.

Staff: Any individual who receives payment from a Medicaid funded long-term support program to provide direct support services to an individual. Common examples of staff are providers, provider agency staff, and participant-hired workers (PHWs).

Supported Living Arrangement: Services that offer supports to individuals who require assistance to live in the least restrictive community setting possible and to engage in community life. Examples of supported living arrangement settings include an individual's own home, rented home, or family home.

Team: In these guidelines, the term team refers to the individual, their legal decision maker, if applicable, MCO care management staff, IRIS consultants, the provider, and any other person the individual wishes to be a member of their team. Teams may include, if possible, the

individual's family members, physician, other professionals involved with the support of the individual, and other people who are significantly involved in the individual's life.

Voluntary Movement: In relation to restrictive measures, voluntary movements are movements the individual is able to control and that are purposeful.

Appendix B: Definitions of and Information Specific to Isolation and Seclusion

This appendix defines and clarifies isolation and seclusion with examples and situations.

Isolation: Isolation is the involuntary physical or social separation of an individual from others by the actions or direction of staff, contingent upon behavior.

DHS does **not** consider the following examples of situations Isolation or a restrictive measure:

- Staff separates an individual from others to prevent the spread of communicable disease.
- An individual goes to another area to cool down, the individual's presence in that room or area is voluntary, and there are no adverse consequences to the individual if he or she refuses to go there. If a behavior plan includes a directive to an individual that he or she go to another area to calm down, it must be clear if this a suggestion the individual may refuse without any adverse consequences.
- An individual decides on their own, without any suggestions or prompting from staff, to go to another area, this is voluntary and does not constitute isolation. If staff suggests to an individual that he or she should go to another area to calm down and the individual chooses to go, this is also voluntary and does not constitute isolation.

At times, a physical or social separation from others may occur, but the intent of the action must be considered in order to determine whether isolation is occurring. For example:

- A behavior plan may direct staff to use a physical escort to move an individual to a different room or area of the home. Without additional information, the intent of this is unclear, and DHS would ask the provider for clarification. If the intent was to separate the individual from others, then this **would** constitute isolation. If the intent was solely to move the individual away from an unsafe location (such as away from broken glass on the floor, direction out of someone's home they entered after eloping or out of a busy road), then this **would not** constitute isolation.
- Two individuals are fighting in a narrow hallway and staff needs to implement a physical restraint with the aggressor. Staff initiates a physical escort and moves the individual out of the hallway to a location with sufficient room to implement a stationary physical hold safely. Even though the individual is being moved away from the housemate, the primary intent was not to separate them, so DHS **would not** consider this scenario to be isolation.
- Staff directs the individual to go to another area to calm and the individual goes because he or she believes they must go (such as someone who tends to comply automatically with staff directives), this **would** constitute isolation because the individual is unable to refuse or unaware that he or she has the option to refuse.
- If an individual is engaging in dangerous behaviors in an area where peers are located and staff directs the peers to leave the area, this **would not** constitute isolation. Staff is simply verbally directing the peers to go elsewhere to attempt to ensure safety.
- It is **not** considered isolation if an individual is involuntarily isolated from others in response to their behavior, but the staff allows the individual to leave the area he or she had been taken or directed to whenever he or she likes (such as before the individual has calmed).

- If an individual were involuntarily isolated from others in response to their behavior, and staff remains with the individual in the area he or she is directed to or taken to, this **would** constitute isolation if the individual must meet criteria of calm prior to leaving.
- If a home has a room built for the use of seclusion and an individual is involuntarily isolated from others in that room, but staff does not engage the locking mechanism, this **would** constitute isolation if the individual must meet criteria of calm prior to leaving. If, at some point, staff engages the locking mechanism on the door, isolation has ended and the use of seclusion has begun. Isolation and seclusion are two distinct measures, and staff must document the frequency and duration of the use of each separately.

Isolation by Staff Withdrawal: Isolation by staff withdrawal occurs in situations where, for safety reasons, the support team determines staff should withdraw from the individual due to the presence of behaviors that present imminent risk of harm to staff. When staff withdraws, they retreat to a predesignated room or area for a specific amount time to allow the individual to calm. It is considered to be isolation by staff withdrawal when the individual is either unlikely to follow, or unable to follow, or unable to reach staff after they have retreated to the designated area. Typically, this involves staff locking the door between them and the individual, but not always. If staff go into the office and close the door without locking it because they know the individual would never try to enter the staff office, this would also be isolation by staff withdrawal. If staff goes into the basement and leaves the door open, knowing the individual would never try to follow them, this would also constitute isolation by staff withdrawal.

While staff have retreated to the area the individual is unwilling or unable to access, they must be able to assure the safety of the individual through an appropriate method of monitoring (such as windows, auditory monitoring, video monitoring, ceiling-mounted mirrors, peephole in door). If, at any time, staff is not able to monitor the individual directly, staff must leave the secure area to ascertain safety. When submitting request for approval of the use of isolation by staff withdrawal, a diagram of the home's layout or images of the home must be provided for the review panel to ascertain how much of the home can be observed from the area staff is isolating in. Consideration must also be given to environmental risks to the individual, such as potential for self-harm or elopement. Approval will take into consideration whether the individual shares supports and any potential impact this would have on others.

During isolation by staff withdrawal, the individual will have access to most, if not all, of the home while staff is in another area. If a behavior plan states staff need to move away from an individual or give the individual space in response to a behavior, it must clearly define giving space. For example, is staff supposed to simply move a few feet away from the individual, yet remain in the same room? These details are necessary to ensure applications to use isolation by staff withdrawal are clear and staff clearly knows the expectations in these types of situations.

Seclusion: A restrictive measure in which staff physically set the individual apart from others inside a room using locked doors equipped with a pressure-locking mechanism. Seclusion does not include the use of devices like "wander guards" or similar products that may also involve locking doors. DHS does not permit the use of seclusion as a form of behavior modification or as a consequence for noncompliance. DHS only permits the use of seclusion as a response to a

behavior that involves an imminent risk of harm and for the shortest duration possible to maintain safety. Examples of appropriate use of seclusion are to ensure safety of the individual and others due to prolonged physical aggression or to clear an area of harmful items, such as broken glass. The behavior support plan must indicate the method staff uses to transport an individual safely to seclusion.

DHS permits seclusion only with the use of a pressure-locking mechanism that requires the constant manual application of some form of pressure to maintain the locked condition. **DHS does not permit locking an individual in any room where the door would or could stay locked without constant pressure under any circumstance.** Other requirements around the use of seclusion include continuous visual monitoring, safety precautions specific to the individual's needs (non-breakable windows, recessed lighting, adequate ventilation, padded walls or floors), and adequate room size.

When the MCO or ICA submits a request to use seclusion, information should be provided as to whether it is a newly constructed seclusion room or has previously been inspected and approved. The Bureau of Adult Quality and Oversight (BAQO) and Bureau of Adult Programs and Policy (BAPP) requires inspection and approval of newly constructed seclusion rooms by the DHS Restrictive Measures Coordinator, or a designee, prior to use. The MCO or ICA must arrange with the restrictive measures coordinator or designee to travel to the home and complete the inspection prior to the use of the new seclusion room. The minimum acceptable standards for a seclusion room are:

- The room must be at least the size of a small bedroom so there is sufficient space for the individual to move.
- Features are in place to allow staff to engage in continuous visual monitoring of an individual in the room, such as an observation window with ceiling-mounted mirrors or video cameras.
- The room must have adequate ventilation, heating, and cooling.
- The locking mechanism must be a pressure-locking device, such as magnetic locks or another mechanical device that requires the continual presence of support staff to apply pressure to keep the door lock engaged.
- Padding of the walls and floors is required in the room if the individual is likely to engage in self-harm (such as head-banging or hitting walls) to the extent that such behavior could cause significant injury if the padding was not present.
- There must be efforts to ensure the individual would not be able to reach or damage any light fixtures in the room (such as recessed lighting or high ceilings).
- There must be protective covering over any electrical outlets in the room.
- There must be protective covering or specialized windows in place to ensure the individual would not be able to break any windows in the room.
- If a mirror is located in the room to ensure staff can see all areas of it, the mirror must be made of a non-breakable material or have protective covering around it to prevent the individual from being able to break the mirror.

Appendix C: Supporting Individuals with Complex Behaviors

This appendix provides information to teams to assist with supporting individuals who have complex behavioral health supports.

Rule Out Medical Conditions

A best practice in determining the reason behind any sudden change in mood or behavior is to rule out possible medical conditions that could be contributing towards the change in condition. The team should determine whether there are any medical conditions contributing to the challenging or dangerous behavior and implement interventions to reduce or eliminate symptoms. After the team has ruled out or addressed medical issues, they should explore other stress triggers.

Determining the Reason Behind the Challenging Behavior

All behavior serves a function. The team can assist with completion of a wide variety of assessments to gain useful and essential information about the factors associated with the individual's challenging and dangerous behaviors. These assessments may include:

- **Medical and health assessments** determine whether any illnesses, injuries, conditions, efficacy of current treatments or medications, pain concerns, or dental health issues affect, contribute, or even cause the challenging and dangerous behavior.
- **Quality of life assessments** determine the extent to which an individual has or has not realized their preferred lifestyle and vision of him or herself. Such assessments should consider the amount of control the individual has over their immediate environments and whether the individual lives the way he or she wants to live. This includes whether the amount of independence the individual has during daily activities is acceptable to the individual; how much access the individual has to friends, family, and places in the community; and the extent to which these factors influence behavior.
- **Environmental assessments** determine if factors in the individual's physical environment cause or contribute to the challenging behavior. These may include noise level, space, attractiveness, cleanliness; access to desired materials or possessions; opportunities to make decisions and choices about the physical environment; the responsiveness of others present in the places the individual frequents; and the individual's communication style and how housemates, friends, family, staff, and others communicate and interact with the individual.
- **Functional assessments** identify the purpose or function of the individual's challenging and dangerous behavior. This assessment may include an analysis that systematically manipulates and studies antecedent and consequent events, which may influence the individual's behavior. This analysis helps the team to understand the function of the behavior.
- **Psychiatric assessments** identify if a psychiatric condition is present, identify the extent to which it may influence the dangerous and challenging behavior, identify if psychotropic medication may be recommended, and determine whether changes or additions in current medication are necessary.
- **Other assessments**, such as a trauma, sensory evaluation, speech and language, communication, hearing, happiness, psychological, or psychological needs assessments,

help to determine if there are other factors that may be influencing or causing the individual's dangerous and challenging behavior.

Record Behavior Information and Intervention Strategies

Data collection is the process of gathering and measuring information in order to examine trends and evaluate the effectiveness of interventions. It serves a twofold purpose:

1. Functions as a tool to help identify new and emerging behaviors, potential triggers, and successful ways to respond.
2. Determines the effectiveness of the supports and interventions when the team incorporates known patterns and trends into a plan.

The team should collect and analyze data on behaviors, as this information is critical to the development of a behavior support plan and its ongoing evaluation. For example, does the data indicate behaviors targeted for decrease are in fact decreasing and behaviors targeted for increase are increasing? If the goals of the behavior plan are not met (or at least showing some improvement), the team's hypothesis for the function of the behavior may be incorrect and further assessment is needed or some of the planned strategies and interventions are ineffective and need to be revised. Reviews may also involve monitoring the collected data to determine whether staff utilize and follow the plan as intended.

Formalizing Behavior Support Plans

All behavior, including challenging and dangerous behavior, has a purpose and meaning for the individual. Teams must treat individuals who exhibit challenging behaviors that may cause harm to themselves or others with respect and ensure individuals have a high quality of life.

A behavior support plan is a written plan intended to provide unique strategies or specific protocols as a method to build on positive behaviors and replace or reduce a challenging behavior. This may include improving communication, enhancing relationships, or using clinical interventions. The purpose of the plan is to ensure the team supports the individual in the most effective manner possible, while understanding cultural and personality differences, maintaining self-worth, opportunity, and respect. The plan focuses on being mindful, individual-centered, and trauma-informed, while supporting the individual in the least restrictive and most integrated manner possible.

Positive behavioral supports offer an approach for developing an understanding of why an individual engages in the challenging and dangerous behavior and focuses on supporting them in a respectful, dignified, and person-centered manner through empowerment, choice, and connections in order to prevent the reoccurrence of behaviors with negative outcomes.

Behavior support plans provide caregivers a structure to strategize support in a way that is unique to a given individual. Preparation of a behavior support plan can be a valuable forum for gathering input from everyone involved. Once complete, a behavior support plan has numerous uses. For ongoing staff, the plan is a behavioral snapshot that is useful as a summary of current support strategies, as well as a future gauge of progress. For new staff, the plan provides information about the unique needs of the individual. A behavior support plan can serve as a detailed written record of the team's work to support an individual.

In order for individuals to attain and maintain the highest quality of life, the support team must provide the individual with positive, proactive, and consistent support and understand the social, physiological, medical, and environmental influences to challenging and dangerous behaviors. The goal of any positive support strategy is to improve quality of life. A plan meets this goal by teaching the individual skills or strategies that increase their ability to meet their own needs and thereby increase the individual's autonomy. Approaches outlined in the plan must be flexible and incorporate, as appropriate, a full integration of social, emotional, environmental, occupational, intellectual, spiritual, and physical wellness. It is through this holistic and balanced plan that the individual and support team can maximize strengths, preserve rights, learn and enhance skills and tools, maintain resilience, and create positive social change to fit the individual's needs, preferences, and outcomes.

There is a common misperception that a behavior support plan fixes the individual or behavior. Although the plan will assist in reducing the likelihood of challenging and dangerous behavior through replacement of adaptive and desirable behavior, the main intention is to devise a consistent caregiver approach that best supports the individual's well-being.

Components of Behavior Support Planning

This section guides the team through planning supports around an individual's challenging behavior.

- A. Assembling the support team and brainstorming: It is necessary to have input from all parties providing support to the individual for the team to best understand what the individual is trying to convey through their behavior and to create support strategies that will actually work for this unique individual. Team members bring different and valuable information based on their relationship with the individual.
- B. Describing the challenging and dangerous behavior (also referred to as target behavior):
Things to consider:
 - What are the behaviors of concern?
 - What would you see and hear during the behavior? What does the behavior look and sound like for this specific individual? (Include specific statements the individual uses.)
 - How long does the behavior last? How often does it occur? Does the individual repeat the behavior?
 - What need is the individual trying to fulfill? (escape, avoidance, attention, stimulation, pain relief)
 - What emotions does the individual connect to the behavior?
- C. Discussing situations and circumstances where behaviors are likely to occur (such as triggers and meaning). Questions to ask:
 - Have the individual's physical needs been addressed by staff?
 - When is the behavior most or least likely to occur? (confrontation, under or over-stimulated, specific activity, specific request from others, power struggle, specific time of day)
 - Where is the behavior most or least likely to occur? (Home, day program, outing, doctor visit)

- With whom is the behavior most or least likely to occur? (Staff, family, peers, strangers)
- What activities are most or least likely to produce the behavior? (Transition, familiarity, routine)
- Are there positive or negative stressors? (Family visit, holiday, hungry, tired, in pain, ill)

D. Noting behavioral signs and signals that occur prior to the behavior:

- Does the individual change their tone of voice or content of language? (Yelling, mumbling, negative self-talk, threats)
- Repeated questioning of others or refusal of task? (Power struggles)
- Does the individual have a change in facial expression or body language? (Glaring, staring, grimacing, pouting, arms closed, stomping)
- Is there a change in activity or engagement level? (Pacing, fidgeting, invading personal space)
- Are there signs the individual is over or under-stimulated? What are the potential causes (no activity, large crowd)?

E. Identifying how staff should respond to the individual when the behavior occurs such as:

- Engage with the individual by using appropriate eye contact.
- Use a non-threatening approach and engage in de-escalation strategies.
- Be positive and be personalized in the approach.
- Suggest the individual go to another area to calm.
- Direct staff to not react to certain behaviors, as appropriate.

Questions the team should consider when developing the staff's verbal and physical responses:

- What self-soothing and self-calming strategies does the individual know?
- What calming strategies can staff assist with?
- What can staff say in the situation?
- How should staff deliver the message? Include specific examples of what usually works with the individual. What approaches should staff avoid? (Power struggles, dismissal, complaining, lack of empathy)
- What amount personal space does the individual prefer?
- How should the staff position themselves to maintain safety?
- What restrictive measures techniques are approved as part of the plan? What are the criteria for use, maximum amount of time, criteria for release, and documentation required if used? (May not be applicable to all behavior support plans)
- What are emergency procedures if additional staff or police intervention is needed?
- Should the staff and the individual engage in a discussion of behaviors after the incident is over?

F. Identifying how staff can support and engage the expression of safer, alternative behavior:

- What is the best approach to interacting with the individual? (Rapport, nonverbal communication, staffing pattern)
- What types of praise, reassurance, and positive support does the individual like?

- What type of activity does the individual like? (Quiet, social, long or short duration, physical or sedentary)
- What stress coping mechanisms does the individual know? What new coping mechanisms can staff teach the individual? When is the best time to practice new coping mechanisms? Include sensory integration if it is beneficial to the individual.
- What are the individual's likes and dislikes? (Objects, food, smells, type of music)
- What type of environment does the individual prefer? (Lighting, temperature, number of people, noise level)
- What does a consistent routine or timely communication about routine changes look like for the individual? Does the individual need gradual introduction of new information, new routines, or a new residence?
- Is there a reward or incentive program for positive reinforcement of appropriate behavior (tangibles or special activities)? Does the incentive program cause stress or anxiety for the individual? Is everyone involved following the incentive program the exact same way?

Essential Elements of a Behavior Support Plan

A thoroughly developed behavior support plan typically contains the following elements.

- A. **Introduction to the Individual:** Provide a summary of the individual's personality, family involvement, living situation (setting and with whom they live), likes and interests, strengths, dislikes, cultural considerations, communication preferences and accommodations, daily routine (the usual work, school, or activity schedule), and behaviors of concern.

An introduction to the individual may include an exploration into medical diagnoses the individual has, a focus on their strengths, and any identified challenges. This should not simply be a summary of what the individual is "not capable of doing," but instead be a positive approach to working with the individual and improving their quality of life. The goal here is if someone did not know the individual, and were to read this, they would have an accurate "snapshot" of the individual.

- B. **Psychosocial History:** Provide a summary of the individual's life experiences, essential for caregivers to know. By providing caregivers' with information on the life experiences the individual has encountered, this can cultivate compassion, understanding, and patience when interacting with the individual, and can assist staff to have a better understanding of why the individual may exhibit challenging or dangerous behavior.

This history could include:

- **Family history:** Includes information about where the individual was born, where the individual grew up, and important relationships in the individual's life (spouse, significant other, parents, siblings, and children).
- **Significant recent events:** Major life changes the individual experienced in the recent past, which might include deaths, hospitalizations or institution for mental disease stays, residential moves, change of primary care providers, job loss or change, or new diagnosis or medical condition.

- **Legal involvement:** Include information about any pending charges or convictions, such as probation, parole, registered sex offender status, mental health commitments, court orders, and restraining orders.
 - **Residential background:** A summary of prior living situations, such as independent living, community residential settings, any institutionalizations, frequency of residential changes, and what led to the change.
 - **Complex needs:** Information detailing challenging and dangerous behaviors the individual previously demonstrated, but no longer occur, including the reason behind the behavior and what successes led to the elimination or reduction in the behavior. Also, include what interventions have been previously attempted for the existing challenging and dangerous behavior (medication regime, psychological evaluations, hospitalization, behavioral interventions), including what has worked and what has been unsuccessful.
 - **Trauma history:** Examples of past trauma experiences can include, but are not limited to, emotional, physical, or sexual abuse, neglect, or observation of these occurring to others in the past. Triggers refer to those things that take the individual back to the traumatic event. When an individual exhibits a behavioral response triggered by past traumatic experiences, the behavioral responses can be exaggerated or seemingly coming from nowhere. The response may seem to be huge in comparison to the situation that triggered the response.
 - **Diagnostic history:** An individual with complex behavioral health needs is likely to have diagnosed conditions in their treatment records. It is important to think of a diagnosis as only one part of understanding an individual because, as an individual changes and is assessed by different providers, their current diagnosis may change.
- C. **Health Concerns and Care Coordination:** Identify chronic and acute medical conditions that are or could be attributed to challenging and dangerous behavior, how chronic and acute conditions are coordinated and monitored when identified as stress triggers, and which medical caregivers should be contacted, if any.
- D. **Stages of Behavior:** Identify how the individual signals a given behavior stage and tailor strategies for support during each specific stage, including proactive and reactive supports. Common stages of behavior include:
- **Adaptive:** Describe the individual’s baseline or normal behavior (how the individual appears when calm, regulated, and comfortable around others and in their environment).
 - **Tension:** How the individual presents when irritable or tense. This is the optimal time to intervene in order to prevent the situation from escalating to the next stages.
 - **Emotional Distress:** How the individual emotionally responds when experiencing mental distress, mental suffering, or mental anguish.
 - **Physical Distress:** How the individual physically responds to their environment and others when experiencing psychological distress, suffering, or anguish.
 - **Recovery:** Describe the physical signs that demonstrate the individual is coming out of a state of distress or beginning to calm down.

- E. **Approved Restrictive Measures:** Include specific restrictive measures approved as part of the individual's supports. It is essential to include when it is appropriate to use the restrictive measure, maximum length of time, criteria for release, and documentation of use.
- F. **Restrictive Measures Reduction and Elimination Plan:** Teams should not think of restrictive measures as the solution for addressing the dangerous or challenging behavior but should instead think of them as a temporary strategy the team will work towards eliminating as quickly as possible. The plan should include what alternate support methods the team will attempt to work toward reducing and eliminating the need to use restrictive measures, as well as a measurable goal or benchmark that, once met, would lead to the team consider eliminating the use of the measures.
- G. **Notification of Team Members:** Outline the process and criteria for direct caregivers to notify supervisors, legal decision makers, and other stakeholders of behavioral events.
- H. **Review Schedule:** Identify the people responsible for reviewing the plan for effectiveness and safety. This section should also include the frequency of review, as it is important to conduct a regular review of these plans for efficacy. Indicators that the behavior support plan will require a more rigorous review schedule are frequent incident reporting, involvement with law enforcement, county crisis services, psychiatric hospitalizations, and frequent provider or caregiver changes.

A plan review is the optimal time to ask what is working or not working and why. Behavioral incidents present as an opportunity to explore whether the behavior support plan was used, whether it was helpful to caregivers, and whether it kept the individual, staff, and peers safe.

When specific target behaviors no longer exist, the team should highlight the successes staff are having and ensure the plan matches the strategies staff is actually using to support the individual. This will also provide new caregivers and settings with the same tools, so they are not starting from scratch and will know how to best care for the individual from the start.

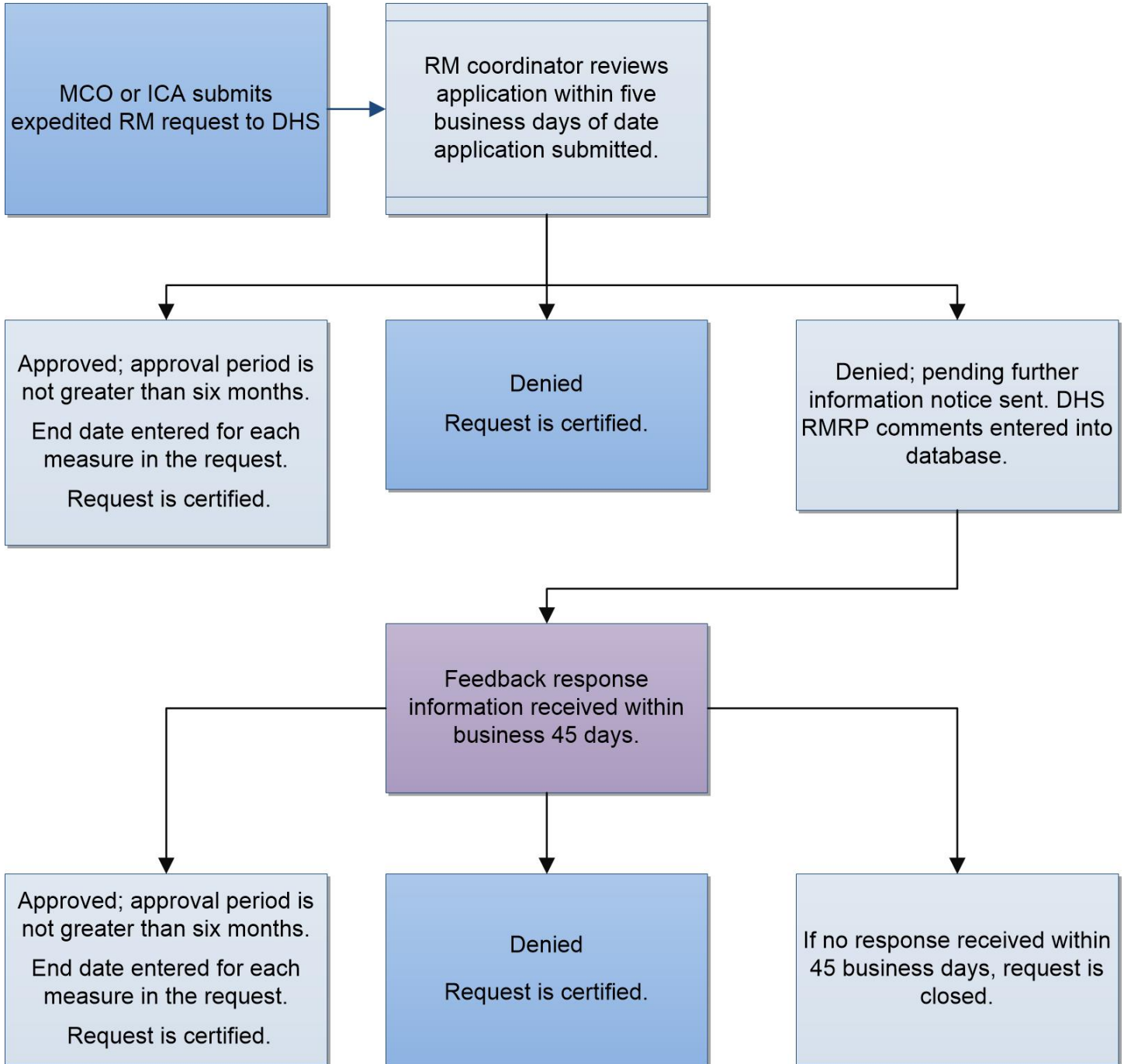
- I. **Addendums to Behavior Support Plans:** In some support situations, it may be helpful to have additional information accompany a behavior support plan as an addendum.

Examples of addendums include:

- Proactive police and emergency professional plans, which include the team's preference for outcome of police contact, such as returning the individual to their home if safety is not a concern.
- Protocols about use of specific restrictive measures.
- Images or diagrams of specific approved restrictive measure techniques.
- Completed client rights limitations or denials forms.
- Information about the individual's incentive program, if applicable.
- Protocol about use of prescribed PRN (as needed) medications.

Appendix D: Request Flowcharts

Expedited Restrictive Measure Review Flowchart



Standard Restrictive Measure Review Flowchart

