MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Service Delivery		
Title:	Behavior Treatment Plans		
Policy: ☐ Procedure: ☑ Page: 1 of 6	Review Cycle: Biennial Author: Chief Compliance & Quality Officer, Quality Improvement Council	Adopted Date: 01.12.2021 Review Date: 03.04.2025	Related Policies: Behavior Treatment Plans

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Purpose

The purpose of this procedure is to guide Mid-State Health Network (MSHN) in monitoring the delegated function of Behavior Treatment Plan (BTP) Review Committees to the Community Mental Health Service Program (CMHSP) Participants in accordance with the Michigan Department of Health and Human Services (MDHHS) Medicaid Managed Specialty Supports and Services Contract, Technical Requirement for Behavior Treatment Plan Review Committees (BTPRC).

Procedure

A. Each CMHSP Participant shall have a Behavior Treatment Committee to review and approve or disapprove any plan that proposes limitations to recipient rights, use of any intrusive techniques, or any use of psychoactive drugs for behavior control purposes.
   a. Membership of the CMHSP Committee: at least 3 voting members including:
      i. Licensed behavior analyst and/or Licensed psychologist, if the behavior analysis services provided by the psychologist are within their education, training and experience.
      ii. Licensed physician/psychiatrist
      iii. Recipient Rights officer shall be ex-officio, non-voting member
      iv. Other non-voting members may be added with the consent of the consumer whose plan is being reviewed.
   b. The committee shall meet as often as needed.
   c. The committee shall keep minutes that clearly delineate the actions of the committee.
   d. A committee member who has prepared a Behavior Treatment Plan (BTP) for review shall recuse him/herself from the final decision-making on that plan.
   e. Each Committee must establish a mechanism for the expedited review of proposed behavior treatment plans in emergent situations. "Expedited" means the plan is reviewed and approved in a short time frame such as 24 or 48 hours.

B. Functions of the Behavior Treatment Committee:
   a. Approve only BTPs that do not contain techniques prohibited by law or regulation including:
      i. Aversive techniques
      ii. Physical management
      iii. Seclusion
      iv. Restraint
   b. Expeditiously review all BTPs proposing to utilize limiting intrusive techniques
   c. Ensure that causal analysis of the behavior has been performed and positive behavioral techniques and interventions have been pursued before approving the plan.
   d. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. The review shall occur at a frequency that is clinically indicated or when the individual has requested a review as determined through the person-centered planning process.
   e. Plans with limiting or intrusive interventions require a quarterly review at minimum.
   f. A causal analysis must be completed that rules out known medical, psychological, or other factors that may place him/her at risk for an adverse outcome.

g. Following approval of the BTP by the committee and the individual/guardian/ parent with legal custody of a minor or designated patient advocate and written consent to the plan has been obtained, it will become part of the written individual plan of service (IPOS).
h. The individual/guardian/parent with legal custody of a minor or designated patient advocate has the right at any time to request that person-centered planning committee be reconvened to reconsider the BTP.

C. Evaluation of the BTP Committee's effectiveness shall occur annually as part of the Prepaid Inpatient Health Plan's (PIHP's) Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP).

D. The CMHSP Behavior Treatment Committee, on a quarterly basis, will collect, track and analyze the use of all physical management, involvement of law enforcement for emergencies, seclusion and restraint by each individual receiving the intervention:
   a. The data collected shall include the following:
      i. Dates and numbers of interventions used.
      ii. The settings where behaviors and interventions occurred.
      iii. Observations about any events, settings, or factors that may have triggered the behavior.
      iv. Behaviors that initiated the techniques.
      v. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
      vi. Description of positive behavioral supports used,
      vii. Behaviors that resulted in termination of the interventions,
      viii. Length of time of each intervention,
      ix. Staff development, training, and supervisory guidance to reduce use of the interventions.
      x. Review and modification or development, if needed, of the individual's behavior plan.

E. Data on the use of intrusive or limiting interventions, emergency physical management, and involvement of law enforcement will be:
   a. Evaluated by the PIHP's Quality Assessment & Performance Improvement Program (QAPIP) or the CMHSP's QIP.
   b. Available for review by the PIHP and/or MDHHS.

F. Emergency physical management and involvement of law enforcement:
   a. Is treated as a critical incident.
   b. Any injury or death that occurs from behavior intervention is considered a sentinel event.
   c. Must be analyzed by the BTP Committee.
   d. Must be reported and managed according to the QAPIP standards.

G. In addition, a BTP Committee may:
   a. Advise and recommend specific staff or home based specific training in positive behavioral supports and other interventions.
   b. Advise and recommend acceptable physical management techniques to be used in emergency or crisis situations.
   c. Review other formally developed BTPs, including positive behavior supports and interventions.
   d. Provide specific case consultation when requested by professional staff.
   e. Serve another entity (e.g. sub-contractor) if agreed upon by the involved parties.
   f. Advise the agency regarding administrative and other policies affecting BTPs and evidence-based practices.

H. Behavior Treatment Plan standards:
    a. Person Centered Planning process will identify when a BTP needs to be developed and where documentation of assessments to rule out physical, medical or environmental causes of the behaviors and use of positive behavioral supports and interventions have failed to change the behavior.
        i. The IPOS must be revisited if use of physical management or request for law enforcement should occur more than 3 times during a 30-day window.
    b. BTPs:
        i. Must employ positive behavior supports and interventions using applied behavior analysis (ABA) or other evidence-based practices, including specific interventions designed to develop functional abilities in major life activities.
        ii. Consider other kinds of behavior treatment interventions that are supported by peer-reviewed literature or practice guidelines.
        iii. Must be developed through the Person-Centered Plan (PCP) process
        iv. Have written consent by the individual, his/her guardian, or parent with legal custody of a minor child prior to implementation of the plan.
        v. That include the use of physical management, aversive techniques, seclusion, restraint, or requesting involvement of law enforcement are prohibited from being included in the BTP and will not be approved
    c. Plans sent to the BTP Committee for review shall be accompanied by:
        i. Results of assessments to rule out relevant physical, medical, and environmental causes of the challenging behavior.
        ii. A functional assessment.
        iii. Results from inquiries about any medical, psychological, or other factors that might put the individual subjected to limiting or intrusive techniques at high risk of death, injury or trauma.
        iv. Documented evidence of the kinds of positive behavioral supports or interventions, including amount, scope and duration that have been attempted but proven unsuccessful in reducing/eliminating the behaviors within the last 12 months.
        v. Evidence of continued efforts
        vi. Practice guidelines that support the proposed use of limiting or intrusive techniques.
        vii. References to peer reviewed literature, and where the intervention has limited or no support in the literature, and why the BTP is the best option available.
        viii. References to the literature should be included in the BTP, and where the intervention has limited or no support, why the plan is the best option available.
        ix. The plan for monitoring and staff training to assure consistent implementation and documentation of the interventions. This should include who will provide the training and how it will be monitored for fidelity and modifications if needed.

I. The PIHP shall establish a process for Behavior Treatment Plan data collection, monitoring and reporting through the Quality Improvement Council (QIC) and Clinical Leadership Committee (CLC). The purpose of the QIC/CLC is to provide consultation, guidance and oversight as required through the MDHHS Medicaid Contract.
    a. The Behavior Treatment data collection, monitoring and reporting shall:
        i. Collect data by each CMHSP Participant regarding Behavior Treatment Committee information that includes:
            1. Number of plans that include intrusive and limiting interventions.
            2. Number of emergency physical management interventions that occurred during the reporting period
            3. The number of calls to the police for behavioral assistance
            4. Number of individuals that had repeated emergency physical management during the reporting period
    b. Based on the review of the information above, QIC/CLC will review a summary report and approve recommended strategies for improvement.

Applies to

☐ All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☒ MSHN's CMHSP Participants: Policy Only ☒ Policy and Procedure
☐ Other: Sub-contract Providers

Definitions

Applied Behavior Analysis (ABA): A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious, or other targeted behaviors that place the individual or others at risk of physical harm by conducting a functional assessment and teaching new skills and making changes in an individual's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.

Aversive Techniques: Techniques that require the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may often generate physically painful responses in the average individual or would have a specific unpleasant effect on a particular individual) by staff to a recipient to achieve the management and control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist, or other noxious substance to cons equate target behavior or to accomplish a negative association with a target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the BTP and that are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques for the purpose of this technical requirement.

BTP: Behavior Treatment Plan

BTPRC: Behavior Treatment Plan Review Committee

CLC: Clinical Leadership Committee

CMHSP: Community Mental Health Service Program

Consent: A written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.

Emergency Interventions: There are only two emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement intervention. Each agency shall have protocols specifying whet physical management techniques are approved for use. All interventions must comply with chapter 7 of the mental health code and associate administrative rules.

Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage, control an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.

IPOS: Individual Plan of Service

Limiting Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques as limiting are prohibiting communication with others when that communication would be harmful to the individual; access to personal property when that access would be harmful to the individual; or any limitation of the freedom of movement of an individual for behavioral control purposes. Use of any intrusive techniques for behavior control purposes requires the review and approval of the Committee.

MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PCP: Person Centered Plan
Physical Management: A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff, each agency shall designate emergency physical management techniques to be utilized during emergency situations.
PIHP: Prepaid Inpatient Health Plan
QAPIP: Quality Assessment & Performance Improvement Plan
QIC: Quality Improvement Council
QIP: Quality Improvement Plan
Restraint: The use of physical devise to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support.
Request for Law Enforcement Intervention: Calling 911 and requesting law enforcement assistance as a result of an individual exhibiting seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Law enforcement should be called for assistance **only when**: caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.
Seclusion: The temporary placement of a recipient in a room, alone, where egress is prevented by any means. Note: Seclusion is prohibited except in a hospital operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.

Other Related Materials
MSHN Behavior Treatment Review Project Description
Behavior Treatment Data Collection Template

References/Legal Authority
1. Michigan Department of Health and Human Services
2. Michigan Mental Health Code
3. Michigan Department of Health and Human Services Standards for Behavior Treatment Plans Technical Requirement
4. Mid-State Health Network QAPIP
5. 1973 PA 116, MCL 722.111 to 722.128.
6. 1997 federal Balanced Budget Act at 42 CFR 438.100
7. MCL 330.1700, Michigan Mental Health Code
8. MCL 330.1704, Michigan Mental Health Code
9. MCL 330.1712, Michigan Mental Health Code
10. MCL 330.1740, Michigan Mental Health Code
11. MCL 330.1742, Michigan Mental Health Code
12. MCL 330.1744, Michigan Mental Health Code
13. MDHHS Administrative Rule 7001(l)
14. MDHHS Administrative Rule 7001(r)
15. MDHHS Administrative Rule 7199(2)(g)

Change Log:

Date of Change	Description of Change	Responsible Party
08.18.2014	New	Chief Compliance Officer
11.2015	Annual Review	Director of Compliance, Customer Service and Quality
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service & Quality
03.2019	Annual Review Updated language to be consistent with the FY17 revisions to the Standards for BTPRC Committees	Director of Compliance, Customer Service & Quality
10.2020	Biennial Review	Quality Manager
10.2022	Biennial Review	Quality Manager
12.2024	Biennial Review- revisions were made to comply with MDHHS Technical Requirement	Chief Compliane and Quality Officer