

Part III *Provision of Core Services and Participants' Eligibility/Access to Services*

Section 29.0 *Health Education*

- 29.1 DDOs shall develop human sexuality policies and health education policies that reflect the philosophy that people with developmental disabilities are people with sexual identities, feelings and needs.
- 29.2 Agencies shall offer training in human sexuality and/or health education to educate persons with disabilities to protect themselves from sexual abuse, sexual exploitation, pregnancy, sexually transmitted diseases and other areas pertaining to sexuality.

Section 30.0 *Behavioral Supports and Treatment*

- 30.1 Behavioral Supports are interventions or treatment to develop and strengthen adaptive, appropriate behaviors through the application of behavioral interventions, and to simultaneously reduce the frequency of maladaptive or inappropriate behaviors. Behavioral Supports and interventions encompass behavioral analysis, psychotropic medication, or other similar interventions that refer to purposeful, clinical manipulation of behavior.
- 30.2 Behavioral Treatment shall be developed and implemented in accordance with Positive Behavioral Theory and Practice as a proactive approach to individual behavior and behavior interventions that:
- a) Emphasizes the development of functional alternative behavior and positive behavior intervention;
 - b) Uses the least restrictive intervention possible;
 - c) Ensures that abusive or demeaning interventions are never used; and
 - d) Evaluates the effectiveness of behavior interventions based on objective data on a regular and frequent basis.

Behavioral Treatment Programs

Written Policy Required

- 30.3 The DDO shall have and implement a written policy for behavior support that utilizes individualized Positive Behavioral Theory and Practice Support Techniques and prohibits abusive practices.
- 30.4 Each day or residential site and/or program from which the DDO conducts a given behavioral treatment procedure shall have readily accessible to all staff members an up-to-date policy and procedures manual outlining the steps for each behavioral treatment used, as well as the Department licensing regulations and section 40. 1-26-1 *et seq.* of the Rhode Island General Laws, as amended, entitled "Rights of Persons with Developmental Disabilities" and readily on hand to trained staff the specific behavioral treatment procedure of Participants receiving services at that service location.

Behavioral Intervention Policy and Procedure Manual

- 30.5 In accordance with best practices, each DDO shall develop and submit to the Department a Behavioral Intervention Policy and Procedure Manual for inspection, review and approval. Such manual at a minimum shall include proactive policies and procedures to address and anticipate the implementation and development of behavioral plans, positive clinical strategies, emergency behavioral crisis prevention and intervention procedures and interventions to be used in emergencies to keep a Participant and/or others safe. In addition, the Behavioral Intervention Policy and Procedure Manual shall contain any and all duly authorized and approved Participant Behavioral Treatment Plans.
- 30.6 The Behavioral Intervention Policy and Procedure shall identify and detail all positive strategies and interventions utilized to reduce the ongoing use of emergency restraints or restrictions on a participant's rights. Such policies shall also include clear guidelines for when the ISP shall be reconvened to clinically determine the need for the development of a specific individualized Behavioral Treatment Plan for a Participant.
- 30.7 If such Behavioral Intervention Policy and Procedure Manual does not comply with these regulations, the provider shall not be authorized by the Department to conduct any behavioral interventions.
- 30.8 Revisions to the Behavioral Intervention Policy and Procedure Manual shall be submitted to the Department within thirty (30) days prior to implementation for inspection, review and approval.
- 30.9 At least annually, each provider shall submit to the Department a fully updated Behavior Intervention Policy and Procedure Manual.

Staff Qualifications

- 30.10 There shall be written documentation available in each DDO for inspection and review by the Department for the following requirements:
- 30.10.1 A description of the specific training (type, content, number of hours, frequency) required of all staff in order to assure that staff are competent to apply each behavioral treatment procedure used, and to apply the provider emergency behavioral crisis prevention and intervention procedures.
- 30.10.2 Names of all staff members who are qualified to administer behavioral treatment, and the provider emergency behavioral crisis prevention and intervention procedures.
- 30.10.3 Assurance that all instructors of provider staff who teach behavioral intervention procedures and techniques as well as emergency behavioral crisis prevention and intervention do so in accordance with the prevailing standard of care.
- 30.10.4 Method to assess staff competency in behavioral intervention and crisis prevention procedures.

Supervision

- 30.11 Supervisory and training practices shall be designed to protect the person with developmental disabilities from the following:
- a) the application of aversive behavioral techniques in a non-contingent manner;
 - b) the failure of a staff member to positively reward a competing, appropriate behavior which is incompatible with the undesired target behavior as prescribed;
 - c) the application of behavioral treatment techniques or individualized emergency behavioral crisis prevention and intervention procedures which have not been formally approved for a Participant;
 - d) the failure to document the time at which a supervisor was notified of the application of Aversive Behavioral Procedures, per approved behavior treatment program specifications; and
 - e) physical abuse, neglect, mistreatment, and other human rights violations.

Development of an Individualized Plan to Alter a Person's Behavior

- 30.12 A decision to develop a plan to alter a person's behavior must be made by the ISP team. Documentation of the ISP team decision must be maintained by the program. Behavioral treatment programs shall be generally designed to develop and strengthen adaptive, socially appropriate behaviors, and to facilitate communication, community integration, and social interactions. Behavioral treatment programs shall be implemented and supervised as part of a person's individualized service plan. They shall be clinically approved and reviewed at least annually by the ISP team and the HRC, as needed.
- 30.13 Any intervention to alter a Participant's behavior must be based on positive behavioral theory and practice and must be:
- a) Annually approved in writing by the Participant, Legal Guardian, family and/or advocate where appropriate; and
 - b) Described in detail in the Participant's record and ISP.
- 30.14 Psychotropic medications and medications for behavior shall be:
- a) Prescribed by the treating physician through a written order; and
 - b) Regularly reviewed by the prescribing treating physician for desired responses and adverse consequences.

Behavioral Treatment Programs

- 30.15 No behavioral treatment programs shall be approved in the absence of a determination, arrived at by the ISP team and HRC when applicable, in accordance with all applicable requirements of these regulations, that the predictable risks as weighed against the benefits

of the procedure would not pose an unreasonable degree of intrusion, restriction of movement, physical or psychological harm.

30.15.1 All procedures designed to decrease inappropriate behaviors may be used only in conjunction with positive reinforcement programs.

30.15.2 Aversive behavioral interventions shall be used only to address specifically identified extraordinarily difficult or dangerous behavioral problems that significantly interfere with appropriate behavior and/or the learning of appropriate and useful skills, and/or that have seriously harmed or are likely to seriously harm, the individual or others.

30.15.3 No behavioral treatment programs may be administered to any person in the absence of a written behavior treatment program.

30.15.4 All behavioral intervention plans shall be developed in accordance with these regulations, and in accordance with the behavioral intervention policies and procedures of the provider in which the plan is to be implemented.

30.15.5 All behavioral intervention plans shall conform to and abide by section 40. 1-26-1 *et.seq.* of the Rhode Island General Laws, as amended, entitled “Rights of Persons with Developmental Disabilities.”

30.16 Any behavioral intervention procedures that are aversive should be used only as a last resort, subject to the most extensive safeguards and monitoring contained herein.

Functional Behavioral Assessment Required

30.17 The DDO shall conduct a functional behavioral assessment of the behavior, which shall be based upon information provided by one (1) or more persons qualified and trained to perform such assessments who know the Participant. The functional behavioral assessment shall include:

a) A clear, measurable description of the behavior which includes (as applicable) frequency, antecedents, duration and intensity of the behavior;

b) A clear description and justification of the need to alter the behavior;

c) An assessment of the meaning of the behavior, which includes the possibility that the behavior is one (1) or more of the following:

1. An effort to communicate;

2. The result of medical conditions;

3. The result of psychiatric conditions;

4. The result of environmental causes or other factors;

- d) A description of the context in which the behavior occurs; and
 - e) A description of what currently maintains the behavior.
- 30.18 In constructing an overall plan for reducing or eliminating inappropriate behaviors, the Behavioral Treatment Plan shall include:
- a) An individualized summary of the Participant's needs, preferences and relationships;
 - b) A summary of the function(s) of the behavior, (as derived from the functional behavioral assessment);
 - c) Strategies that are related to the function(s) of the behavior and are expected to be effective in reducing problem behaviors;
 - d) Prevention strategies including environmental modifications and arrangement(s);
 - e) Early warning signals or predictors that may indicate a potential behavioral episode and a clearly defined plan of response and de-escalation;
 - f) A general crisis response plan;
 - g) A plan to address post crisis issues;
 - h) A procedure for evaluating the effectiveness of the plan which includes a method of collecting and reviewing data on frequency, duration and intensity of the behavior;
 - i) Specific instructions for staff who provide support to follow regarding the implementation of the plan;
 - j) Positive behavior supports that includes the least intrusive intervention possible;
 - k) Adjusting environments to decrease the probability of occurrence of the undesirable behavior;
 - l) Training functional behavioral replacements for the behaviors targeted for reduction; and
 - m) The DDO shall make every reasonable effort to bill the Participant's medical insurance.
- 30.19 Behavioral treatment programs shall be formalized and written to include the following:
- a) Specified, measurable target behaviors;
 - b) Specified, measurable baseline information;
 - c) Specified, measurable goals and objectives;
 - d) Specified, measurable intervention strategies and tactics;

- e) Sufficient, qualified, trained staff to conduct the written treatment program;
- f) Specified named individuals responsible for implementing and monitoring the program;
- g) Location(s) where the program intervention(s) as well as the devices, materials, and equipment needed to conduct the treatment program may/will be used;
- h) Length of time of each program component or intervention;
- i) Specific, measurable, objective documentation of the Participant's progress in the treatment program;
- j) Specific methods, time frames and individuals responsible for program review, supervision, and monitoring;
- k) A description of each of the interventions to be used, as well as a rationale based upon a comprehensive functional analysis of the antecedents and consequences of the targeted behavior;
- l) Specific interventions are clearly identified, as well as the associated behaviors.

Section 31.0 *Notification of Policies and Procedures*

- 31.1 The program must inform the Participant, legal guardian, family and/or advocate of the behavior support policy and procedures at the time of entry to the program and as changes occur.

Section 32.0 *Use of Aversive Therapy*

- 32.1 Aversive therapy, including but not limited to physical or mechanical restraint, shall only be applied in such exceptional circumstances that shall meet the heaviest burden of review among all treatments. The use of such procedures will be allowed for a particular person only after a review and approval by clinicians, families, guardians, Human Rights Committees and the Department. This process shall insure that before the Participant can be subjected to this type of procedure, that clinicians have exhausted other less aversive procedures, and further, that the likely benefit of the procedure to the Participant outweighs its apparent risk of life safety.
- 32.2 The application of an approved aversive procedure shall be strictly monitored by the DDO as well as by the Department.
- 32.3 All behavioral treatment techniques, programs, methodologies and applications which utilize any aversive behavioral interventions shall be implemented only under the following conditions:
 - 32.3.1 Prior written approval shall be present in the Participant's central record and shall be attached to the ISP. Authorizing signatures shall be present, including:
 - a) The Participant, if competent;

- b) Family or advocate or legal guardian (as appropriate);
 - c) Executive Director or duly authorized representative;
 - d) Support coordinator;
 - e) Department-approved program/peer review committee (see below);
 - f) Chair or designee of the human rights committee;
 - g) Supervising clinician.
- 32.4 A duly constituted program/peer review committee shall be composed of three (3) or more clinicians (including at least one (1) person who has at a minimum a Master's degree in psychology with demonstrable expertise in the development, implementation, and oversight in the care and treatment of individuals with needs similar to those served by the DDO, expertise in behavior treatment, and familiarity with the use of psychotropic medications. The program/peer review committee shall be approved by the Department or its designee. For this purpose, a human rights committee may serve this function if its membership meets the above criteria regarding composition.
- 32.5 Any clinician serving as a treating clinician within the provider proposing to use Aversive Behavior Interventions shall not be a member of the Program/Peer Review Committee. This committee shall review all Aversive Behavioral Interventions Plans to ascertain if they conform to the requirements for appropriate treatment established by these regulations.
- 32.6 The director of a provider that is proposing to use aversive behavioral interventions may request that the Department, or its designee, perform such reviews. The Department, or its designee, shall provide for such reviews in response to such a request in the event that he/she determines that the provider is unable to provide for such reviews itself or that the purposes of these regulations will be served by the provision of such reviews.
- 32.7 Written documentation in the record of the person with developmental disabilities shall include data and narrative data summaries which demonstrate that current or earlier positive reinforcement methods, and/or less aversive procedures, have not adequately alleviated the Participant's problem behaviors.
- 32.8 Written procedures designed to develop competing behaviors shall be present in the Participant record. Procedures shall include safeguards to be implemented (e.g. medical supervision, proposed and expected duration, frequency, and precautions to prevent injury).
- 32.9 A statement of possible risk, possible side effects, benefits, cautions, and precautions shall be documented, and shall be described to and discussed with the Participant and/or parents, guardian, or advocate, prior to gaining their authorization signatures.
- 32.10 Treatment applications shall be applied as prescribed in the individual written behavioral treatment program, and by staff who are trained and well-versed in the treatment techniques being conducted.

- 32.11 Staff shall also have access to a supervisor to determine whether to continue the intervention.
- 32.12 If the person with developmental disabilities shows symptoms of physical injury or distress during the use of any behavioral treatment procedure, the physical injury or distress shall be alleviated. Staff and the person's responses shall be documented.
- 32.13 Any person receiving behavioral treatment shall have his/her health monitored by a physician or registered nurse over the course of behavioral treatment, as medically indicated. The physician or registered nurse shall document their monitoring activity.
- 32.14 All behavior treatment programs shall be reviewed on a regular basis by a human rights committee and/or a Department-approved program/peer review committee.
- 32.15 Individual records pertaining to the use of behavioral interventions shall be kept and made available for review by the executive director of the DDO, representatives of the Department, the human rights committee, the Participant and/or parent, advocate, or guardian (as appropriate) and a Department-approved program/peer review committee.
- 32.16 At the time of initial approval of any aversive behavioral interventions, the Department-approved program/peer review committee and the human rights committee shall advise the ISP team how often the specific procedure shall be reviewed and reauthorized. The span of time between reauthorizations shall be determined by the specific procedure used. Reauthorizations, however, shall be performed at least annually. Signatures required for reauthorization shall include:
- a) Person with developmental disabilities, if competent;
 - b) Family, advocate, or guardian;
 - c) Licensed physician;
 - d) Executive director or authorized representative;
 - e) Support coordinator;
 - f) Department-approved program/peer review committee;
 - g) Chair or designee of the human rights committee; and
 - h) Supervising clinician.
- 32.17 Any alterations in the use of aversive behavioral techniques incorporated into an operating Participant behavioral treatment program shall have prior authorization from the individuals or groups named in section 32.16 above.
- 32.18 The Department, or its designee, shall have the right to review, inspect, and/or revoke the use of any specified behavior treatment procedure at any time if the health and safety of the Participant is at risk.

32.19 Any use of aversive behavioral techniques that result in injury to either the Participant or any other individual shall be considered reportable to the Department.

Prohibited Aversive Procedures

32.20 The following procedures shall be specifically prohibited from use under any circumstances:

- a) Contingent or non-contingent emetics for anything other than medical purposes;
- b) Contingent or non-contingent application of cold showers;
- c) Contingent or non-contingent corporal punishment;
- d) Contingent or non-contingent electric shock;
- e) Unobserved time-out;
- f) Liquid spray mist in a person's face;
- g) Shouting, screaming, using a loud, sharp, harsh voice to frighten or threaten, or use of obscene language;
- h) Withholding and/or denial of meals or other basic necessities of life (e.g., toilet, clothing, shelter). This is not intended to prohibit use of meal or other "modification" behavioral interventions that are part of a comprehensive approved behavioral treatment plan contained in the ISP.
- i) Permanent removal of a Participant's personal property;
- j) Pinching, hitting, slapping, kicking or punching;
- k) Withholding or denial of visitation, as a punishment;
- l) Any form of humiliation.
- m) Utilizing law enforcement in lieu of a clinically approved therapeutic emergency intervention or behavioral treatment program.
- n) Utilization of behavioral interventions for the convenience of the staff or as a result of less than minimum staffing levels.

32.21 The use of such prohibited aversives is reportable as abuse to the Office of Quality Assurance/Improvement.

Section 33.0 *Staff Training*

33.1 Staff supporting a Participant must be trained by a Master's Level Psychologist with expertise in the development, implementation and oversight of physical interventions when the Participant has a history of behavior requiring physical intervention and the ISP team has determined there is probable cause for future application of physical intervention.

Documentation verifying such training must be maintained in the staff's personnel file. Such training must occur annually at a minimum.

Section 34.0 *Crisis Prevention and Intervention*

Physical Intervention Techniques in Emergency Situations

- 34.1 Use of physical intervention techniques that are not part of an approved plan of behavior support in emergency situations must:
- a) Be reviewed by the program's executive director (or designee) or physician within one (1) hour of application;
 - b) Be used only until the Participant is no longer an immediate threat to self or others;
 - c) Submit an incident report to the Office of Quality Assurance/Improvement, and the person's legal guardian no later than one (1) working day after the incident has occurred; and
 - d) Prompt an ISP team meeting if an emergency intervention is used more than three (3) times in a six (6) month period.
- 34.2 In the Behavioral Intervention Policy and Procedure Manual, methods of dealing with behavioral crisis within the DDO shall be developed and documented. Emergency behavioral crisis prevention and intervention procedures, including any provision for individualized techniques or methods shall be documented.

Use of Physical or Mechanical Restraints

- 34.3 Documentation of all physical/mechanical behavioral interventions, both behavior treatment and crisis, shall include, but shall not be limited to:
- a) Signs and symptoms of physical condition during all behavioral interventions; and
 - b) Specific outcomes of behavioral interventions.
- 34.4 Description of the application of all approved physical and/or mechanical restraints and holds, must be detailed in writing in the ISP. The following procedural stipulations must be strictly adhered to and specifically stated:
- 34.4.1 One (1) qualified and trained person must be designated the lead person on site for each and every hold situation, with primary responsibility for directing any other person(s) who is (are) involved in the hold.
 - 34.4.2 No staff can lay across the back of a Participant in a hold.
 - 34.4.3 One (1) person should have responsibility for observing the Participant involved in the hold to watch for any problems that may be a signal of a life-threatening situation. The lead person should determine who shall have this responsibility.

34.4.4 In the extraordinary and unusual event that only one (1) staff person is available during a restraint or a hold, that individual is responsible to act as both the lead person as well as the observer.

Incident Report

34.5 Any use of physical intervention(s) shall be documented in an incident report and shall be made available to the Department upon request. The reports shall be kept on file for no less than five (5) years and shall include:

- a) The name of the Participant to whom the physical or mechanical intervention was applied;
- b) The date, type, and length of time the physical or mechanical intervention was applied;
- c) A description of the antecedent incident precipitating the need for the use of the physical or mechanical intervention;
- d) Documentation of any injury;
- e) The name and position of the staff member(s) applying the physical or mechanical intervention;
- f) The name(s) and position(s) of the staff witnessing the physical or mechanical intervention;
- g) The name and position of the person providing the initial review of the use of the physical or mechanical intervention; and
- h) Documentation of an administrative review that includes the follow-up to be taken to prevent a recurrence of the incident by the Executive Director or his/her designee.

Copies Submitted

34.6 The Services Coordinator, HRC or when applicable the Department designee will receive complete copies of incident reports.

34.7 Copies provided to a legal guardian or other service provider must have confidential information about other individuals removed or redacted as required by federal and state privacy laws.

34.8 All interventions resulting in injuries to any Participant and/or the involvement of law enforcement must be documented in an incident report and forwarded to the Office of Quality Assurance within one (1) working day of the incident.

DDO Annual Restraint Report

- 34.9 All physical and mechanical restraints that are used to control acute, episodic behavior of Participants shall be reported to the Department on an annual basis. All DDOs shall submit an *Agency Annual Restraint Report* during an annual timeframe specified by DDD.

Section 35.0 Eligibility and Access to Services by Participants

- 35.1 An adult with developmental disabilities who applies for waiver services funded by the Department shall be deemed to be eligible in accordance with the following process:
- 35.1.1 ***Eligibility Determination:*** Adults applying to BHDDH for services shall be assessed according to applicable statutory requirements.
- 35.1.2 ***SIS Assessment:*** If determined eligible, a Participant selects a team of individuals, including themselves, care planners, providers, local education authorities, family members, or friends to help in conducting and informing the SIS assessors. SIS assessors verify that selected individuals, other than those selected by the Participant, are knowledgeable and appropriate to participate in the SIS interview.
- 35.1.3 ***SIS Level Is Assigned Based Upon Assessed Needs:*** Based upon SIS scores, the Participant is assigned a SIS Level based upon their needs.
- 35.1.4 ***Resource Allocation Identified:*** Based on the SIS level assignment, a Participant will be assigned a resource allocation reflected in quarterly resources. In SFY 2012, this resource allocation will be based upon prior year authorizations for the Participant. If the Participant is new to the system, the interim resource allocation for SFY 2012 will be based on the results of the SIS score, the placement in a SIS level, and the authorizations established for Participants currently served by BHDDH in the same SIS level. As of July 1, 2011, in accordance with RIGL 40.1-21-4.3(7) and RIGL 40.1-26-2(9) all resource allocations will be allocated on a quarterly basis.
- 35.1.5 ***Agency Selection or Decision to Self-Direct:*** Once the Participant is assigned a resource allocation, they will either make a selection of which DDOs will provide services to them or the Participant will make the decision to self-direct services.
- 35.1.6 ***Care Planning with a Support Coordinator:*** If the Participant selects a DDO, he/she will also select a support coordinator to assist in developing goals and objectives for the Individualized Service Plan (ISP) which will provide a detailed description of the services and supports to be delivered by the Participant by the selected DDO. If the Participant chooses to self-direct, he/she will select from the list of licensed DDO fiscal intermediaries who will facilitate the selection of providers and setting up the necessary legal and financial documentation to self-direct.
- 35.1.7 ***BHDDH Approves Person-Specific Individualized Support Plans:*** BHDDH Social Services staff will review the ISP developed for the Participant. If approved, BHDDH will develop authorizations specific to the Participant's ISP that will ensure that only the providers selected by the Participant will be able to be paid for the services selected by the Participant.

- 35.1.8 ***Providers Bill for Services Against the Authorization:*** Providers authorized to deliver services within an Participant's ISP will bill the state's fiscal agent on a fee-for-service basis for services rendered based upon the Provider rates. The state's fiscal agent will ensure that payments will only be made for services billed, authorized by the ISP and that payments do not exceed the authorized amount based upon the provider rates.
- 35.1.9 ***ISPs Reviewed Annually:*** The ISP shall be reviewed at least once annually. The focus of the ISP review shall be to determine if the goals identified in the ISP were achieved and to determine which services assisted in achieving those goals and whether new goals and service levels are required. On an annual basis, a new ISP will be developed (Step 6) which will be submitted to BHDDH for review. Upon submission to BHDDH, Steps 7 and 8 will be repeated.
- 35.2 Prior to participating in a program administered by a DDO, the Participant, legal guardian, family and/or his/her advocate, if appropriate, shall be informed of any charges for services. No co-pays or charges for services by the DDO can be made without the prior written authorization of the Department and the State Medicaid authority.

Section 36.0 ***Supports Intensity Scale***

- 36.1 When a Participant has been determined by the Department to be eligible for services, the Supports Intensity Scale and Rhode Island Supplemental SIS Questions shall be completed by the Department's SIS assessors.
- 36.1.1 Each Participant shall be reassessed no less than every three (3) years. Participants may be reassessed more frequently due to major life changes.
- 36.1.2 Based upon the Department's assessment, the Participant shall be notified in writing of their Resource Allocation Level that the Department will make available to the Participant to purchase needed supports and services from the set of services authorized by these regulations. For the period July 1, 2011 through June 30, 2012, a Participant eligible for services shall be notified of their Interim Funding Level.
- 36.1.3 The Participant and the provider(s) chosen by the Participant shall an individualized service plan that will serve as the basis for the agreed upon supports and services for the Participant. The individualized service plan shall be signed by the DDO(s), the Participant, legal guardian, family or advocate, as appropriate.
- 36.1.4 The components of the individualized service plan, including the agreed upon and described supports and other forms, as required, shall be submitted to the Department. When the Department approves the individualized service plan, it shall create authorization(s) to implement and fund the deliverables contained in the ISP.
- 36.1.5 If the Department does not approve the individualized service plan, it shall notify the Participant and the provider(s) and shall specify the reasons for the denial. The Participant may either submit a new individualized service plan for the Department's approval or the Participant may file an appeal of the denial of the ISP.

- 36.1.6 The individualized service plan shall be updated annually. The Department shall assign an anniversary date for each Participant that will serve as the milestone date for when the individualized service plan are due to the Department each year. Participants and agencies may submit an updated individualized service plan up to forty-five (45) days prior to the anniversary date. The Department shall send the approved authorization(s) to the Participant and provider(s).
- 36.1.7 For Participants who are new to a provider, the Participant and the provider shall submit an initial support agreement so that an authorization can be created. The Participant and provider shall have up to ninety (90) days to submit an individualized service plan with revised support deliverables for approval by the Department for authorization(s) beyond the first ninety (90) days.
- 36.1.8 Authorizations shall not span any longer than twelve (12) months. Providers shall not bill for services nor shall they be paid for services if an approved ISP authorization is not on file with the Department covering the time span that the services were rendered. The Department shall not pay for services prior to the completion of the ISP funding authorization process unless there is a finding that the Participant applied for Medicaid at the time of the service and the service was an emergency or crisis.
- 36.1.9 The Department is solely responsible for determining the resource allocation level or interim funding level available to each Participant. The provider(s) who the Participant has requested to support them shall assist the Participant in understanding the necessity of working within the allocated resources to develop an ISP. It is the provider's responsibility to insure that a Participant and his/her representative or family understand possibilities regarding support and service options available to them within the resource allocation level, especially as this relates to shared and unshared supports and services.
- 36.1.10 On an annual basis, only one (1) individualized service plan containing the agreed upon supports shall be submitted to the Department. If the Participant has chosen more than one (1) DDO to provide supports, the DDO responsible for support coordination shall submit the individualized service plan to the Department.
- 36.1.11 Providers shall submit claims to the Department's Medicaid fiscal agent for documented services delivered to the Participant in support of the individualized service plan. In order to receive payment, providers must ensure that the amount billed does not exceed the amount available in the rate based authorization. Providers must also submit claims to the Medicaid fiscal agent in the format specified by the Medicaid fiscal agent and/or the Department.
- 36.1.12 No significant change in the amount, duration, and scope of services shall be made without a change in the ISP and the prior authorization of the Department even if no additional funding is involved.
- 36.1.13 Providers are encouraged to submit claims to the Medicaid fiscal agent for services even if there is no authorization or the authorization amount has been exceeded.

36.2 Any overpayment to a DDO by the Department or DHS shall be recovered through a withhold against a future payment.

Section 37.0 Development of an Individualized Service Plan

37.1 All Participants receiving services from DDOs licensed by BHDDH shall have an annual ISP. The support coordinator assigned to the Participant shall have primary responsibility for activities related to the ISP process, including preparation for the ISP meeting, conducting the ISP meeting, follow-up documentation of the ISP meeting, and ongoing monitoring of the ISP.

ISP Team Membership

37.2 The ISP shall be developed through a team approach and the membership of the team may vary, depending on the unique needs of the Participant and the services being provided. Each member shall have equal participation in discussion and decision making. No one member shall have the authority to make decisions for the team. Representatives from service provider(s), families, the Department, or advocacy agencies shall be considered as equal member for the purpose of reaching majority agreement.

- a) The ISP team shall at a minimum, include the Participant, legal guardian, and service provider representatives.
- b) The Participant may suggest additional participants. Typically, family members, advocates or other professionals involved in providing service to the Participant shall be appropriate ISP team members.
- c) The Participant has the right to raise an objection to participation by a particular person. When a Participant raises an objection to participation by a particular individual, the team shall attempt to accommodate the Participant's objection while allowing participation by team members.

Initial and Annual ISP Timelines

37.3 An ISP shall be completed within sixty (60) calendar days following entry into Department-funded residential, day or supported employment services and at least annually thereafter. All ISPs shall be sent to the Department for placement in the Participant's Department file. If the Department finds that the ISP does not meet the requirements specified in these rules, the ISP team shall be reconvened.

37.4 The timing of the ISP shall coincide with the anniversary month of the Participant's enrollment into services. The anniversary month shall be determined by BHDDH.

ISP Meeting Process

Preparation for the ISP Meeting

- 37.5 Between thirty (30) and sixty (60) days prior to the Participant’s anniversary date, the Support Coordinator shall meet with the Participant, or his/her legal guardian, family member or designated advocate, to prepare for the annual ISP meeting.
- 37.6 At this meeting, the Support Coordinator shall discuss, at a minimum, the following topics with the Participant:
- a) the goals that were identified in the current year ISP;
 - b) a review of the action items completed and not completed to achieve each goal;
 - c) the level of success the Participant had in achieving each goal;
 - d) any goals that the Participant would like to remove in the new ISP;
 - e) any goals that the Participant would like to add in the new ISP;
 - f) who the Participant would like to attend the ISP meeting (the “ISP team”);
 - g) who, if anyone, the Participant would not want to attend the ISP meeting;
 - h) any specific topics the Participant would like to address in the ISP meeting;
 - i) any specific topics the Participant would like to address but outside the ISP meeting;
and
 - j) any other requests of the Participant to prepare for the ISP meeting, including the style of communication in the meeting itself.
- 37.7 When soliciting feedback from the Participant to prepare for the ISP meeting, the support coordinator shall make every effort to customize the goals, objectives and outcomes to the Participant. After the meeting with the Participant, the support coordinator shall plan the agenda for the ISP meeting.
- 37.8 Either prior to or during the ISP meeting, the BHDDH social caseworker or his/her designee (other than the support coordinator) shall validate with the Participant that he/she is aware that he/she has a choice of support coordinators and that he/she is satisfied with his/her support coordinator.
- 37.9 The Support Coordinator shall document either from the pre-meeting or from the ISP meeting itself that the Participant was asked about the following service areas from which goals could be set:
- a) home living;
 - b) community living;
 - c) physical wellbeing and safety;
 - d) emotional wellbeing;
 - e) socialization and relationships;
 - f) learning and education;
 - g) employment; and
 - h) self-direction.

ISP Meetings

- 37.10 The support coordinator selected by the Participant shall initiate the ISP meeting and shall be responsible for assuring that the ISP meeting is scheduled and Participants notified. The support coordinator shall invite the Participant's BHDDH social caseworker at least fourteen (14) days prior to the scheduled ISP meeting and shall document same. An agenda shall be developed so that all Participants are aware of the topics to be covered. At a minimum, the topics shall include:
- a) a review of the prior year goals;
 - b) identification of which goals were fully met, partially met, or not met;
 - c) a review of the upcoming year's goals and the actions that will be put in place to achieve success; and
 - d) who will be responsible for assisting the Participant in working to achieve each goal.
- 37.11 The support coordinator role in the development of the ISP: At the ISP meeting, the support coordinator or designated team leader shall:
- a) Initiate the discussion of the Participant, Participant's legal representative's, family's, advocate's or other team member's preferences. The support coordinator shall invite the individuals that the Participant would like to attend the meeting and solicit their feedback on any items that were covered in the pre-ISP meeting with the Participant.
 - b) Initiate a discussion that the Participant and/or legal representative have the right to request that information not be shared across service providers unless the preference is likely to create a situation detrimental to the Participant's health and safety as determined by the ISP team.
 - c) Initiate discussion of and document the need for evaluations in the areas of medical, dental, vision, hearing; and any other evaluations based on the specialized needs of the Participant (such as, but not limited to, neurological evaluations for Participants with seizure disorders, augmentative communication evaluations for Participants with limited speech, physical therapy and equipment evaluations for Participants in wheelchairs, psychiatric or psychological evaluations for Participants who are dually-diagnosed or nutritional evaluations for Participants with metabolic disorders);
 - d) Initiate and document discussion of specialized health care needs and health maintenance services (such as, but not limited to, required periodic lab work), including what services are needed and the Participant or provider who is responsible for assuring that they are provided;
 - e) Determine with the ISP team whether home visits, vacations and other community or family-based activities are considered to be community-based experiences preferred by the Participant. If so, then these activities must be considered part of the Participant's overall ISP and shall be documented as such through the ISP process;
 - (f) Initiate the review of and discussion regarding outcome of any previous plan;

- g) Initiate discussion of proposed service provider plans and assist the team to make any needed modifications emphasizing health, safety, and rights;
- h) Determine the extent to which the ISP reflects the Participant's choice and preferences in his/her daily activities which are defined in the ISP;
- i) Make efforts to build consensus among the members regarding services and supports included in the ISP, giving the most weight to the preference of the Participant receiving services, unless the Participant's preference is likely to create a situation detrimental to his/her health and safety as determined by the ISP team;
- j) Initiate discussion in developing and obtaining natural supports responsive to the Participant's choices and needs that will provide him/her with the greatest level of integration and inclusion into the community in which he/she lives. Develop, whenever possible, alternative natural supports to augment paid supports; and
- k) Assist a Participant in expanding his/her network so he/she is not dependent only upon a few family members or paid support staff. Natural supports shall be required in order to maximize the limited resources available for paid supports, and also to enhance the quality of life for persons who need assistance in daily life.

ISP Document

37.12 The ISP document shall include:

- a) Each service provider's program plan, with team modifications;
- b) Documentation of the need for additional evaluations or other services to be obtained and the person or provider responsible for assuring that these evaluations or services are obtained;
- c) Documentation of the specialized health care needs, health maintenance services and the person or provider responsible for assuring that these services are provided;
- d) Documentation of the Participant's safety skills including the level of support necessary for the Participant to evacuate a building (when warned by a signal device), the Participant's ability to adjust water temperature, and the amount of time a Participant can be without supervision before the missing notification protocol is implemented;
- e) Documentation of the reason(s) any preferences of the Participant, legal representative and/or family members cannot be honored;
- f) Documentation concerning the development and availability of natural supports. Natural supports shall include, but not be limited to, the supports that are provided by non-paid friends, relatives, neighbors, co-workers and others in the community.
- g) Document strategies to assist the Participant in developing natural supports in the community.

- h) Documentation of the role and responsibilities of each Participant in implementing the ISP plan, with specific ISP team member concerns, if any, noted.
 - i) If the Participant has given permission to release the information, the Participant's prior year ISP shall be distributed to each attendee as well as the draft of the new ISP.
- 37.13 The plan shall include quality indicators that demonstrate the plan has met the expectations of the Participant and the Participant is satisfied with the support services he or she is receiving.
- 37.14 The Support coordinator shall lead a discussion of the services that the Participant would like to purchase with his/her resource allocation to support the Participant's ISP goals. This discussion shall serve as the basis for the support agreement between the Participant and his/her provider(s).
- 37.15 The social caseworker or his/her designee shall review the selection of services to be purchased with the Participant's resource allocation and confirm with the Participant that they are aware of all of the services available to them and the choice of providers that are available to them to deliver these services. These items shall be documented in the new ISP.

Distribution of the ISP Document, Document Format and Follow-up Documentation of the ISP Meeting

- 37.16 No later than thirty (30) days from the date of the ISP meeting, the DDO who employs the support coordinator shall deliver the following documentation to BHDDH:
- a) The final version of the new ISP;
 - b) A listing of who was invited to the ISP meeting and the signatures of those who attended the ISP meeting ("the ISP Attendance Sheet");
 - c) The support agreement between the Participant and the provider(s) for the coming year shall be part of the ISP.
- 37.17 The following elements shall be required in every ISP in a format specified by BHDDH. This "ISP Summary" includes:
- 37.17.1 A listing of each goal in the new ISP with its start date and end date.
- a) For each goal, at least one objective shall be written that is measurable and indicates the desired level of performance or behavior that the Participant is trying to achieve.
 - i. For each objective, at least one outline of steps that the Participant will complete to accomplish the objective.
 - b) For each goal, a listing of the method of how objectives will be measured and how often.
 - c) For each goal, a listing of the person(s) with primary responsibility for assisting the Participant in achieving the goal.
- 37.17.2 A listing of each goal in the prior year ISP.

- a) For each goal, a listing of the objectives that were developed associated with the goal.
 - i. For each objective, a conclusion of whether the objective was fully met, partially met, or not met.
- b) For each goal, a conclusion of whether the goal was fully met, partially met, or not met.
- c) If the goal was terminated, a statement indicating the reason that the goal was terminated.
- d) A listing of any services that the Participant declined to accept.
- e) Documentation of the reason(s) any preferences of the Participant, their legal representative, and/or their family members cannot be honored.

37.18 Upon approval by BHDDH of the new ISP, the ISP summary, and the support agreement, BHDDH shall create authorizations for the coming year that reflect the intent of the Participant as to how he/she would like to spend his/her resource allocation and the deliverables contained in the ISP and accompanying support agreement.

Ongoing Monitoring of the ISP

37.19 The frequency of the monitoring of an ISP shall be determined by the needs of the Participant. The support coordinator shall monitor the ISP to assure that supports are being provided as defined in the ISP.

37.20 Monitoring shall include the review and documentation of the Participant’s outcome data, review of any incident and unusual incident reports, and a review of the manner in which the Participant is accessing services based on their total resource allocation.

37.21 The support coordinator shall develop specific tools to monitor each Participant’s ISP on an ongoing basis. These may include case notes, monthly, weekly or daily tracking sheets, and documentation of meetings of those supporting the Participant. At a minimum, the support coordinator shall maintain the following in the Participant’s ISP file (in electronic or hard copy format):

- a) On a monthly basis, a summary of the data collected related to the Participant’s efforts to meet each of his/her objectives identified in the ISP.
- b) On a quarterly basis, a summary of the Support Coordinator’s evaluation of the level of progress that the Participant has met in achieving each of the goals outlined in the ISP.

ISP Process for New Participants

37.22 All Participants new to receiving services from BHDDH-licensed providers shall have an annual ISP, but an interim ISP shall be developed prior to the final ISP. The final ISP shall be created within ninety (90) days of the date at which the Participant began receiving services from the provider that employs the support coordinator. Once the final ISP is completed, it shall be delivered to BHDDH in the same format, as well as an ISP summary.

- 37.23 The ISP summary shall follow the same format as one delivered to BHDDH for Participants already receiving services, with the exception that the section related to listing the goals from the prior year ISP shall be left blank.
- 37.24 An interim ISP shall also be required of all new Participants. This shall be completed and delivered to BHDDH no later than thirty (30) days from the date on which the Participant began receiving services.

Section 38.0 *Specialized Support Services*

- 38.1 If a Participant has been determined and received written approval by the Department to need Specialized Support Services requiring additional staffing and services beyond those which are included in the Core Support Service Rate and/or are not otherwise covered by the Participant's medical insurance. Such Specialized Support Services include increased specific clinically appropriate staffing levels, additional required professional services, behavioral supports and medical supports required. Specialized Support Services shall not include short-term additional professional or direct care supports or minor increments in services. Specialized services shall not include services otherwise covered by the Participant's medical insurance. It shall be the responsibility of the support coordinator to provide written documentation of the final denial of coverage by the insurance provider of any requested services ordinarily covered by private or public health insurance.
- 38.2 Day Program and Residential Support Services may be augmented with Specialized Support Services if the Participant is behaviorally and/or medically in need of clinically appropriate services that require:
- 38.2.1 Additional staff, trained and supervised to provide specific and direct care, behavioral supports and/or medical care to the Participant that is above the minimum staffing levels required in the provision of Core Residential Support Services or Day Program Services;
 - 38.2.2 Professional Services, including but not limited to psychological, psychiatric, Physical therapy, occupational therapy, speech therapy, registered nursing and interpreters not otherwise covered by the Participant's medical insurance coverage or the core services;
 - 38.2.3 Behavioral Supports, to address chronic and severe behavioral problems and concerns that severely and persistently interfere with the Participant's and/or others' health and safety not otherwise covered by the core services; and/or
 - 38.2.4 Medical Supports to address chronic and long-term medical conditions that require services outside of the residential core services and/or are not covered by a health plan.
- 38.3 The Department may approve Specialized Support Services based upon the SIS with the production of clinical data supporting such additional clinically appropriate services and staffing.