Ohio | Department of Developmental Disabilities

Behavioral Support Strategies FAQ

Person-Centered Planning

Q. *Can consent be given for only the ISP but NOT the behavior support strategies in the plan?*

A. No, the ISP and behavior support strategies are no longer separate plans. If there are team members who dissent to a part of the ISP, the team needs to reconvene and come to agreement on what strategies are acceptable and which strategies will be removed. The planning process is a team-oriented function that requires agreement from all involved parties, including the person. Please remember that restrictive strategies require informed consent.

Q. *What are some acceptable ways to prove/document that a risk of harm is direct and serious?*

A. Through already established practices such as the UIR, doc sheets, case notes, MUI process, Discovery, medical records, counseling assessments/notes, and etc. With this rule change, the Ohio Department of Developmental Disabilities (DODD) did not create prescriptive forms for documentation or interweaving the ISP and BSP together.

Human Rights Committee

Q. *Will self-advocates take the same training to be on an HRC or will there be training geared for them?*

A. Yes, all members of the HRC must attend the required training, including self-advocates. If a member is having difficulty understanding the material, reasonable accommodations should be made in order for the person to be able to participate.

Q. *Is there a minimum number of training hours for HRC members? Can it be combined?*

A. There is no stated number of training hours only specific training topics for each committee member.

Q. *Who is approving training at DODD?*

A. DODD has approved training in advance and announced this to the field through the Pipeline, the DODD Website, Behavior Support Workshops and other communication methods. All new HRC members must complete the same required training. Annual training is completed by selecting one of six pre-approved webinars/modules from the DODD Webinar Catalogue.

Q. *Do plans need to be reviewed by HRC every 90 days or just the team?*

A. The minimum requirement states the team needs to review the plan every 90 days and annually by HRC. The team is reviewing the plan to ensure the restriction is still warranted and cannot be discontinued or lessened.

Q. *Can there be more than one HRC committee in a facility?*

A. Yes, the requirement is to have an HRC in the facility and County Board, but how those are created and implemented is up to the organization.

Q. *Does the SSA turn in the entire ISP for review to the HRC or just the behavior portion?*

A. Each HRC will need to decide how much information they would like to see in order to make an informed decision about the proposed restrictive measure(s).

Q. *The required 90-day review that is in rule, how is this review done? Does it have to be a formal team meeting or can it be done in other ways?*

A. The 90-day review can be done in a manner that best fits the team. It does not have to be formal.

The Role of Ohio Department of Developmental Disabilities

Q. *Does the rule apply to people in nursing facilities and other places by Ohio Department of Health?*

A. No, this rule only applies to DODD certified providers of specialized services and County Boards.

Q. *Are hospitals being trained since they receive Medicaid dollars?*

A. No, hospitals do not follow guidelines under this rule.

Q. *Is the Behavior Add-On affected since BSPs are being woven into the ISP?*

A. No, a person can receive the Behavior Add-On without having restrictive measures in their interwoven plan. For the person to be eligible for the Behavior Add-On, one must meet the criteria for the add-on assessment. Rule states the person SHALL receive the add-on if all criterion is met. All new Behavior Add-ons are paid for by DODD and submitted through the CRM Imagine application. (http://dodd.ohio.gov/workspace/Pages/default.aspx)

This is the current link to the most up to date Behavior Add-on guidance (2017).
http://files.constantcontact.com/141902ea301/953a0567-91c8-405c-8fb4-8d0394d227f6.pdf

Q. *On Restrictive Measure Notification (RMN) reporting, what about risks of harm or risks of legal sanction that require restrictive strategies that are not "behaviors"? IE, fall risk*

A. For purpose of the RMN, DODD is only interested in behavior related restrictions. If the restriction is due to a medical condition, then it does not fall under the Behavioral Support Strategies rule and would not need to be reported on the RMN.

Q. *Licensure says yearly physical; the person does not want to have it completed. Accreditation says his choice, but licensure rule says he has to. What do you do?*

A. Document your attempts along with the date and time of all appointments. Accreditation and licensure alike are looking to ensure the person had ample opportunity and choice to have preventative medical care.

Rights Restrictions

Q. *Restitution – a person receiving services understands what money is, how it works, and that damage to items cost money to replace. This person has behaviors that they damage other's property and house property – where and what does restitution look like?*

A. If restitution is part of a behavioral strategy (and all of the above is true) the informed consent must be thorough. Meaning that the person is fully aware that at any time they can choose to not pay the restitution. They should be aware of what alternatives there are and what legal sanctions might result, etc. Teams should seriously consider what exactly this means. Historically, we have generally found that most individuals do not realize a person can't 'make them' pay for something they've broken. Often times their financial assessments do not support the understanding of the value of money that the behavioral strategy includes.

Q. *What about GPS devices for children?*

A. If there is a paid waiver provider in place and the GPS device is utilized for behavioral purposes and the person is required to wear/use it, the device and its function of monitoring will need to be approved by HRC.

Q. *What about restrictive strategies for roommates? Then how do you assess roommate, track, and monitor?*

A. There is not a requirement for a roommate to have a behavior strategy due to the other roommate's actions. There is no need to track or monitor the roommate. If restrictive strategies are put in place, the roommate should have access to any locked items and be able to live freely in their home.

Q. If *Thicket or pureed food prescribed as a treatment for a medical condition (swallowing disorder) is it considered a rights restriction?*

A. No, a modified diet ordered for a medical condition is not considered treatment for behavioral challenges. Every effort should be made to help support the individual in following their medically necessary prescribed diet. Modified diet textures such as mechanical soft, thickened liquids, chopped or pureed are ordered to aid someone in proper swallowing. Not following these diets place an individual

at risk for choking, aspiration and even death. If an individual not wish to follow their prescribed diet, then the team should reconvene to discuss the risks, ensure individual/guardian understand the risk, needed supports and communicate such conversations with the prescribing physician. Often there are supports that can assist the individual with exercising their choices while still following their dietary guidelines.

Q. *What if the individual agrees to a restriction within the context of an ISP? (If they are requesting the help)*

A. All restriction strategies would need to be approved by HRC along with informed consent from the individual and/or guardian.

Q. *Guardians who are in favor or choose "restrictive" that are not imminent risk or legal sanction, how do you handle that?*

A. Guardians are a member of the team and do not supersede the rule requirements for implementing a restrictive measure. A guardian's decision must meet rule criteria. It is the responsibility of both the ISP/IP team and HRC to ensure the requests of the guardian follow the rule.

Q. Are alarms, chimes, or bells restrictive?

A. Alarms, chimes, or bells are not restrictions but it's the action staff take when the alarm goes off that could be a restriction. If a staff person won't let the person leave the room or house, then it is restrictive. If the person is able to continue moving where they want to go, then it's not a restriction. The only time the alarm, chime, or bell would become restrictive in itself is situations where the person does not want it (asks that it be removed, etc…) and the team believes it must be kept due to risk of harm. It would go through all the approval of restrictive measure steps at that point.

Manual Restraint

Q. *Manual Restraint – there is no time limit on the manual restraint… I am certain this does not mean there is no limit at all, my thought is it is the same guidelines as the Time Out?*

A. Some crisis intervention models do include time limits, but there is no specific limit in the rule. The other guidelines require it to be used only when there is risk of harm. This means that the restraint should cease as soon as risk of harm is no longer met. Each team and HRC committee will need to assure that the strategies they authorize are the least restrictive action that assures health and safety of all; including the individual in distress. The strategies should include the limits so that everybody involved is implementing as safely as possible.

Q. *Does blocking, as in blocking someone from self- injurious behavior, constitute physical (manual) restraint or is it only when we place our hands on them that it is considered manual restraint? At our last accreditation, the surveyors stated that blocking is not manual restraint. I just want to make sure when we*

are incorporating behavior strategies into the new Imagine plans that I am not informing the SSAs wrongly.

A. Blocking someone from self-injurious behavior is not a manual restraint but there are some things to consider.

- Blocking egress due to behaviors is time out.
- Putting a pillow between the floor or wall and somebody's head would not be restraint (manual or mechanical).
- Putting my forearm up to block when somebody goes to hit me would not be restraint. I should also remove myself from the situation and not put any force toward them with my arm.
- Grabbing their hands to prevent them from hitting their head would be a restraint.
- Grabbing somebody to turn and push them away (a blocking move in one of the common crisis programs) when they are trying to hit you would be a restraint because you put your hands on them. Even if you used a blocking pad to push them away you're still putting force on them and it would be considered a restraint.

Q. *Is "graduated guidance" hands on for short "assist" considered restrictive?*

A. For graduated guidance to be considered restrictive, it depends on the amount of resistance and pressure applied during the intervention.

Chemical Restraint

Q. *If medication/sedation is used for dental work, etc., should on-going attempts to try without medication/sedation occur at each annual review or is it sufficient to try one time only? Or should each appointment be a time to try without sedation first?*

A. It is not necessary to try without sedation/medication as long as the method used is a method that would be used for a person with or without a disability. The use of sedation should be individualized and their medical and trauma history considered. The use of sedation should be reviewed with the person's physician/specialist if they have certain medical conditions. For some people waking up after sedation can also be traumatic. There are several person-centered tools and webinars on the Training @ DODD page that can help teams understand trauma and alternative measures to use.

Assessment Qualification

Q. *How do people get trained to be qualified to develop behavioral strategies. Is their training an SSA can take to become qualified?*

A. The requirements are specifically for the assessments related to and the development of behavioral strategies. The qualifications for those that perform those functions are:

(6) Persons who conduct assessments and develop behavioral support strategies that include restrictive measures shall:

(a) Hold professional license or certification issued by the Ohio board of psychology; the state medical board of Ohio; or the Ohio counselor, social worker, and marriage and family therapist board; or
(b) Hold a certificate to practice as a certified Ohio behavior analyst pursuant to section 4783.04 of the Revised Code; or
(c) Hold a bachelor's or graduate-level degree from an accredited college or university and have at least three years of paid, full-time (or equivalent part-time) experience in developing and/or implementing behavioral support and/or risk reduction strategies or plans.

- That being said, a) and (b) are licensure/certification requirements that would require education and training outside of the DODD service delivery system. You would need to refer to the governing boards for those entities for that information.
- Some of the SSAs may already qualify under (c). They should already have the bachelor's or higher degree. In addition, if they've worked with individuals on their caseload that had behavior support plans for whom they were responsible in the coordination/authorization of the plan that time counts toward the 3 years. Even if somebody else actually wrote the plan it should then have went to the SSA to incorporate as a part of the ISP. That role in the development counts toward the 3 years.
- Also, previous direct care or other provider positions supporting (implementing strategies) individuals who had BSPs might also meet the requirement.
- You should look at the experience and credentials of each SSA to determine who does/does not meet the requirements. It will be up to each CB/ICF to determine how to assist their SSAs/Qs with getting the time in. It is really about the time. Examples might be an internal mentoring program with co-workers who meet the criteria, working in conjunction with a behavior support specialist (who meets the criteria) on the development of the strategies, working with a supervisor who meets the requirements for those on their caseload that need behavioral support strategies, etc...
- Separately from conducting assessments and developing behavioral support strategies the SSAs are responsible for many parts of the planning, coordination, and oversight process. These internal processes should become routine around data collection, approval processes, meeting schedules, etc... as determined by each CB/ICF to live within the requirements of the rule. The SSA/Q should have understanding of the complete process (as described in rule), person centered planning, trauma informed care. They should have appropriate training to be able to ensure the can complete the following steps:

    (8) When a behavioral support strategy that includes restrictive measures is deemed necessary by the individual and his or her team, the qualified intellectual disability professional or the service and support administrator, as applicable, shall:
    (a) Ensure the strategy is developed in accordance with the principles of person-centered planning and incorporated as an integral part of the individual plan or individual service plan.
    (b) Submit to the human rights committee documentation based upon the assessment that clearly indicates risk of harm or likelihood of legal sanction described in observable and measurable terms and ensure the strategy is reviewed and approved by the human rights committee in accordance with paragraph (F) of this rule prior to implementation

and whenever the behavioral support strategy is revised to add restrictive measures, but no less than once per year.
(c) Secure informed consent of the individual or the individual's guardian, as applicable.
(d) Provide an individual or the individual's guardian, as applicable, with written notification and explanation of the individual's or guardian's right to seek administrative resolution if he or she is dissatisfied with the strategy or the process used for its development.
(e) Ensure the strategy is reviewed by the individual and the team at least every ninety days to determine and document the effectiveness of the strategy and whether the strategy should be continued, discontinued, or revised. A decision to continue the strategy shall be based upon review of up-to-date information which indicates risk of harm or likelihood of legal sanction is still present.

- SSAs/Qs should be knowledgeable in the rule requirements. There are on-line trainings and webinars that are beneficial in increasing understanding in many areas.

Q. *We have very few behavior support plans. We have been incorporating positive strategies into the ISP's. One of our hab staff has been writing any plans with aversive interventions. I've also had a large turn over in my SSA department. So I was trying to figure out how any of my SSA could get qualified to develop plans. So if they don't have the 3 years of experience in developing or implementing behavior support plans, would they have to mentor with someone who is writing the plans for 3 years? Or take college coursework specific to developing and implementing behavioral strategies? Will there be someone we can contact to find out if someone's experience qualifies them?*

A. The 3-year requirement is for paid work. You should develop an internal process. It sounds like you have somebody in place who could work in conjunction with the SSAs on the assessing/developing strategies.

- You might need to look at the experience outside of the CB that each SSA had. They may have gotten the experience in positions elsewhere.
- College coursework would only replace if it was to meet the qualifications and they were licensed or certified under (a) or (b). Maybe one of your SSAs is a licensed Social Worker or behavioral analyst in the mental health system??

Q. *Does someone have to be approved by DODD to complete an assessment? (in regards to Bachelor's or graduate with 3 years paid experience)*

A. DODD will not be formally approving professionals whom conduct assessments. It is up to the organization to know the rule and implement as stated in the rule. Reviewers will look for proof of credentials at some reviews.

Q. Since SSA's authorize the ISP's most do not have the educational training in writing behavior support strategies. Do they then need to work with someone else who has this training to write that section of the ISP?

A. Most SSA's (who have 3 yrs. experience in the field) will meet the criteria of this rule/qualification, because they are a part of teams who develop strategies, review data, and train on the ISP.

Q. *In instances in which there is a Behavior Support Specialist position within the county board, could that individual perform some of the SSA responsibilities (i.e. secure consent, etc.) or does it have to be the SSA?*

A. This is up to each County Board. There is nothing in the rule that prevents this option.

Data Collection

Q. *Section J in the revised rule indicates the need for analysis of data related to restrictive measures which is then to be reported to the Human Rights Committee. Am I correct in interpreting this to mean that the data should be aggregated across individuals and represent a specified period of time? For example, for item (b) we might report that for the past 6 months there were 100 strategies reviewed, 60 approved, 40 rejected and 20 of those approved were reauthorizations?*

A. Yes, that is correct.

Q. *Can you also clarify or suggest resources on what the analysis of data would look like at the end of the year? Specifically, I am wondering about the depth of analysis by the HRC. Does this mean keeping a running annual tally of approved and rejected programs and number of restrictive measure types?*

A. You are correct that it would be aggregate data. It is up to your agency how they want to compile and analyze the data so long as it is satisfying the requirements in paragraph (J) below.

(J) Analysis of behavioral support strategies that include restrictive measures

(1) Each county board and each intermediate care facility shall compile and analyze data regarding behavioral support strategies that include restrictive measures and furnish the data and analyses to the human rights committee. Data compiled and analyzed shall include, but are not limited to:

(a) Nature and frequency of risk of harm or likelihood of legal sanction that triggered development of strategies that include restrictive measures;

(b) Nature and number of strategies reviewed, approved, rejected, and reauthorized by the human rights committee;

(c) Nature and number of restrictive measures implemented;

(d) Duration of strategies that include restrictive measures implemented; and

(e) Effectiveness of strategies that include restrictive measures in terms of increasing or decreasing behaviors as intended.

(2) County boards and intermediate care facilities shall make the data and analyses available to the department upon request.

This analysis is not to be done by the HRC but presented to HRC. It is a requirement for the county board and/or ICF to complete.

Q. *I assume this part of the rule means cumulative data. Specific data on frequency of restrictive measured used would be contained within each person's plan and routinely that data is maintained by the program author. So if a person has an approved plan for manual restraint, should the HRC be keeping data on how often that restraint is being used, per person, with cumulative data on number of times all plans with manual restraint are being used annually?*

A. You are correct that it would be aggregate data. It is up to your agency how they want to compile and analyze the data so long as it is satisfying the requirements in paragraph (J) above.

The HRC does not have to keep the data. The county board or ICF maintains this data.

Restrictive Measure Notification Application

Q. *Where do I submit the Restrictive Measure Notification?*

A. County Boards: https://doddportal.prodapps.dodd.ohio.gov/Pages/default.aspx
Providers/ICF: https://imagineportal.prodapps.dodd.ohio.gov/login

Q. *Is the notification requirement still 5 days?*

A. No, it could be less than 5 days. Per paragraph (H) of the rule, DODD will be notified "after securing approval by the human rights committee and prior to implementation of a behavioral support strategy that includes restrictive measures."

Q. *For the projected Expiration Date of restrictive measures, would this typically be one year after implementation if a shorter time period is not delineated in the plan?*

A. Yes. The approval cannot be longer than one year. A shorter time frame is permissible.

Q. *Does the notification need to be re-submitted if there is a change to the dosage/frequency of a chemical restrictive measure, but the medication stays the same?*

A. Yes, please update the person's RMN if their medication dosage for their chemical restraint is changed. In the application, you will select the existing entry for the person. Click on "revision" and update the change. If the target behavior is no longer a part of the person's plan, you will click discontinue and update the record.

Q. *Must the RMN be completed and submitted annually*?

A. Yes, please complete an RMN for the person at the initial implementation of the restrictive measure, as well as any revision, and annual renewal of the restrictive measure. You must complete a new RMN prior to the 365th day or it cannot be updated as an annual. If the annual date expires prior to the annual update, it will have to be re-entered as an initial.

Q. *Is it required to complete the RMN when a restrictive measure is discontinued?*

A. No, it is not required by rule but would be best practice to update the RMN as being discontinued to maintain updated, required data. You would select "Discontinued" on the RMN application that is applicable to your RMN submission.

Q. *Does a certain person at the county board have to complete the RMN?*

A. No. Although someone from the county board must submit the RMN, the county board may determine which of its staff submits the RMN to DODD. The same is true for ICFs.

Q. *Does the team have to wait to implement the restrictive strategies in the plan until DODD approves the RMN?*

A. The submission of the RMN is not an approval process. The RMN is used for state level data collection to analyze the types of restrictions being used, where the restriction is being used, method, and why. Its intent is not to approve or disapprove. The final approval of a restriction is the local Human Rights Committee.

Strategies for Interweaving the BSP into the ISP/IP

Q. *What do you mean BSPs are going away?*

A. The rule now requires all plan information be contained into one interwoven plan. Restrictive measures no longer have a separate plan. The ISP/IP should have continuity as to where the restrictive measures are placed in order for providers to understand the full picture as to how to best support the person in each environment.

Q. *How is the elimination of separate BSPs going to impact our ability to meet ODH rules? They will cite ICF's! Letting DODD know doesn't change the cite.*

A. ODH and DODD are working together to resolve any conflicting regulations. While just reporting to DODD the conflicting regulation does not change the citation, you have the right to appeal the finding explaining your stance and understanding of the rule. DODD will work in conjunction with ODH to resolve the citation. Please refer to the DODD workspace where you will find a recorded webinar with DODD and ODH explaining how the rules are similar.

Q. *Where do we document the time information that was on the previous form, or does DODD no longer want that as the rule spells out the time for time out?*

A. The rule provides the maximum time limits for timeout usage. The individual's behavior strategies should provide the specifics for the person. It is expected these will not go beyond the allowable limits. The number of minutes for usage is not required on the form.