Best Practice

(based on surveyed results of IN-ABC membership November 2017)

Final Board Approval January 12, 2018

All members of IN-ABC are required to be informed and uphold the Centers of Medicaid and Medicare (CMS) HCBS Final Rule, Indiana Administrative Code (IAC) 460 Rule 6, Policies and Procedures issued by the Division of Disabilities and Rehabilitation Services (DDRS), Bureau of Developmental Disabilities Services (BDDS), Bureau of Quality Improvement Services (BQIS), implement employer's plan issued by national accreditation body (as appropriate), and provide services to Medicaid Waiver recipients as a member in good standing. To be in good standing and uphold the credibility of IN-ABC, the following "Best Practice" table is a reference tool for all members.

Practice	Defined
IN-ABC's mission is relevant as stated: "Through professional advocacy, support and development, IN-ABC promotes effective, ethical and quality behavioral services."	• Adhere to IN-ABC's Code of Ethics • Report ethical violations to IN-ABC Ethics Committee • Report per DDRS policy on Incident Reporting and Management (460 0301 008) • Abide by DDRS Provider Code of Ethics (460 0228 014) • At least once every 90 days, determine the efficacy and quality of services provided in a quantitative and qualitative manner communicated via quarterly report to all IST members
Identity of member of the Indiana Association of Behavior Consultants (IN-ABC)	As a member of IN-ABC, the title a member may reference him/herself to identify role/definition (specialist, clinician, analyst, therapist, etc.) may be interchangeable with "Behavior Consultant". The "BC" in IN-ABC occurred in 2001, as the trade association became a legal entity

Members of IN-ABC are experienced and well trained to provide behavioral support services.	• Supervision and training is provided for at least the first year providing waiver services for all behavior consultants providing services to waiver recipients • Direct experience in the field of disability services for at least one year in other capacity previous to being a behavior consultant (direct support professional, role within school system, role within health care realm, social services, human services, etc.) • Accept referrals based on skill set and knowledge of diagnoses, medication regimen, availability to team of support)
Functional Behavior Assessment (FBA) is individualized for each person on caseload	• Required to include: o Record review including information from past and current assessments including mental health history and relevant behavioral history o Face to face interviews with knowledgeable informants o Direct observation of the person in multiple settings o Identification of what is reinforcing for the person in multiple settings o Identification of what is a "meaningful day" for the person (when alone, with natural supports, with paid supports, specific settings and activities) o History of abuse, neglect, exploitation and/or mistreatment is identified

	○ Length of billed time against a person's waiver budget should rarely exceed 7 hours in a total budgeted year ○ Reviewed annually at minimum ○ Follow DDRS Policy (460 0221 007)
Behavior Support Plan (BSP) is strengths-based ★ Positive Behavior Supports ★ Prevention of abuse, neglect, exploitation and mistreatment (ANEM) ★ Restrictive Interventions	• Core principles of Appreciative Inquiry are applied (Discovery: best of what is, Dream: what might be, Design: define methods of change and growth, Delivery: steps toward what will be) • Utilizes strength-based documentation and training • All BSPs include: description of individual, psychiatric medication list, Proactive strategies, operationally defined behaviors with function, antecedents/setting events, reactive strategies, replacement behaviors, measurable behavior goals, data collection instructions, risk vs. benefits • Focused on positive supports and proactive strategies/replacement strategies vs. reactive interventions • Prevention of ANEM are included in all BSPs due to heightened prevalence among individuals with intellectual and developmental disabilities and consistent with the IN-ABC's member's mandatory training as a provider • Restrictive interventions are incorporated as a last option and are time limited (DDRS policy 460 0221

★ Fading Plans ★ Human Rights Committee (HRC)	007) to include with the Plan documentation from the Individualized Support Team failed to identify other reasonable or feasible alternatives • Use of restrictive interventions are in compliance with DDRS "Use of Restrictive Interventions, Including Restraint" policy (460 0228 025) • Includes fading plan of all restrictions and that plan is evaluated at least once every 90 days • Supported decision making tools guide the development of informed consent procedures, guardianship review, and awareness by the person and entire team (paid and unpaid) of restrictive interventions and fading plans • No BSP that includes restrictive interventions may be implemented without informed consent by a Human Rights Committee (DDRS policy 460 0221 012) • The author of the BSP presenting the document to the HRC must ensure guardianship, psychotropic medications and reduction plans, PRNs, intensive staffing to include 1:1 ratio, historical information that non-restrictive strategies and interventions failed in the past and why, a fading plan to remove restrictive measures based on the data within quarterly reports, risk vs. benefit of each restrictive measure, and past 12 months of BDDS and

★ Aversive Techniques ★ Use of annual budget ★ Training of BSP	internal Incident Reports are considered by the HRC • Aversive techniques are PROHIBITED (DDRS policy 460 1207 003) • Knowledge of aversive techniques being used are required to be reported to BQIS, the entire IST, APS or CPS • Use of waiver recipients budget for completion of the BSP should rarely exceed 7 hours in an annual budgeted year • Competency based training on the implementation of all BSPs must include all direct service staff or the service provider's supervisory staff prior to identified direct service staff working with the individual • Competency to implement the Plan should include: o Understanding of all diagnoses and how those diagnoses impact the individual o the individual's strengths o Defined maladaptive behaviors o Proactive/preventive strategies o Replacement behaviors o Approved restrictive measures o Psychotropic medications, use of those medications, and side effects o Data collection

Service delivery model is consistent across all IN-ABC members	• 75% of reimbursed service delivery should encompass direct interaction with the individual for engagement, all members of the Individual's Support Team (IST), modelling, building natural supports and using local resources • Adhere to person-centered planning and self-determination expectations • Increased active support in all environments the individual is involved in and desires to be involved in • Use Person First Language in all written documents and verbal references to an individual (eliminate use of client, consumer, customer, etc.)
Training and Professional Development elevates IN-ABC members as preferred choice as a service provider	• Prompts policy and system-wide change • Forward thinking for a sustainable service as resources lessen • Efficient in completion of billable activities • Fading of paid supports is included in conversations with individual, fellow providers, and community members • Training and professional development is planned from IN-ABC members' suggestions and feedback • Assurance that all members providing behavior support services via Medicaid waiver funding demonstrate completion of at least 10 hours of continuing education credits annually

	• Annual satisfaction survey of caseload in mode the waiver recipient can complete and submit anonymously