

## CHAPTER 12

# BEHAVIORAL HEALTH

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### 12.1. Introduction

This chapter will provide a discussion of the importance of integrating behavioral health services into the overall provision of services and direction for achieving integration. This information will be followed by a description of behavioral health services available through Medicaid waivers and DMRS state-funded programs.

The overall state of a service recipient's health depends upon the ability to assure safety, stability and well-being. Good mental health is indispensable in maintaining personal wellness, interacting with the family and establishing relationships with others. A Surgeon General's report on mental health issued in 1999 (*Mental Health: A Report of the Surgeon General*, available as a publication of the United States Public Health Service), established that health and mental well-being are an integral part of health care and are inextricably linked. Coordination of care between the primary care physician and other behavioral health care practitioners is necessary if optimal health status is to be obtained/maintained. Specific behavioral health services that promote good mental health include psychiatry, psychology, social work, behavior analysis and other specialty services (e.g., music therapy, development pediatrics, as well as non-professional services such as clergy, etc.) A holistic healthcare approach of biopsychosocial care combines the prevention and treatment of disorders of mind and body. The multimodal approach of assessment and treatment of biological, psychological and social conditions is recognized as the standard of treatment which must be achieved.

Comprehensive behavioral health treatment includes the integration of all aspects of healthcare. In addition to medical care, behavioral health treatments may involve any combination of counseling, pharmacological treatment, education, habilitation and environmental interventions. Achieving integration is not an easy task. There may be a number of different types of medical and mental health practitioners involved, a number of funding sources involved in providing reimbursement for needed services and a number of state and federal agencies involved in regulating and overseeing the provision of services. The resulting scenario is a complicated maze of laws, rules, regulations, professional practice standards and guidelines that must be successfully navigated to reach the goal of integration. Further complicating the issue is the fact that practitioners and those involved in the regulation and reimbursement of the services do not "speak the

same language”. Common knowledge of the services available and the requirements affecting different service delivery systems is lacking.

Despite the challenges in achieving integration of services, DMRS intends to work toward that end. DMRS has no authority to impose requirements upon medical and mental health practitioners external to the DMRS system. However, DMRS and DMRS providers must make reasonable efforts to foster and promote relationships with external practitioners and state agencies involved in reimbursement and regulation of such practitioners. It is anticipated that such efforts will eventually result in improvements in the integration of services for DMRS service recipients.

## **12.2. Diagnostic Considerations for People with Mental Retardation**

### **12.2.a. Prevalence of Mental Health Disorders in People with Mental Retardation:**

People with mental retardation are at greater risk for the full range of mental health disorders as the general population (i.e. mental health disorders occur in one in every five people). However, the incidence may be increased in people with mental retardation, based on underlying etiological issues, such as brain damage or limitations of life experience, including the lack of ability to cope.

**12.2.b. Interpretation of Symptoms in Determining Diagnoses for People with Mental Retardation:** Symptoms and diagnostic testing results should be interpreted the same for people with mental retardation as for people who do not have a developmental disability. However, people with mental retardation may present symptoms in unusual ways or in ways that make it difficult to recognize common symptoms, especially if practitioners have no special training or experience in evaluating people with mental retardation. Depending on the strengths and weaknesses of the person being evaluated, these symptoms may need to be interpreted in a slightly different way. Guidelines for interpretation of symptoms in people with mental retardation will be published in 2005 by the National Association of Dual Diagnosis, in cooperation with the American Psychiatric Association.

**12.2.c. Causes of Challenging Behaviors Manifested by People with Mental Retardation:** Challenging behaviors in people with mental retardation are often manifested as a reactive response to a particular situation which generally parallels that which would occur if individuals not having mental retardation encountered a similar situation. Aberrations in behavior may be representative of a mental illness which fits classic criteria for diagnosis. However, not all maladaptive behaviors can be attributed to mental illness. Manifested behaviors may be related to health problems (e.g., toothaches, abdominal pain, constipation, etc.), environmental issues, issues of temperament, behavioral phenotyping (genetic syndromes which have specific behavioral features) or life circumstances such as grief or frustration. Many individuals with mental retardation

use behavior as a form of communication; therefore, behavior must be interpreted carefully. Individuals with mental retardation who also have an identified mental illness are classified as being “dually diagnosed”. Parameters for diagnosing mental illness are the same as for the general population, but symptoms may present differently, particularly in persons who are non-verbal. People with mental retardation are often victims of “diagnostic overshadowing”. Diagnostic overshadowing occurs when all symptoms, including maladaptive behavior, are attributed solely to mental retardation. Diagnostic overshadowing may also occur if asymptomatic behavior is not recognized as being attributable to a specific mental illness syndrome.

**12.2.d. Medications as a Factor Affecting Challenging Behaviors:** People with mental retardation are often on multiple medications, including medications used for behavior disorders. Particular medication(s) or medication interactions may cause behavior manifestations. The possibility of medication affecting the occurrence or incidence of challenging behaviors should be carefully considered.

**12.2.e. Psychological Causes of Challenging Behaviors:** Psychological causes of challenging behaviors include separation, losses, deprivation, abuse, learning experiences and communication disorders.

**12.2.f. Social Causes of Challenging Behaviors:** Social issues that contribute to challenging behaviors may include family problems, bereavement, life cycle transitions, attitudes, rejections, limited coping strategies, inadequate supports, under- or over-stimulation or limited relationships.

**12.2.g. Service Recipient Life Experience as a Factor Affecting Behavior:** Life experiences, such as institutionalization, which fail to foster effective coping mechanisms or contribute to lack of control or limitations in the amount of control may predispose people to have behavioral variations which might appear as mental illness.

**12.2.h. Health Care Professional/Clinician Life Experience as a Factor Affecting Interpretation of Behavior:** Life and professional experience of health care professionals who come in contact with people with mental retardation may also affect the ability to achieve integrated behavioral health supports. Many clinicians, including mental health professionals, may be lacking in educational opportunities and opportunities for exposure to people with mental retardation who also have mental illness issues. Problems interpreted as mental illness may be overstated related to lack of understanding of the person’s past medical and behavioral history, current environmental situation and/or other issues.

### 12.3. Diagnostic Assessments

Proper diagnosis is essential to the initiation of effective treatments for people with mental retardation. Because common language for describing the behavior of people with mental retardation is often lacking, practitioners may use labels and/or vague, nondescript diagnostic terms such as “psychopathology” or “behavior disorder” to define what is occurring. Such terms provide little insight into the cause of the challenging behaviors and the potential interventions that could be effective in alleviating or eliminating causative factors and/or providing appropriate interventions. It is exceedingly difficult to arrive at the appropriate intervention if the cause or underlying factors contributing to the challenging behaviors being assessed are not determined. Consequently, it is imperative that assessments are based on complete and accurate information, performed by the appropriate type of professional(s) and inclusive of a specific diagnosis and causative factors to the extent possible.

**12.3.a. Initiating Assessments Based on the Occurrence of Atypical or Challenging Behaviors:** When changes in behavior occur, when behavioral symptomology increases in incidence or severity and/or when challenging behaviors occur that affect health/safety/welfare, a determination must be made as to whether assessment is needed. Everyone may have “temporary” behavioral or emotional reactions which may be part of normal life, such as anger associated with not getting your way, grief with loss of an important person or frustration with inability to do a task or activity. In addition, each individual has their own temperament which may be viewed as a “behavioral problem” by others with a different temperament. Underlying normal variation should be addressed in an appropriate manner.

If determined that assessment is needed, the type of assessment needed must be considered. Several different types of assessments may be required, depending upon the service recipient’s previous history and the nature of the atypical or challenging behaviors causing concern. For instance, a physician visit may be necessary for completion of a medical evaluation to rule out medical causative factors of the challenging behavior. Medical evaluation should be completed to rule out medical factors when atypical or challenging behaviors present for the first time. Medical evaluation should also be completed when challenging behaviors that were attributed to medical causative factors recur following a period of absence of such challenging behaviors. An evaluation performed by a mental health professional, such as a psychiatrist or psychologist, may be required to rule out mental illness. Psychiatric/psychological evaluations are to be completed in the same manner and format as those completed for the general population. A behavior analyst may be called upon to complete a behavior services assessment including evaluation of past behavioral history and environmental/situational factors that could be causing the challenging behaviors. A

standard assessment format is utilized for DMRS funded behavior services assessment reports (provided in *Appendix D*).

**12.3.b. Securing a Reimbursement Source for an Assessment:** The process for planning and obtaining a reimbursement source for assessments and treatment is described in *Chapter 3*. If a service recipient is eligible for Medicare or private insurance, benefits available for obtaining reimbursement through those sources must be exhausted prior to accessing TennCare or DMRS funded services. If a service recipient is eligible for TennCare, MCO and BHO benefits for which the service recipient is eligible must be exhausted prior to accessing DMRS services. TennCare MCOs and BHOs do not reimburse for services provided by behavior analysts or behavior specialists; however, depending on the nature and cause of the atypical or challenging behavior, mental health services may be available to address behavior intervention needs. A TennCare MCO typically provides treatment when a behavior intervention need results from a medical condition. A TennCare BHO typically provides assessments and treatments for symptoms related to a psychiatric diagnosis. DMRS funds behavior services through Medicaid waiver and state-funded service options. DMRS behavior services are intended to treat challenging behavioral symptoms that have been demonstrated to be functional responses to environmental and social events.

**12.3.c. Sources of Information for Assessment of Challenging or Atypical Behaviors:** An assessment of an atypical or challenging behavior generally includes activities such as observation of the person in a variety of different settings, extensive record review and collection of relevant data. Essential information that should be collected and reviewed during an assessment includes, but is not limited to, a list of current medications, a medical history, observed status of the service recipient, direct support staff interviews, psychological testing, information describing the nature and frequency of occurrence of symptoms and general health data such as elimination records, seizure records, menstrual records, etc. A complete, accurate assessment cannot be completed by a single clinician, absent interaction with other individuals and medical professionals involved in the life of the person being assessed. Interaction may take the form of interviewing people (e.g., by telephone, e-mail or in person) or obtaining records for review and consideration. Accurate information from the people most familiar with the service recipient being assessed is essential to prompt identification of symptoms and potential causative factors of the challenging behaviors being assessed. Those most familiar with the service recipient may also assist greatly in interpretation of the service recipient's interview responses or in identification/interpretation of symptoms that present during the assessment if the service recipient is non-verbal or language-impaired.

**12.3.d. Factors that Affect the Ability to Perform an Assessment:** It is important that those involved in planning and making arrangements for assessments, those involved in

completing assessments, those involved in furnishing information for assessments and those involved in responding to assessment recommendations be aware of factors that have a negative effect on the validity and usefulness of assessments. Proper assessment is often hampered by such factors as:

- 1) Inability to communicate effectively with the person being assessed (e.g., the person may be non-verbal or lack the sophistication to describe feelings or symptoms such as hallucinations);
- 2) Inaccessibility to complete medical information (e.g., an accurate list of current medications was not provided or relevant medical records were not obtained/provided);
- 3) Unavailability of provider staff, family members or other persons able to effectively, accurately and objectively describe the person's medical history and/or significant current medical symptomology;
- 4) Occurrence of "psychosocial masking" where the presentation of possible mental illness symptoms is diminished or disguised by a functional deficit such as concrete content or lack of imagination;
- 5) Occurrence of "medication masking" where the use of medications for challenging behavior or other medical problems diminishes or disguises the presence of readily identifiable mental health symptoms;
- 6) Episodic presentation of symptoms (e.g., symptoms may not be observable at the time the person is being assessed);
- 7) Lack of clinical expertise with people with mental retardation, particularly those with co-occurring mental health issues (e.g., lack of formal training and exposure to the population, lack of information about the mental retardation service system and/or lack of knowledge of the mental health system);
- 8) Differences in professional opinions regarding whether a person should be assessed/treated in the mental health system or the mental retardation system;
- 9) Differences in professional/personal opinions regarding whether or not treatment will have a significant effect on the person's quality of life;
- 10) Time constraints resulting when people with mental retardation require additional time for completion of assessment because of individual disabilities or problems with obtaining needed information from available records (e.g. incomplete records, excessive record volume, inaccurate records);
- 11) Atypical presentation of mental health symptoms due to features of mental retardation and/or functional deficits, compounded by clinicians who are inadequately trained to recognize variations in symptoms that may occur when people have cognitive or physical impairment;
- 12) Inability to discriminate between several possible reasons for the symptoms presented (e.g., the person expresses distress symptoms for different events in the same way such as crying when upset, in pain or frustrated); and

- 13) Presentation of behavioral phenotypes (i.e. behavior specific to a particular behavioral syndrome is mistaken for symptoms of mental illness).

**12.3.e. Provider Responsibilities Related to Behavior Services:** Provider requirements include:

- 1) Providers employing direct support staff must ensure that direct support staff are provided training, supervisory instruction or mentoring opportunities to foster understanding that service recipients, like all other human beings, will experience the normal ups and downs of everyday life, and that service recipients are likely to express anger, grief and other emotions appropriate to the situation at hand;
- 2) Providers employing direct support staff must ensure that direct support staff have sufficient individual specific training and knowledge of provider policy to be able to identify normal from unusual or atypical behaviors and to respond appropriately;
- 3) Providers who employ direct support staff must assure that direct support staff appropriately document behavioral data and staff notes describing unusual or atypical behavioral events;
- 4) Providers who employ direct support staff must ensure that any known information pertaining to environmental circumstances, life events or recent changes in the persons life is provided to any professional/clinician involved in completion of an assessment of atypical or challenging behavior;
- 5) Providers of residential, day and personal assistance services must ensure timely scheduling of health-related and mental health-related appointments;
- 6) Any provider that supplies documentation to a physician, psychiatrist, psychologist, behavior analyst or other professional/clinician performing an assessment related to atypical or challenging behaviors must ensure that data and records are complete, relevant to the issue at hand and organized in an easily accessible manner; and
- 7) Support coordinators/case managers are responsible for coordinating the planning of assessments in accordance with **Chapter 3**, including amending/updating the Individual Support Plan (ISP) as necessary and obtaining approval for reimbursement for the assessment through the appropriate source.

#### **12.4. Documentation of Information Related to “Behavior”**

Optimal success in integrating medical, mental health and mental retardation services may be achieved only with partnership between the different entities involved. Documentation and information provided to health care professionals/clinicians is vital to determining a correct diagnosis and appropriate treatment. Once a diagnosis is made, continued documentation of behavioral information, including description of the response

to interventions is crucial. Presentation of such information to medical and mental health professionals allows evaluation of the appropriateness of the diagnosis and effectiveness of any interventions implemented. Diagnoses and treatment interventions may change or be refined over time as additional information is available. Documented information describing challenging behaviors should be presented as an objective, factual statement of events. Opinions, assumptions and diagnostic interpretations made by staff who are not trained to make such interpretations are to be avoided. An example of an inappropriate interpretation that may be documented would be a staff note that described a service recipient as “acting demented” instead of describing the actual behavior, such as “wandering in the hall asking a doll the way to the bathroom.” Another example would be to describe inability to sleep, lack of appetite and reluctance to interact with others as opposed to noting that the person was “acting depressed”. Information collected/recorded pertaining to behavior and behavior interventions which occurred since the previous visit should be presented/available to the medical or mental health practitioner in a concise and accurate format.

Information provided regarding the response to prescribed medications must be sufficient to allow the psychiatrist or physician on subsequent visits to determine whether a medication intervention is effective and if the person has experienced any side effects as a result of taking a medication.

### **12.5. Treatment Challenges**

Major challenges to the treatment of people with mental retardation who have behavioral issues are not limited to the ability to complete an accurate assessment. Determining the entity responsible for providing the treatment also may prove difficult in certain situations. DMRS service recipients are eligible for the full range of psychiatric and behavioral health services available to the general population; however, needed services may be delayed due to differing opinions as to where the responsibility lies for reimbursing the cost of providing treatment. Identifying an accessible provider and making appointment arrangements may be equally challenging. Challenges may be related not only to problems with accessing the services, but helping in adapting procedures such as record keeping and treatment to the unique needs to individuals with mental retardation.

**12.5.a. Fragmentation in Treatment:** People with dual diagnoses of psychiatric and developmental conditions frequently receive fragmented treatment related to the organization and delivery of health services and the division between medical services and psychiatric treatment. Unfortunately, neither the developmental nor the mental health sectors have good programs or working relations in place to ensure integration in serving people with psychiatric and cognitive deficits. When DMRS behavior services

are needed, attention must be directed to integrating these services with those that are already in place to avoid increasing treatment fragmentation.

**12.5.b. Initiatives to Improve the Integration of Behavior, Medical and Psychiatric Services:** On going initiatives are in place to attempt to bridge the gaps between the different entities that may be involved in providing behavior, medical and psychiatric services to service recipients. In 2002, Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD), attempted to begin to address this issue by publishing guidelines for adults with mental retardation and co-morbid disorders. This protocol was intended to improve the care of adults presenting with mental retardation and mental health disorders, as well as, aid practitioners in the difficult task of assessing and choosing correct treatments. Information included in the protocol was based on contributions of panel members and protocols/guidelines previously published by the American Psychiatric Association.

## 12.6. Treatment Considerations

Treatment of atypical or challenging behaviors should be initiated only after a careful holistic evaluation of all aspects of a service recipient's life. The range of treatment options is variable in terms of complexity and restrictiveness to the service recipient. Treatment options may include:

- 1) Treatment of underlying medical or dental issues, such as toothaches, constipation, skin problems, etc. that may affect pre-existing psychiatric or behavioral symptoms or cause changes in normal behavior;
- 2) Treatment and care of psychiatric conditions which could involve such services as crisis evaluation, medication administration, psychiatric services or psychiatric hospitalization (It is important to note that there are specific criteria applying to admission/discharge to/from mental health settings; a service recipient may have challenging or atypical behaviors and either not qualify for admission or be discharged from such settings, requiring close coordination between DMRS providers, the Circle of Support, mental health hospital staff and the treating psychiatrist.);
- 3) DMRS behavior services, involving the development or revision of Behavior Support/Maintenance Plans (BSP) to either address challenging behaviors in their entirety or enhance other treatments such as medication administration;
- 4) Other modalities such as counseling, art therapy, anger management etc. (These options may be inaccessible to people with mental retardation due to opinion that they are incapable of responding to such treatment; however, it is often possible and quite beneficial to adapt these treatment options to individual needs); and

- 5) Basic everyday interventions implemented by clinical and direct support staff employed by DMRS providers.

## **12.7. Psychopharmacology**

Many atypical/challenging behaviors result in a diagnosis of mental illness. In this situation, medications may be prescribed to treat behavioral symptoms. When prescribed, medications should be integrated into a comprehensive treatment plan that includes aspects of behavior planning, monitoring and support, as well as, communication between the clinicians involved in providing mental health and medical care to the service recipient, including the primary care physician.

### **12.7.a. Considerations in Prescribing Medications:** Medication decisions should:

- 1) Relate to a recognized mental health diagnosis and not be made merely for convenience or control;
- 2) Involve adjustment of medication doses according to service recipient need, with a treatment goal of minimizing dosages or eliminating the medication altogether if possible. (At the same time, it should be recognized that some diagnoses warrant life long medication treatment.);
- 3) Result from careful consideration of accurate and adequate information about the service recipient; including past medical history; other prescribed medications and current medical problems;
- 4) Involve careful consideration for potential problems of polypharmacy, with a treatment goal of the administration of the least number of different medications possible at the lowest dose;
- 5) Involve consideration of efforts that could be made to avoid unnecessary side effects, including compromised cognitive function or exacerbation of the other neurological symptoms; and
- 6) Involve consideration as to whether the benefits of prescribing the medication outweigh the risks.

**12.7.b. Provider Responsibilities Related to Psychotropic Medications:** Provider responsibilities related to the administration of medications, including psychotropic medications are discussed in *Chapter 11, Sections 11.6, 11.7 and 11.8.*

**12.7.c. Informed Consent and Human Rights Committee Review of Psychotropic Medications:** Informed consent must be obtained for individuals prescribed to receive psychotropic medications. Informed consent is discussed in *Chapter 11, Section 11.14.* A Human Rights Committee (HRC) must review psychotropic medications prescribed for

DMRS service recipients. Human Rights Committees and HRC review of psychotropic is discussed in *Chapter 2, Section 2.22*.

## **12.8. Crisis Prevention and Support**

Situations occur when a service recipient's challenging behavior(s) escalates, culminating in a crisis. In many cases, a service recipient's potential escalation into a crisis can be predicted and behavior escalation and crisis can be prevented with an appropriate crisis plan. The management of such behavioral events should be considered in advance of their occurrence. Management options include staff or caregiver response at the local level or accessing other services, including services external to DMRS. Local approaches, when effective, are generally in the best interest of the service recipient. Although a crisis plan may or may not be in place, staff training and education should include basic responses to behavioral abnormalities. If local methods are not effective, or if the challenging/atypical behavior is deemed to be much more severe than can be addressed locally, service recipients are eligible for crisis treatment through the mental health system. In situations where service recipients already have a BSP or access to behavior services provided through DMRS, emergency consultation of behavior service providers is an option. In some cases, a respite admission may be sought through DMRS for short term treatment or removal from the current environment. Behavioral respite services are described in *Section 12.22*.

**12.8.a. Crisis Intervention Teams:** The major function of a crisis intervention team is to assess the need for additional services. This may or may not lead to admission to a mental health inpatient facility. In addition to Mobile Crisis Teams that operate to respond to mental health crisis situations, DMRS has formed consultation teams in each Regional Office. These teams are responsible for developing a response network to help prevent, manage and respond to behavioral crises. Crisis teams may be instrumental in helping DMRS providers in accessing appropriate services and defining plans to prevent crisis.

**12.8.b. Maintaining a Support Environment that Prevents Breakdowns in Supports:** The Planning Team, including the COS should foster the development of environments that are responsive to the needs of service recipients with challenging behaviors. The likelihood of a breakdown in supports during crisis situations should be minimized to the extent possible. Supports aimed at achieving this end must be considered and included in the ISP and other documents (e.g., crisis prevention plans or a behavior support/maintenance plans). Both proactive and reactive strategies should be considered in designing support environments that minimize the possibility of a breakdown in supports.

**12.8.c. Proactive Support Strategies:** Proactive strategies include:

- 1) Designing an environment that supports a lifestyle that is meaningful and preferred by the service recipient;
- 2) Supporting significant relationships with family, friends or staff;
- 3) Helping the individual to develop and use a communication style that effectively expresses desires, feelings, needs and frustrations;
- 4) Developing routines, activities schedules, teaching strategies and reinforcement mechanisms that encourage participation in the community;
- 5) Training staff to recognize the service recipient's communication style, including behaviors that may be used as a way to communicate;
- 6) Recognizing precipitating events that may lead to behavior or mood changes and promoting changes in staff behavior to accommodate (e.g., ordering an individual to do something or demanding compliance may be replaced with offering suggestions, making cooperative requests or providing alternative choices); and
- 7) Maintaining an environment that processes information about factors that influence behavior (e.g., current medical state; current stressors) and making adjustments as needed.

**12.8.d. Reactive Support Strategies:** Reactive strategies include:

- 1) Providing instruction regarding how staff should respond to behaviors that serve as indicators (ranging from mild to intense) of an impending behavior incident, including utilization of approved crisis intervention techniques;
- 2) Providing description of precipitating events that have been shown in the past to lead to changes in the service recipient's behavior or mood, as well as, appropriate staff response to such events;
- 3) Providing information regarding when to seek assistance in attempting to manage behavioral events, including contact information and the type of assistance that may be provided;
- 4) Providing information about appropriate supports to access as behavior challenges intensify, such as the Mobile Crisis Team;
- 5) Detailing when and how to contact the psychologist, psychiatrist, nurse, behavior analyst, behavior specialist, the team leader, or other staff; and
- 6) Providing information regarding appropriate times and guidelines for staff documentation of responses to challenging service recipient behavior.

**12.8.e. Emergency Consultation System:** An emergency consultation system serves the purpose of providing guidance to direct support staff who are responding to an unplanned, unstable behavior incident for which the steps in the crisis prevention plan have been unsuccessful in stabilizing the situation. The emergency consultant assesses

the situation, determines whether an on-site consultation is necessary, makes recommendations and documents interactions with the caller. Information about how to access emergency consultation is recorded in either the ISP, a crisis prevention plan or a behavior support/maintenance plan. Emergency consultation information should be easily accessible to direct support professionals. Elements of an emergency consultation system include:

- 1) Emergency consultants/contacts who agree to be available to respond or are responsible for responding to emergency consultation requests when there is a crisis (e.g., the behavior service provider, provider on-call administrators, provider on-call behavior analysts/behavior specialists, the DMRS Regional Office administrator on duty or Regional Office on-call behavior services staff);
- 2) Description of a call sequence to emergency consultants ensuring that consultants most familiar with the environment and situation are contacted first and additional consultants are be contacted as needed;
- 3) Procedures for accessing emergency consultation; and
- 4) Procedures for documenting the emergency consultation (by both the person seeking consultation and the consultant) , inclusive of:
  - The name of the service recipient;
  - The name of the person requesting consultation;
  - The name of the consultant;
  - The date/time of the call;
  - The reason for the call;
  - The response provided by the consultant; and
  - The actions taken by the person requesting consultation.

### **12.9. Continuity of Care Related to Psychiatric Hospital Admissions**

It may be necessary for somebody with very challenging behaviors or a mental illness diagnosis to be admitted to a mental health facility. In this situation, it is imperative for staff and others that normally have contact with the service recipient to continue to maintain contact with the service recipient.

**12.9.a. Planning Prior to Admission for In-Patient Psychiatric Services:** For those individuals who have had a history of admissions to psychiatric facilities, the support coordinator/case manager is to facilitate the development of the ISP to include clear information about planning for situations that require in-patient psychiatric admissions. Additional documents may be attached to the ISP as needed. For service recipients with no prior history of admissions to psychiatric facilities, the Circle of Support/Support Team may choose to provide similar planning information as part of the ISP or may choose to rely on the generalized crisis management approaches used within the provider agency. At

a minimum, planning information for service recipients with prior history of psychiatric admissions is to include:

- 1) Symptoms or behaviors indicating that attention needs to be directed toward responding to the service recipient's current status;
- 2) Actions that need to be taken in response to the symptoms/behaviors described above to help stabilize the situation and prevent admission to a psychiatric facility;
- 3) Contacts to call about psychiatric issues and description of the circumstances under which calls should be initiated;
- 4) Description of the circumstances or criteria for considering a psychiatric hospital admission;
- 5) Preferences related to choice of psychiatric facilities and the course of action if the first choice for a facility does not have a vacancy;
- 6) Materials that should be taken to the psychiatric facility including personal items, the Health Passport and copies of relevant records such as the ISP, BSP as applicable, the most recent physical examination and other relevant records;
- 7) Contact information for people who should be notified following admission (e.g., legal representatives, family members, the support coordinator/case manager, medical staff, the psychiatrist and behavioral staff) and person(s) responsible for making such contacts;
- 8) Circle of Support members available to assist staff during a psychiatric event and description of the type of assistance that may be provided;
- 9) Identification of persons who will visit the service recipient in the facility, including the frequency of visitation and how the results of the visits will be communicated; and

**12.9.b. Admission for In-Patient Psychiatric Service:** Support coordination/case management and primary provider responsibilities in the event of psychiatric hospitalization mirror those pertaining to medical hospitalization provided in *Chapter 11, Section 11.16*.

**12.9.c. Discharge Planning:** DMRS provider responsibilities and elements of an appropriate discharge plan are described in *Chapter 11, Section 11.16*.

## **12.10. DMRS Funded Behavior Services**

**12.10.a. Waiver Definition for Behavior Services:** The waiver definition shall apply to all behavior services provided in a Medicaid waiver. The waiver definition shall also be used to define behavior services provided in other DMRS-funded programs. The waiver

definition for behavior services approved by the Centers for Medicaid and Medicare Services (CMS) is:

**Behavior Services** - Behavior Services shall mean (1) assessment and amelioration of enrollee behavior that presents a health or safety risk to the enrollee or others or that significantly interferes with home or community activities; (2) determination of the settings in which such behaviors occur and the events which precipitate the behaviors; (3) development, monitoring, and revision of crisis prevention and behavior intervention strategies; and (4) training of caregivers who are responsible for direct care of the enrollee in the prevention and intervention strategies. Therapeutic goals and objectives shall be required for enrollees receiving Behavior Services.

Behavior Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Training, or Speech, Language, and Hearing Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently. Behavior Services shall be provided face to face with the enrollee except that enrollee-specific training of staff may be provided when the enrollee is not present.

Behavior Services are not intended to replace services available through the Medicaid State Plan/TennCare program.

**12.10.b. DMRS-Approved Behavior Analysts and Specialists:** Behavior services provided by a behavior analyst or specialist will only be reimbursed if provided by a DMRS-approved provider. A list of approved behavior analyst/behavior specialist providers will be maintained by the DMRS Central Office Director of Behavior Services and will be accessible on the DMRS website. To be included on the list of approved behavior analysts/specialists, an independent practitioner or behavior analyst/specialist employed by another DMRS behavior service provider must apply for approval through the process described in *Chapter 5*. Approval will be based on meeting the criteria specified in *Chapter 5*. Once approved, the provider must remain in good standing in accordance with requirements specified in this chapter in order to remain on the list of approved providers. In addition to other credentials, behavior service providers approved by DMRS shall use the designation "DMRS Approved Behavior Analyst", "DMRS Approved Behavior Analyst/Provisional", "DMRS Approved Behavior Specialist" or DMRS Behavior Specialist/Provisional. It is the responsibility of the DMRS approved behavior service provider to provide updated documentation of credential maintenance (e.g. a license or certification renewal) to DMRS in a timely manner. Failure to do so could result in removal from the list of approved providers.

**12.10.c. Services Provided by a Behavior Analyst:** Services provided by a behavior analyst include:

- 1) Completing assessments to determine the relationship between environmental events and behaviors;
- 2) Developing behavior support/maintenance plans and evaluating and revising plans as needed to meet service recipient's needs;
- 3) Training direct support staff or unpaid caregivers to carry out the approved behavior support/maintenance or crisis prevention plans with or without assistance from a behavior specialist;
- 4) Observing staff and service recipient behavior for correct implementation (reliability) of the behavior support/maintenance plan and completing retraining as needed;
- 5) Observing service recipient behavior to determine effectiveness of the behavior support/maintenance plan or crisis prevention plan; and
- 6) Providing on-site assistance and training in a difficult or crisis situation.

**12.10.d. Services Provided by a Behavior Specialist:** Services provided by a behavior specialist include:

- 1) Training direct support staff or unpaid caregivers to carry out the approved behavior support/maintenance plan developed by the behavior analyst or in conjunction with the behavior analyst;
- 2) Observing staff and service recipient behavior for correct implementation (reliability) of the behavior support/maintenance plan and completing retraining as needed;
- 3) Observing service recipient behavior to determine effectiveness of the behavior support/maintenance plan or crisis prevention plan and consulting with the behavior analyst when behavior support/maintenance or crisis prevention plan changes are needed; and
- 4) Providing on-site assistance and training in a difficult or crisis situation.

**12.10.e. Behavior Services Provided Jointly by Behavior Analysts and Specialists:**

It may be determined that a service recipient's behavior support needs are sufficient to warrant both behavior analyst and behavior specialist services. In the event that services are provided by both types of clinicians are approved, the following shall apply:

- 1) Behavior services will not be reimbursed when provided by a behavior analyst and behavior specialist during the same time period;

- 2) Reimbursement will not be provided for behavior analysts to complete oversight activities required to supervise activities completed by a behavior specialist; and
- 3) The behavior analyst and specialist are responsible for collaborating sufficiently to avoid duplication of services and ensure integration of efforts.

### **12.11. The DMRS Behavior Service Model**

The DMRS Behavior Service Model is comprised of four support phases. For each phase, service objectives are required to define the services to be provided, the service goals and the projected date of completion. The phases are:

- 1) Professional assessment;
- 2) Behavior change services;
- 3) Behavior maintenance services; and
- 4) Closure (discharge).

Determination of a service recipient's support phase is based upon behavior support needs identified in the ISP and the progress made toward behavioral stability.

### **12.12. The Assessment Phase of Behavior Services**

**12.12.a. Indicators for Behavior Service Assessment:** Requests for behavior assessments are typically received from a service recipient's support coordinator/case manager. Indicators may include:

- 1) The need for a service review assessment prior to the annual ISP update to determine current progress in achieving behavioral stability, determine the effectiveness of a behavior support/maintenance or crisis prevention plan and/or to document current behavior service needs (The service review assessment should be completed within thirty (30) calendar days of the date of service authorization;
- 2) A sudden change in behavior that results in high risk of harm to self or others; and
- 3) Administration of psychotropic medications when behavior services may be an alternative for reduction of medication dosage or elimination of the need for the medication.

**12.12.b. Planning for Behavior Services Assessment:** *Chapter 3*, describing the planning process, indicates that when the need for a professional assessment is determined, sufficient information must be provided to allow the clinician to determine why evaluation/assessment is being requested. Please refer to *Chapter 3* for requirements pertaining to assessment referrals, timely completion of assessments,

planning for behavior services assessments and approval of reimbursement for behavior services, including assessments. Behavior services assessments must be completed within thirty (30) days of service authorization.

**12.12.c. Completing Behavior Services Assessments:** Earlier sections of this chapter discuss assessment considerations and challenges. Behavior services assessments must be completed by a behavior analyst (input from a behavior specialist is appropriate when a behavior specialist has been involved in the provision of behavior supports). Additional requirements specific to behavior service assessment reports are provided in *Appendix M*. A description of requirements for the development of a BSP are provided in *Appendix K*.

**12.12.d. Distributing Behavior Services Assessment Reports:** Behavior services assessment reports are to be distributed to the service recipient's support coordinator/case manager, other members of the Planning Team, (including other providers) as appropriate and the Regional Office Director of Behavior Services. The behavior analyst is expected to discuss the results of the assessment and recommendations with the service recipient and legal representative as appropriate. Requirements pertaining to documentation of clinical service assessments in *Chapter 8, Section 8.9*. and distribution of records in *Chapter 8, Section 8.16*. are applicable to behavior services providers.

### **12.13. The Behavior Change Service Phase**

This phase in the DMRS Behavior Service Model involves development of a BSP, training direct support staff to implement the BSP as necessary, monitoring for the effectiveness of interventions included in the plan and adjusting the plan as necessary to promote progress toward behavioral stability.

**12.13.a. Obtaining Approval for Behavior Services:** Written approval from the DMRS Regional Office must be obtained prior to the implementation of behavior support services. The support coordinator/case manager is responsible for obtaining approval in accordance with the planning process described in *Chapter 3*.

**12.13.b. Development of a BSP:** Requirements for the BSP include:

- 1) The BSP must be written by a behavior analyst (Collaboration with a behavior specialist is appropriate if a behavior specialist is involved in the provision of behavior services.);
- 2) If the development of a BSP is a collaborative effort between a behavior analyst and a behavior specialist; responsibility for the plan and its implementation is retained by the behavior analyst;

- 3) The clinician developing the plan must consider input from the Planning Team and others having direct experience with the service recipient;
- 4) The plan must contain a listing of individuals having input in development of the plan, including the service recipient and direct support staff; and
- 5) The plan must utilize the least intrusive interventions expected to be effective in decreasing target behaviors and increasing appropriate alternative behaviors.

**12.13.c. The BSP Format:** The BSP format (provided in *Appendix K*) is comprised of two (2) sections described below:

- 1) Behavior Analysis and Technical Assessment which is inclusive of time-limited behavior change outcomes, behavioral definitions, a functional assessment; the behavior function hypotheses and the clinical rationale for the interventions recommended; and
- 2) “What I Do to Carry Out this Plan”, which is a clearly written, user- friendly description of how to implement the plan for direct support professionals, including sections titled “What to do to Increase Behavior”, “What to do to Decrease Behavior”, “What to do in Response to a Crisis”, “What Not to Do” and “What to Write Down”.

**12.13.d. Review of the BSP by the Behavior Support Committee (BSC):** The BSP must be reviewed and approved by the local BSC affiliated with the service recipient’s primary provider. The BSC is discussed in more detail later in this chapter. BSC approval is required prior to implementation of the BSP. The BSC is discussed in greater detail in *Section 12.20*.

**12.13.e. Review of the BSP by the Human Rights Committee (HRC):** HRC review and approval is required for any BSP including restrictive interventions and/or rights restrictions. In some situations involving very complex cases, the BSC may request review of a BSP by the HRC, even though restrictive interventions are not proposed. HRCs are discussed in detail in *Chapter 2, Section 2.22*. If HCR approval of a BSP is required, it must be obtained prior to implementation of the BSP.

**12.13.f. Implementation of the BSP:** Any necessary staff training must occur to assure appropriate implementation of the plan. The number of direct support staff needed to implement the BSP must be determined. In some cases, the provider and therapist may agree that a supervisor or house manager can provide staff training to new/replacement staff. Designation of a “trainer” may not be appropriate if the service recipient’s behavioral health status is unstable, if frequent changes in the BSP are required or if the BSP is unusually complex. In such situations, the behavior provider may be the most appropriate provider to manage ongoing staff training for therapy-related staff

instructions. The reason(s) that a therapist must provide ongoing staff training must be thoroughly documented in either therapy contact notes or therapy monthly reviews. The therapist must continue to reassess for changes in the situation that would allow designation of a trainer employed by the provider of the direct support staff. These ongoing reassessments are to be documented in therapy monthly reviews. If there are no primary provider staff available for staff training, the behavior support provider must provide training until a primary provider trainer is identified and trained.

Monitoring for appropriate implementation of the BSP, including a graphical analysis demonstrating BSP effectiveness is to be documented in a monthly review. If the BSP is not effective or is minimally effective, BSP revision should be considered. The behavior analyst responsible is expected to seek input from the appropriate entities (as described previously) in revising the BSP. Revisions to the BSP require approval from the BSC and may require HRC approval (if restrictive interventions are altered) as noted in *Sections 12.13.d. and e.*

**12.13.g. Clinical Service Monthly Reviews:** General requirements for clinical service monthly reviews are provided in *Chapter 3, Section 3.14. and Chapter 8, Section 8.9.f.* Additional requirements regarding behavior service monthly reviews are contained in *Appendix Q.*

#### **12.14. The Behavior Maintenance Service Phase**

When behavior change outcomes have been achieved as documented by a behavior services assessment, preparation of a behavior maintenance plan is appropriate. Requirements for development and implementation of the maintenance plan are the same as for the BSP. The maintenance plan, however, focuses on ensuring that behavioral changes achieved continue long-term as behavior services are phased out. Maintenance plans shall not include restricted interventions. Maintenance plans shall include maintenance outcome(s), a description of service units needed to develop and implement the maintenance plan (in terms of amount, duration and frequency). Behavior maintenance plans must be developed by a behavior analyst (collaboration with a behavior specialist is appropriate if a behavior specialist is involved in delivery of behavior services). The behavior support analyst responsible is expected to seek input from the appropriate entities (as described previously) in developing the maintenance plan. Maintenance plans require approval from the BSC and HRC as noted in *Sections 12.13.d. and e.*

## 12.15. The Closure (Discharge) Phase

**12.15.a. Reasons for Behavior Service Termination.** The services of a behavior provider may be terminated due to:

- 1) Success in achieving behavior services outcomes;
- 2) Service recipient or legal representative decision to seek alternative approaches;  
or
- 3) Transfer to another behavior service provider.

**12.15.b. Closure Reports:** When behavior services are terminated or when behavior service providers are changed, a closure report is required. The closure report describes the reasons for service termination, summarizes the behavior services delivered; describes the success in achieving behavior change and behavior service outcomes, defines interventions needed to maintain behavioral stability and provides any other appropriate recommendations. The report may be written as a contact note or as a separate document.

**12.15.c. Notification of Closure Requirements:** The closure report should be provided to the service recipient's support coordinator/case manager. The support coordinator/case manager may request that the behavior support provider attend a Circle of Support or Planning Team meeting to discuss service termination.

## 12.16. Crisis Prevention Plans

An appropriate and effective crisis prevention plan may prevent behavioral crises that can result in harm to the service recipient or staff and/or psychiatric hospitalization. Crisis prevention plans may be requested by a service recipient's support coordinator/case manager when the need for such is determined by the Circle of Support or other members of the Planning Team. In addition, a behavior service provider performing a behavior services assessment may determine that a service recipient's behaviors are indicative of danger to self or others that require immediate action. In such situations, a crisis intervention plan may be created/revised and implemented. Crisis Intervention plans must be developed by a behavior analyst. The purpose of a crisis plan may be to provide a set of procedures for direct support staff to utilize in responding to service recipient behavior during the development of the BSP. In other cases, a crisis prevention plan may be needed to provide a standard set of procedures for direct staff to use to deal with intermittent behavioral crises. A behavioral crisis occurs when a service recipient's behavior escalates to a point where the safety of the service recipient or others in the service recipient's environment is threatened. Behaviors that may result in crisis include

dangerous levels of aggression, self-injury or destruction of property. The following requirements are applicable to crisis prevention plans:

- 1) A crisis plan must be developed by a behavior analyst (collaboration with a behavior specialist is appropriate if a behavior specialist is involved in the provision of behavior services) with input from the service recipient, Planning Team (including the COS) and direct support professionals who provide services;
- 2) A crisis prevention plan must employ clear language to describe actions to be taken by direct support staff to prevent and respond to a crisis, including how to ensure service recipient and staff safety, when to seek assistance and who to contact;
- 3) Crisis intervention plans should be integrated with other outcomes and action steps indicated in the ISP and with any existing BSP to ensure effectiveness within the service recipient's customary environments;
- 4) The roles and responsibilities of the behavior service provider in providing crisis supports must be defined in the crisis prevention plan;
- 5) The behavior service provider developing the crisis prevention plan is to determine the minimum number of staff persons needed to implement the crisis prevention plan;
- 6) The behavior service provider is required to train a primary provider trainer to teach staff how to implement the crisis prevention plan;
- 7) If a primary provider trainer is not available, the behavior services provider is to provide direct support staff training as necessary to implement the crisis plan until a primary provider trainer is available; and
- 8) Following emergency consultation or behavior crisis events, the crisis plan is to be revised as necessary and staff are to be retrained as necessary.

Additional requirements for crisis prevention plans are provided in *Appendix O*.

### **12.17. Training Primary Provider Trainers or Direct Support Staff to Implement Behavior Support/Maintenance Plans and Crisis Prevention Plans**

A behavior analyst responsible for developing a BSP must work with providers employing direct support staff to determine an appropriate person to serve as a "trainer". If the provider employs a behavior specialist, that individual is generally the best choice for a trainer to teach direct support staff to implement behavior plans. Requirements pertaining to the training of trainers or direct support staff include:

- 1) Training must include role playing as a method of training and evaluating competency;

- 2) Documentation must be maintained by the behavior services provider or provider trainer to describe the type/method of training provided, including the signature and credentials of the trainer, the signature of the trainee, the date training occurred, the level of competency achieved by the trainee and a statement from trainer indicating whether the trainee has adequate understanding of the information presented to implement the behavior plan; and
- 3) The trainer should provide copies of training documentation to the trainee and, upon request, to the provider employing the trainee (for personnel records).

### **12.18. DMRS Approved Behavior Interventions**

DMRS has designated three categories of behavior interventions: unrestrictive, restrictive, and undesignated. Specific requirements apply to each category.

**12.18.a. Unrestrictive Interventions:** Unrestrictive interventions may be included in an approved behavior support/maintenance plan or an approved crisis intervention plan. Plans with unrestrictive interventions require BSC approval and a signed consent from the service recipient/legal representative. Unrestricted interventions are those that teach, train, maintain or increase desired behaviors. These procedures rely upon positive reinforcement. Non-contingent reinforcement is included in this category. Unrestrictive interventions include:

- 1) Environmental enhancement or modification;
- 2) Role playing;
- 3) Modeling and imitation;
- 4) Self control monitoring/instruction;
- 5) Prompting;
- 6) Behavioral contracting;
- 7) Shaping;
- 8) Behavioral momentum;
- 9) Fading prompts or cues
- 10) Differential reinforcement;
- 11) Non-contingent reinforcement;
- 12) Compliance training;
- 13) Chaining: forward, backward, total task;
- 14) Simple restitution;
- 15) Redirection: verbal, gestural, physical;
- 16) Social disapproval;
- 17) Response interruption/blocking; and
- 18) Social extinction.

**12.18.b. Restricted Interventions:** Restrictive interventions can be included in an approved behavior support plan, but cannot be included in a maintenance plan or a crisis intervention plan. Plans with restrictive interventions require BSC and HRC approval and a signed consent from the service recipient/legal representative. Restricted interventions emphasize the reduction of the occurrence of challenging behaviors as opposed to skill acquisition, increase or maintenance. Restricted interventions include:

- 1) Contingent effort;
- 2) Escape extinction;
- 3) Non-exclusion and exclusion time-out;
- 4) Negative practice;
- 5) Contingent use of personal property or freedoms;
- 6) Delay of meals;
- 7) Manual restraint;
- 8) Overcorrection, positive practice;
- 9) Response cost;
- 10) Satiation;
- 11) Substitution of food/meals;
- 12) Mechanical restraint;
- 13) Protective equipment;
- 14) Required (forced) relaxation; or
- 15) Sensory extinction.

**12.18.c. Undesignated Interventions:** Undesignated interventions require consent from the service recipient/legal representative and approval from a local (if available) and regional BSC, from a local (if available) and regional HRC, from the service recipient's COS, from the DMRS Central Office Director of Behavior Services and from the DMRS Assistant Commissioner of Facility and Community Services.

## **12.19. Restraint, Protective Equipment and Exclusionary Time-Out**

The information included in this section refers to interventions utilized by behavior service providers for the purpose of impacting service recipient behavior. The requirements contained herein do not apply to other professionals who may use the same or similar interventions. Please see the *Glossary* for terms and definitions applicable to this section.

Restraints and protective equipment may be used only when necessary to protect the service recipient or others from harm and when less intrusive methods have been ineffective. Restraints and protective equipment may not be used excessively or for a time period beyond that which is absolutely necessary, as punishment, for staff

convenience or as a substitute for other services. Take downs and horizontal restraints are prohibited. The application of restraint or protective equipment and exclusionary time-out to a specific location must be implemented carefully to ensure protection from harm and to protect the service recipient's rights. These procedures require extensive documentation and review. The details of application are provided in the *Appendix D*. In special cases, a request for a variance from these procedures may be considered. Information on submitting a request for a variance is contained in *Appendix L*.

## **12.20. Behavior Support Committees**

**12.20.a. Regional Behavior Support Committees (BSC):** Each grand region must establish a Regional BSC. Regional Directors are responsible for initial appointments of Regional BSC members and for appointment of replacement members based on recommendations from the Regional HRC, from TennCare or from DMRS. All members will be familiar with persons with disabilities and have professional, personal or family experience relevant to participation on these committees.

**12.20.b. Local Behavior Support Committees:** One or more providers may establish a local BSC to conduct required functions for service recipients served by those providers. For a local BSC, the provider executive director(s)/chief executive officer(s) is responsible for appointment of BSC members. Local BSC members shall be familiar with people with disabilities and have relevant professional or personal experience which contributes to their role as a BSC member. Provider(s) involved with a Local BSC are responsible for providing adequate staff to administratively support the Local BSC. If a Local BSC has been formed by a single provider, the provider executive director/chief executive officer is responsible for operational oversight and administrative support of the BSC. If multiple providers jointly form a Local BSC, the executive directors/chief executive officers shall determine which of the executive directors/chief executive officers are responsible for operational oversight and administrative support of the BSC.

**12.20.c. BSC Membership:** A regional or local BSC shall be comprised of the following members:

- 1) A behavior analyst who shall serve as chairperson;
- 2) A medical practitioner (e.g., a nurse, a physician, a nurse practitioner);
- 3) Two (2) agency representatives with knowledge of behavior supports; and
- 4) A service recipient or family member of a service recipient who receives behavior services.

In addition to the above members, the Regional BSC shall have a member who is a psychiatrist.

**12.20.d. Behavior Support Committee Functions:** The BSC provides professional peer review of behavior support/maintenance plans. A BSC reviews all such plans developed by behavior service providers. Behavior plans inclusive of restrictive behaviors and rights restrictions are also reviewed by Human Rights Committees. The BSC may also request HRC review of a plan involving a particularly complex situation. Interaction between the HRC and the BSC is discussed in *Chapter 2, Section 2.22*. BSC functions/responsibilities include:

- 1) Completing professional peer reviews of all behavior support/maintenance plans to determine if the plan includes adequate instruction for direct support staff and if the plan meets professional standards;
- 2) Approving plans for implementation when standards are met;
- 3) Reviewing and determining, on an at least an annual basis, the appropriateness of continuing the behavior support/maintenance plans;
- 4) Reviewing plans using restraint or protective equipment procedures at least every 90 calendar days;
- 5) Providing technical assistance and consultation as requested to service recipients, family members, behavior service providers, and other providers concerning best practices in the design and implementation of behavior plans; and
- 6) Conferring as needed with the HRC, including participating in joint meetings if necessary to address complex issues; and
- 7) Providing a roster of BSC membership to the Regional Director at least annually, within thirty (30) days of the beginning of each calendar year.

**12.20.e. Timely Processing Requirements:** The BSC must address all business issues brought before the committee in a timely fashion. Final determinations regarding the approval of behavior plans must be provided no later than thirty (30) business days following presentation of the plan.

### **12.21. Orientation for Behavior Service Providers**

General provider orientation requirements are addressed in *Chapter 5, Section 5.11*. The orientation specific to new behavior service providers, which is conducted by the Regional Office Director of Behavior Services and/or designated staff, includes:

- 1) Provision of copies of the *DMRS Provider Manual* and the *Behavior Service Provider Technical Assistance Manual* and review of relevant sections;
- 2) Review of forms used in documenting the provision of behavior services;
- 3) Provision of a copy of the *Code of Ethics of the Tennessee Association for Behavior Analysis*;

- 4) Discussion of indicators of quality behavior services, as well as, indicators of poor service quality (e.g., improper service delivery; late or nonexistent contact notes; fabricated or falsified documentation);
- 5) Review of circumstances that could result in termination of the provider agreement and/or removal from the list of approved behavior service providers; and
- 6) Completion of a three (3) month period of Regional Office mentoring and review of the provider's work products, with feed back to the provider on a regular basis (The mentoring period may be extended, if necessary).

## 12.22. Behavioral Respite Services

**12.22.a. Waiver Definition of Behavioral Respite Services:** The waiver definition shall apply to all behavioral respite services provided in a Medicaid waiver. The waiver definition shall also be used to define behavioral respite services provided in other DMRS-funded programs. The waiver definition for behavioral respite services approved by CMS is:

**Behavioral Respite Services:** Behavioral Respite Services shall mean services that provide respite for an enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis. Behavioral Respite Services shall be provided in a setting staffed by individuals who have received training in the management of behavioral issues. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider. The Behavioral Respite Services provider may also accompany the enrollee on short outings for exercise, recreation, shopping or other purposes while providing Behavioral Respite Services care.

Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence. Behavioral Respite Services shall be limited to a maximum of 60 days per enrollee per year.

An enrollee receiving Behavioral Respite Services shall be eligible to receive Individual Transportation Services.

**12.22.b. Planning for Returning to the Residence Following Behavioral Respite Services:** If the individual is placed in a behavioral respite setting, an immediate plan should be instituted to address critical issues such as environmental stressors, stabilization and continuation of treatment upon return to the prior residential setting.

### 12.23. Non-Reimbursable Activities

Examples of activities for which reimbursement will not be provided include:

- 1) Time spent waiting for a service recipient to arrive at the location where behavior services are to be provided;
- 2) Time spent performing administrative functions such as documentation, staff supervision, telephone conversations, etc.;
- 3) Time spent writing behavior service plans and analyzing behavioral data;
- 4) Time spent performing telephone consultations;
- 5) Time spent attending team building, peer review, BSC, HRC and (ISP) Planning Meetings
- 6) Time spent traveling to and from service sites;
- 7) Unjustified or excessive time spent monitoring implementation of staff instructions without analyzing measurable data;
- 8) Services or intermittent assessments not included in the ISP; and
- 9) Services provided in a hospital, Intermediate Care Facility for the Mentally Retarded (ICF/MR), Skilled Nursing Facility (SNF), local K—12 educational facility or other federally funded program.