Restrictive Measures Provider Requirements (update 4/15/2020)

In accordance with Wisconsin Statutes and Administrative Rules, including Wisconsin State Statutes: Chapters 46.90 (4), 50.09 (1); 51.61 (1); 54; 55.043 (1m, 1r) and Wisconsin Administrative Code: DHS 83.12; DHS 88.10 (3); DHS 88.11; DHS 94.10, members enrolled in Community Care, Inc. programs will be protected from the unnecessary use of restrictive measures.

- All providers/ caregivers are expected to refrain from using unnecessary restrictive measures with members, and to assist members in understanding and asserting their right to be free of restraints.
- Use of restrictive measures is a last resort, to be used only when previous attempts at less restrictive measures have been implemented, tracked, and determined insufficient; only to be used for the safety of the member, with prior proper approval.
- Provider/caregivers/teams should not think of restrictive measures as the solution for addressing the dangerous or challenging behavior but should instead think of them as a temporary strategy used to maintain safety.
- Community Care, Inc. Policy and Procedure requirements apply to requests for use of restrictive measures for members who live in community settings in Medicaid-funded adult long-term care programs: Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly). Community settings include members residing in their owned or rented home, in other supported living arrangements, adult family homes (AFHs), community-based residential facilities (CBRFs), and residential care apartment complexes (RCACs). Community-based vocational settings and day service programs are also community settings.

PROCEDURE:

Residential and Other Providers

1. *If a contracted residential or other provider identifies a need for restrictive measures, the provider must have a Behavior Support Plan (BSP) in place for the Community Care Member.* Developed by providers, caregivers, interdisciplinary team (IDT), and including the member and legal decision-maker, as appropriate, the BSP must be reviewed and approved by the IDT. The member participates as a team member in the initial and ongoing development of his/her care plan, including BSP. (See also definition of BSP and component parts.)
2. When the member's behavior continues to pose an immediate risk of harm to self or others, and previous support strategies attempted via the BSP have not proven effective, the step by step procedures for applying restrictive measures must be added to the plan in collaboration with the IDT and a licensed behavioral health professional. *If a contracted residential or other provider identifies a need for restrictive measures, the provider must have a BSP in place for the Community Care, Inc. member.*
3. The BSP, including any proposed restrictive measures, along with any additional required documents, is submitted to a preliminary review committee of Community Care, Inc.'s Restrictive Measures Oversight Committee (RMOC), facilitated by the Restrictive Measures Lead. Suggestions for improvement to the plan are communicated to the IDT, providers and caregivers during plan development with assistance provided by the Behavioral Health Resource Team.

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4. Residential providers must comply with State statute and administrative rule regarding the use of restrictive measures. This includes the notification and approval requirements outlined in DHS 83.12 and 88.11, and applicable resident rights outlined in DHS 83.32, 88.10(3) (n) and 94.10. Other providers must comply with applicable State statute and administrative rule regarding the use of restrictive measures.
5. The BSP including proposed restrictive measures, and additional required documentation, is submitted to Community Care, Inc.'s RMOC for review, consideration, improvement and local approval. The RMOC meets monthly and as needed. *The F-62548 for DQA WAVE approvals are submitted by the provider directly to DQA. When DQA makes a decision, written notice will be sent to the provider only; the provider will be accountable to report DQA's decision to Community Care, Inc.*
6. Community Care's RMOC reviews restrictive measures proposals and either approves the proposal as submitted, approves the proposal with conditions, request additional information, or denies the proposal. RMOC will consider approving restraints as part of a BSP only if the following conditions are met:
   a) A support plan including positive supports accompanies the request for approval of restrictive measures.
   b) A restrictive measure is necessary for medical or safety purposes, or for purposes of maintaining community placement.
   c) It benefits the member and allows the member to attain or maintain his/her highest level of independent functioning.
   d) The provider has first assessed for underlying conditions which may cause symptoms or behaviors that require restrictive measures (e.g., a behavior that may be the result of an environmental stressor or medical issue).
   e) Providers/caregivers have attempted/documented alternative methods to minimize or eliminate symptoms/behaviors without success.
   f) The proposed restrictive measure is the least restrictive measure.
   g) Service providers are not using a restrictive measure for discipline, punishment or convenience or as a substitute for necessary staff.
   h) The restrictive measure will be used only during the time necessary and only as approved.
   i) Adequate documentation of behaviors and use of restrictive measures is maintained and communicated to the IDT and a plan for review and termination is documented.
   j) The plan includes when, how and by whom service providers will be trained to use restrictive measures.
   k) The plan includes who can approve use and who can initiate use of the restrictive measure.
   l) The member and/or his/her legal decision maker have been informed of the risks and benefits of the restrictive measure and have approved of its use.
   m) The plan is signed by the member's Licensed Independent Practitioner (LIP) or psychiatrist.
   n) Documentation is obtained by the IDT staff showing that training for use of restrictive measures is completed before implementation.
7. RMOC decisions will be in writing, identify each measure reviewed separately, describe reasons for the return or denial, include any conditions of approval along with adequate descriptions of these conditions, and the RM Lead will sign the decision.
8. Denials must also offer information for both the provider and member or legal decision maker to grieve the decision. The communication will provide guidance on what revisions the provider can make to remedy the defects in the returned or denied application.
9. **Community Care's RMOC must approve the provider's request before the submitting the request to DHS**. Note: *Provider requests to DHS for input, advice, or technical assistance regarding restrictive measures must also come through Community Care, Inc.*

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10. The Division of Medicaid Services, Bureau of Adult Long Term Care Service's designated Lead on Restrictive Measures will approve or deny a request from Community Care through the DHS Restrictive Measures Database (IES).
11. The approval process for restrictive measures is a continuous process that does not end with the approval decision by DHS. The team must continually monitor the use of any approved restrictive measure according to a member-specific plan that must accompany each submission. Continuous monitoring should address whether or not less restrictive supports are available as an alternative to use of the restrictive measure.
12. If Emergency restrictive measures are used (see definition and requirements), the IDT, in cooperation with providers, licensed behavioral health professionals, and administrative staff, will ensure that staff is trained on the process of identifying, responding to, and documenting an emergency situation and the provider has a written policy on file.
13. Any emergency use of restrictive measures must be reported by the residential or other provider to the IDT within 24 hours.

Grievance Process: Family Care, Family Care Partnership, and PACE program members have the right to file a grievance regarding Community Care, Inc.'s decisions related to the use of a restrictive measure. Community Care, Inc.'s existing grievance process applies to all member grievances related to the use of or denial of use of restrictive measures, other than the decision to suspend use. Community Care, Inc. has a written description of the grievance process and written protocols for explaining member rights, including the right to be free from restrictive measures and the right to prompt and adequate treatment. Members or their legal decision makers who wish to contest Community Care's decisions related to the use of restrictive measures should follow the grievance process:

Members may file a grievance in any of the following ways:

• Contacting Community Care's care management staff or the CCI member rights specialist

• Calling MetaStar at 1-888-203-8338

Community Care, Inc.'s contracted Providers are obligated to adhere to this procedure. Failure to do so may result in termination of the Provider's contract with Community Care, Inc. and when warranted, a consultation with or referral to the Division of Quality Assurance.

NOTE: Community Care, Inc. IDTs reserve the right to deny a provider's request to use restraints with a member, even if a Behavior Support Plan is created and steps noted above are successfully completed.

Conclusion:
The use of restrictive measures to control or as a response to a person's behavior is not treatment, nor is it therapeutic. All facilities and programs should become familiar with the changing standards of care and best practice focused on building skills and techniques to de-escalate and redirect behaviors that present safety concerns and work earnestly to promote a trauma-informed culture of care. (DQA publication P-01196)

DEFINITIONS:

Behavior Supports: Behavior supports refer to the components of a member's environment intended to encourage behaviors that replace challenging or dangerous behaviors and help the member attain their desired quality of life. Behavior supports may include, but are not limited to, teaching the member methods to communicate better with others, expanding the opportunities for developing relationships, improving the quality of living environments, or other clinical interventions.

Behavior Support Plan: A behavior support plan is a written document, specific to the member, intended to inform direct support staff how to assist the member in building prosocial and adaptive behaviors. Behavior plans also include direction on how to utilize other supports, strategies, and interventions in order to ensure safety and to decrease the member's challenging behavior. For members with restrictive measures, the behavior support plan must include information about the use of the restrictive interventions. The plan must include a description of the proposed step-by-step procedures for applying or implementing the restrictive measure, along with a description of how it will be monitored and the criteria that govern release of the individual from the measure. The plan should also identify the maximum duration for the use of the measure. In addition, the plan must address the methods or strategies the team will employ to attempt to reduce or eliminate the restrictive measure. When a member has a behavior support plan, it should be attached to the member-centered plan as an addendum.
Required components of a BSP:

- Description of the behavior
- Situations in which the behavior is likely to occur
- Signs and signals that might occur prior to the behavior
- How staff should respond
- How staff and others can encourage and support more appropriate responses

Challenging or Dangerous Behavior: Challenging or dangerous behaviors refer to the member's behavioral response during an incident that place the member or others at risk of serious harm. Teams must only incorporate restrictive measures into a member's support plan for use when the member's behavior puts them or others at imminent risk of serious physical harm.

De-escalation Strategies: Strategies direct support staff use to help a member return to a baseline, adaptive, or calm state. Strategies may include:

1. Staff adopting a caring but neutral position.
2. Remaining calm and using a calm tone of voice.
3. Paying attention to the member; listening, focusing on feelings, and validating them; empathizing; being nonjudgmental (in both body and verbal language).
4. Reminding the member of potential consequences to their behaviors and that he or she is in control.
5. Staff working to reduce environmental stressors.
6. Trying to determine what he or she wants and offering solutions or alternatives.
7. Drawing the member into a more pleasant, positive, and grounded state.

Emergency: An emergency, as it relates to restrictive measures, means an unanticipated situation has occurred where a member suddenly engages in dangerous behavior, placing themselves or others at imminent, significant risk of physical injury, or exhibits signs known to be precursors of such behavior for the member. This may include the appearance of a behavior that has not happened for years or has not been known to occur before or it

could include current behaviors that suddenly and unexpectedly escalate to an intensity the team has not seen before.

Isolation: Isolation is the involuntary physical or social separation of an individual from others by the actions or direction of staff, contingent upon behavior.

Isolation by Staff Withdrawal: Isolation by staff withdrawal occurs in situations where, for safety reasons, the support team determines staff should withdraw from the member due to the presence of behaviors that present imminent risk of harm to staff. When staff withdraws, they retreat to a predesignated room or area for a specific amount time to allow the member to calm. It is considered to be isolation by staff withdrawal when the member is either unlikely to follow, or unable to follow, or unable to reach staff after they have retreated to the designated area. Typically, this involves staff locking the door between them and the individual, but not always. If staff go into the office and close the door without locking it because they know the member would never try to enter the staff office, this would also be isolation by staff withdrawal. If staff goes into the basement and leaves the door open, knowing the member would never try to follow them, this would also constitute isolation by staff withdrawal.

Manual Restraint: A manual restraint, including physical holds and escorts, involves one or more people holding the limbs or other parts of the body of the member in order to restrict or prevent their movement.
DHS does not consider the following actions to be manual restraints or restrictive measures:

1. Holding an individual's limbs or body to provide support for the achievement of functional body positions and equilibrium, such as supporting someone to walk or achieving a sitting or standing position.
2. Holding an individual's limbs or body to prevent him or her from accidentally falling.
3. Use of self-protection and blocking techniques in response to aggressive behaviors.
4. Use of graduated guidance, assisting the individual to move, but not restricting body movement or forcing body movement, as part of an approved intervention

Mechanical Support: A mechanical support is any apparatus used to provide proper alignment of an individual's body or to help an individual maintain their balance. Mechanical supports include but are not limited to, postural supports, position devices, and orthopedic devices. The team must utilize a qualified professional to design a plan for use of mechanical supports in accordance with principles of good body mechanics, with concern for circulation, and with allowance for change in position. Mechanical supports must not impair or inhibit visual or auditory capabilities or prevent or impair speech or other methods of communication.

Medical procedure restraints: Medical procedure restraints utilized while under the care of medical professionals in a medical or dental office or while receiving treatment in a clinic or hospital, *do not need to be approved by DHS as long as the medical provider is directing staff who accompanies the member.*
Note: Community Care must submit a request to DHS for approval of a medical procedure restraint when the procedure is occurring in the individual's home, day program, or other nonmedical setting. Staff may only use medical procedure restraints when necessary to accomplish a specific diagnostic or therapeutic procedure ordered by a medical professional. The use of the restraint must only occur for the minimum duration necessary to complete the procedure. If the medical procedure restraint is necessary as a form of behavioral control, the Community Care must submit a behavioral request.

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Prohibited Practices: Providers may not use the following maneuvers, techniques, or procedures under any circumstances:

1. Any maneuver or technique that does not give adequate attention and care to protection of the individual's head.
2. Any maneuver, technique, or device that places pressure or weight on the chest, lungs, sternum, diaphragm, back, or abdomen.
3. Any maneuver or technique that places pressure, weight, or leverage on the neck or throat, on any artery, on the back of the head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway, such as straddling or sitting on the torso, or any type of chokehold.
4. Any maneuver or technique that involves pushing into an individual's mouth, nose, or eyes.
5. Any maneuver or technique that utilizes pain to obtain compliance or control, including punching, hitting, hyperextension of joints, or extended use of pressure points.
6. Any maneuver or technique that forcibly takes an individual from a standing position to the floor or ground. This includes taking an individual from a standing position to a horizontal (prone or supine) position or to a seated position on the floor.
7. Any maneuver or technique that creates a motion causing forcible impact on the individual's head or body or forcibly pushes an individual against a hard surface.
8. Any use of seclusion where the door to the room would remain locked without someone having to remain present to apply constant pressure or control to the locking mechanism.

Protective Equipment: Protective equipment includes devices that restrict movement or limit access to areas of one's body. Protective equipment refers to devices applied to any part of an individual's body to prevent tissue damage or other physical harm and the individual cannot easily remove the device. Protective equipment must not impair or inhibit visual or auditory capabilities or prevent or impair speech or other methods of communication.

Protective equipment includes, but is not limited to:

• Helmets, with or without face guards
• Gloves or mitts
• Wheelchair seatbelts
• Shower chair seatbelts
• Bedrails
• Wrist cuffs
• Ankle straps
• Goggles
• Pads worn on the body
• Clothing or adaptive equipment designed or modified to restrict access to a body part

The following protective equipment devices are not designated as restrictive measures by DHS:

1. Mechanical supports as defined above.
2. Wheelchair seat belts or foot straps, bed rails, and other transportation safety devices such as stretcher belts intended to prevent an individual from accidentally falling or slipping during transport.
3. Motor vehicle seat belts or harnesses with buckle guards or similar devices in place to ensure a passenger is unable to remove the safety belt in a moving vehicle.
4. Professionally designed therapeutic devices to promote optimal motor functioning.

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Release Criteria: Criteria specified in the behavior plan, which, once met, would result in the termination of the use of the specific restrictive measure for that incident. The criteria for release should identify cues that are unique to the member for determining if he or she appears to be calm and is no longer exhibiting behavior that puts someone at imminent risk of harm. Upon release, staff must offer the member the opportunity to move about. If appropriate to the situation, the staff should also give the member the opportunity to have food and drink and to attend to their other needs.
The member *must* be released:

1. When the criteria outlined in the plan is met.
2. If the criteria for releasing the member from isolation, seclusion, or protective equipment have not been met within 60 minutes of the first use of the restraint.
3. When the use of an approved manual restraint has lasted 15 continuous minutes.
4. When the member's behavior has not been dangerous and he or she has been calm for five full minutes.
5. If there are any threats to the member's health or well-being from use of the measure.

Restraint: A restraint is any device, garment, or physical hold that restricts the voluntary movement of, or access to, any part of an individual's body and the individual cannot easily remove it.

Restraint to Allow Healing: The treatment of acute medical conditions such as lacerations, fractures, post-surgical wounds, skin ulcers, or infections may require the use of a restrictive measure to allow healing. The use of a restraint to allow healing must include a protocol for use. The protocol must be for the specific device or procedure, include the rationale for its use, and specify the limited period of time it may be used. *Community Care must submit a restrictive measures request to DHS if the restraint to allow healing will be utilized for more than three months.*

Restrictive Measure: The term used to encompass any type of manual restraint, isolation, seclusion, protective equipment, medical procedure restraint, or restraint to allow healing as defined in this policy.

Restrictive Measure Oversight Committee (RMOC): This refers to Community Care staff, who are responsible for the review and approval of any requests for the use of a restrictive measure prior to submittal to DHS.

Seclusion: A restrictive measure in which staff physically set the member apart from others inside a room using locked doors equipped with a pressure-locking mechanism. Seclusion does not include the use of devices like "wander guards" or similar products that may also involve locking doors. DHS does not permit the use of seclusion as a form of behavior modification or as a consequence for noncompliance. DHS only permits the use of seclusion as a response to a behavior that involves an imminent risk of harm and for the shortest duration possible to maintain safety. Examples of appropriate use of seclusion are to ensure safety of the member and others due to prolonged physical aggression or to clear an area of harmful items, such as broken glass. The behavior support plan must indicate the method staff uses to transport a member safely to seclusion. DHS permits seclusion only with the use of a pressure-locking mechanism that requires the constant manual application of some form of pressure to maintain the locked condition. DHS does not permit locking a member in any room where the door would or could stay locked without constant pressure under any circumstance. Other requirements around the use of seclusion include continuous visual monitoring, safety precautions specific to the member's needs (non-breakable windows, recessed lighting, adequate ventilation, padded walls or floors), and adequate room size.

Voluntary Movement: In relation to restrictive measures, voluntary movements are movements the individual is able to control and that are purposeful.

References:

Wisconsin State Statutes: Chapters 46.90 (1, 4), 50.09 (1); 51.61 (1); 54; 55.043 (1g, 1m, 1r) and Wisconsin Administrative Code: DHS 83.12, 83.21 and 83.32; DHS 88.10 (3); DHS 88.11; DHS 94.10.

Prohibited Restrictive Measures in Community-Based Programs and Facilities, DMS Memo 2017-01: http://www.dhs.wisconsin.gov/dltc/memos/2017-01.pdf

Restrictive Measures Guidelines and Procedures: https://www.dhs.wisconsin.gov/publications/p02572.pdf

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