The Positive Behavior Support Planning Process for Case Managers

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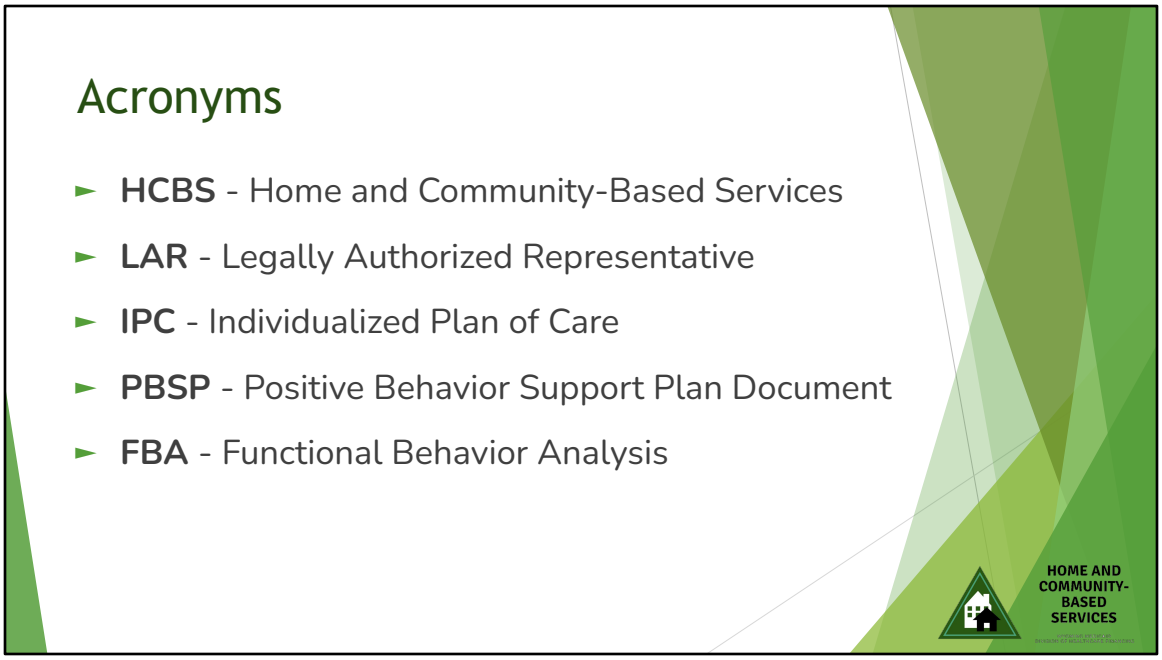
Wyoming Department of Health

HOME AND COMMUNITY-BASED SERVICES

WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

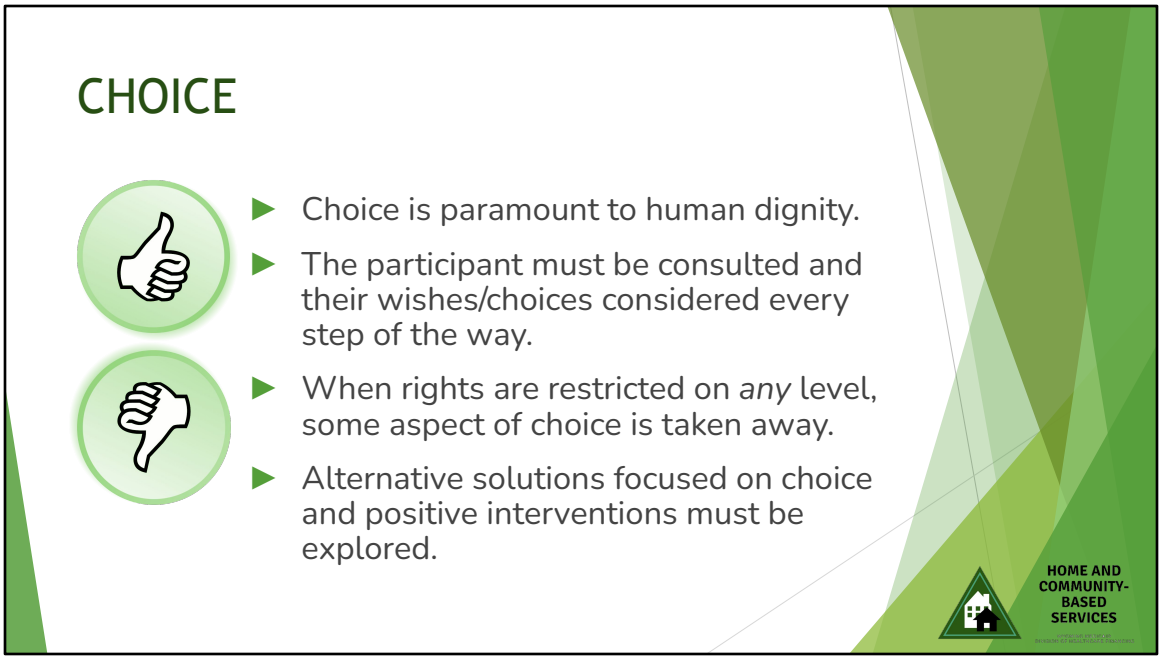
Thank you for joining us for this month's training presentation on the Positive Behavior Support Planning Process for Case Managers. My name is Lacey Magnuson, and I am a Benefits and Eligibility Specialist with the Home and Community-Based Service Section, Division of HealthCare Financing within the State of Wyoming's Department of Health.

The purpose of this training is to help case managers better understand their roles and responsibilities in the positive behavior support planning process and ultimately assist with developing more effective positive behavior support plans for the benefit of participants. Additionally, we want to ensure that case managers are aware of and meet expectations as required in Wyoming administrative rule.



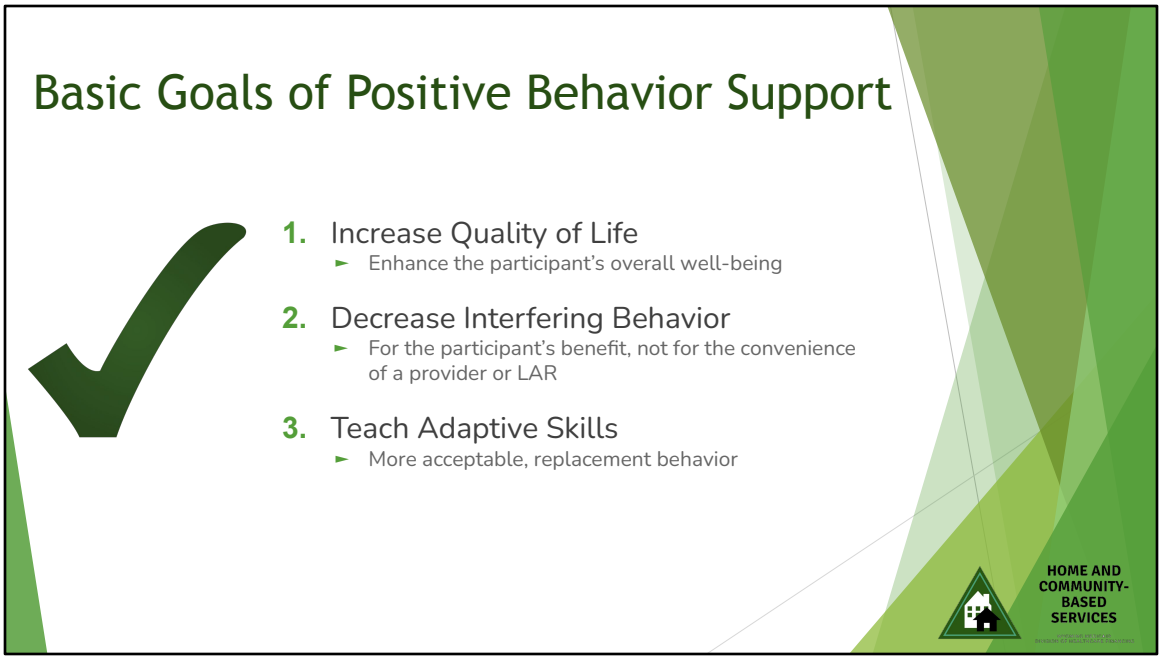
Before we get started, we'd like to review the acronyms and abbreviations you'll see in today's training. The Medicaid system uses a lot of acronyms and although you may already know these, we want to avoid any confusion for those that may not.

- HCBS stands for Home and Community-Based Services
- LAR means Legally Authorized Representative (this may include guardians, parents, or others)
- IPC is short for Individualized Plan of Care
- PBSP will be used often throughout this training and refers to the Positive Behavior Support Plan document. You'll also hear about positive behavior support interventions which are included in the plan and based on the research-based, person-centered approach of the same name - "Positive Behavior Support". Note that the plan document, interventions and overall approach are distinct, but have similar names.
- You'll also hear about the FBA which stands for Functional Behavior Analysis.



We want to take a moment to remind you about the importance of choice. You hear us say it often on these calls because we want it to be in the forefront of your mind. Having choice is paramount to human dignity. Choice is a basic tenet of Home and Community-Based Services – including positive behavior support plans. Participant's need to be given choice throughout the PBSP process and in all other aspects of their lives.

The participant must be consulted during the PBSP process, and their wishes and choices in how to address the situation must be taken into consideration. While a participant's behavior may cause a situation that could become a threat to their health and safety, automatically presuming that they need more supervision or support may not be the best answer. Restricting a participant's basic human rights is a really big deal, and should never be taken lightly. When a participant's rights are restricted on any level, some aspect of their choice has been taken from them. Alternative solutions must be explored, and restrictions should be the *last* consideration when responding to a challenging situation. This is especially important when thinking about developing positive behavior support plans where participant choice and positive interventions are core concepts.

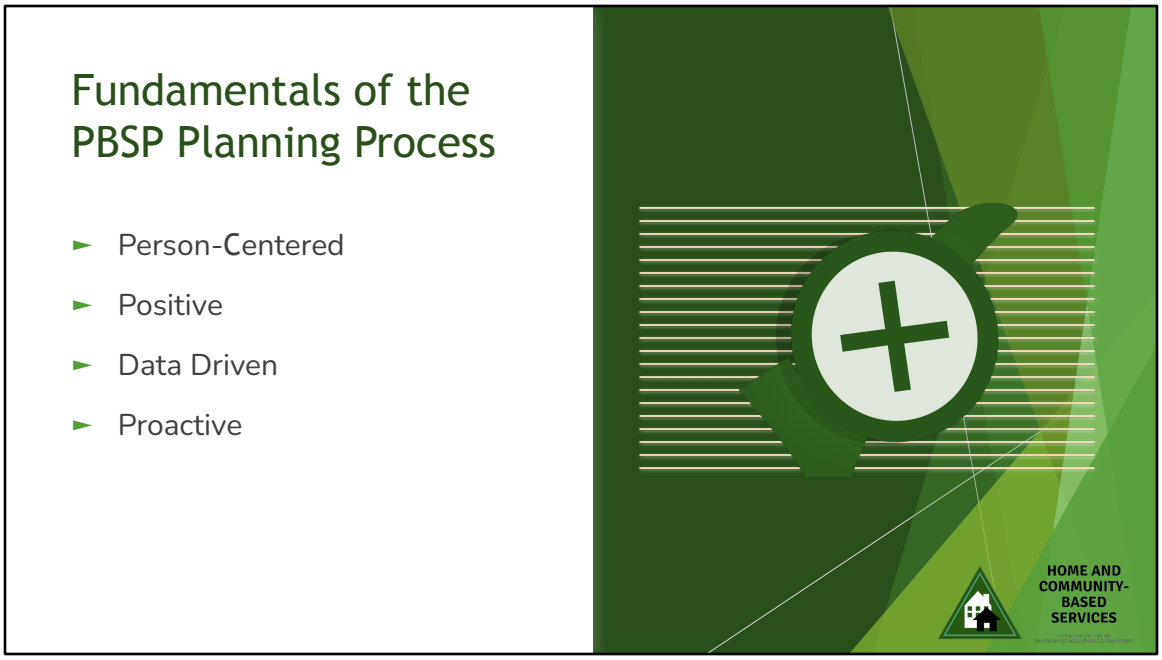


Let's begin by considering the basic goals of Positive Behavior Support. It may seem simple, but meeting these three goals is truly what's at the core of effective positive behavior support plans.

First, positive behavior support is intended to increase the participant's quality of life by enhancing their overall well-being and general satisfaction in their day-to-day activities.

Secondly, positive behavior support helps the participant decrease their use of behaviors that interfere with their ability to live and participate in the community, or that hinder their interpersonal relationships. Plans to decrease an interfering behavior must be for the participant's benefit, not for the convenience of the provider or the participant's LAR.

The third goal of positive behavior support is to teach the participant adaptive skills or replacement behaviors that enable them to communicate their feelings, wants, needs or desires in a more acceptable way.



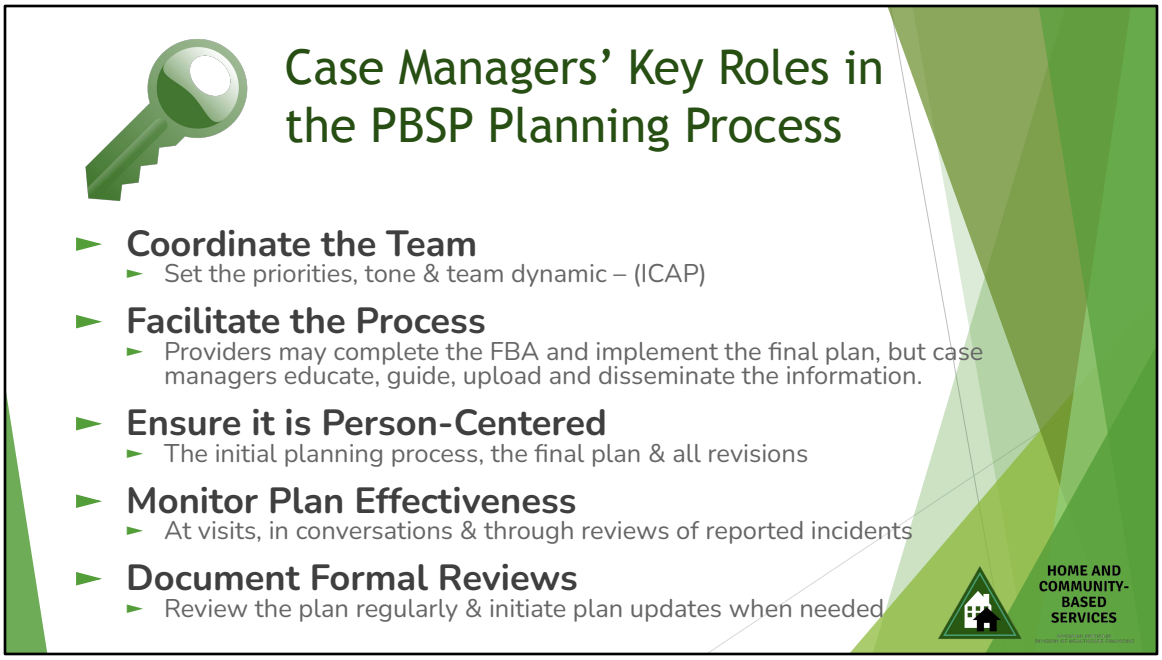
Along with the three primary goals of positive behavior support, case managers (and the team) should keep these four fundamentals in mind throughout the PBSP planning process. The positive behavior support planning process must be person-centered, positive, data driven and proactive. First, maintaining a **person-centered** approach that focuses on the uniquenesses of the individual participant will result in a more effective plan.

Secondly, whether it's guiding the team dynamic, or determining the most effective interventions, a focus on a **positive** approach is key. The planning process must also be **data driven**. The data collected during the Functional Behavior Analysis phase enables a better understanding of the behavior and ultimately informs what interventions will be most effective.

Finally, the process is inherently proactive. When there is a comprehensive FBA, the PBSP can be compiled in a way that deters behaviors from occurring in the first place. Through the FBA and PBSP planning process, we can better understand the reason for the behavior, teach alternative ways to communicate, proactively avoid known triggers and support the participant in learning replacement behaviors.

Now that we've touched on the high-level goals of positive behavior support and the fundamentals of the planning process, let's narrow in on the day-to-day work of writing a PBSP and define the actionable steps you and the team will follow throughout the development process. These essential steps include:

1. Building a behavioral support team
2. Ensuring a person-centered planning process
3. Focusing on a data-driven functional behavioral analysis
4. Defining the hypothesis, motivation or supposed purpose of the behavior
5. Developing a positive behavior support plan with unique *positive* interventions
6. Monitoring outcomes and plan effectiveness
7. Regularly reviewing and revising the plan as needed



Case managers play a critical role on the team and have several **specific** responsibilities within the steps of the PBSP process. As a case manager you are responsible for:

- **Coordinating the Team.** Your priorities, interactions and attitudes help set the tone, focus & overall team dynamic.
- **Facilitating the Plan Development Process.** Case managers facilitate the entire planning process. Although the *team* determines which behaviors to include in the plan, for participants on the Comprehensive Waiver, the ICAP is a tool that can assist you. Providers may also complete the Functional Behavior Analysis and are responsible for plan implementation, but case managers educate and guide along the way. Case managers are also responsible for uploading the FBA and PBSP documents, naming files according to established naming conventions, and ensuring the participant, LAR and providers have access to the information.
- **Case manager must also ensure the entire process is person-centered.** This includes the initial development process, the final plan & all subsequent plan revisions.
- **Monitoring Plan Effectiveness.** Case managers are responsible for monitoring the effectiveness of a PBSP by following-up during visits, initiating

- conversations with the team, reviewing all incident reports and usage of any behavior modifying medications.
- **Documenting Formal Reviews.** Finally, case managers must regularly and formally review the plan with the team and initiate any plan updates or revisions if needed.

We will discuss each of these roles and responsibilities in more detail throughout this training.

First, case managers are responsible for coordinating the entire team and inviting key players in the participant's circle of support. Case managers must ensure that all voices of a participant's team are included in the discussion and can set the tone for a positive team dynamic where everyone's input is valued and welcome. This includes:

- Providers – with an emphasis on direct care staff. While managers may also give valuable input, input from staff that know the individual the best and have daily interactions with them, is simply invaluable. Direct care staff may have the most to offer ***and*** the most to gain as they need to know how to execute the plan.
- The participant's Legally Authorized Representative (LAR), family members, friends and others in their circle of supports should also be involved. This also includes health professionals, therapists, and most importantly, **the participant**.

When coordinating the team, the most important team member is the participant themself. It is critical to seek the participant's input in order to design a plan that works for them. The more vested a participant is in the PBSP, the more successful it will be.

Plans often fail when participants aren't involved or there's no buy-in. If the participant doesn't buy-into a proposed intervention strategy, it could cause frustration and escalate (rather than deescalate) interfering behaviors. It's important to remember that PBSP intervention strategies are not something done TO a participant, but instead must be done WITH them.

Ask questions of the participant.

- What are they trying to communicate? What do *they* want? What motivates them?
- Be sure to meet individuals where they are, and not where you, their LAR, or providers want them to be or think they *should* be.

It's helpful to consider how you might feel if an FBA and PBSP were written about you and your behaviors. What would you want to be asked? What would you like said

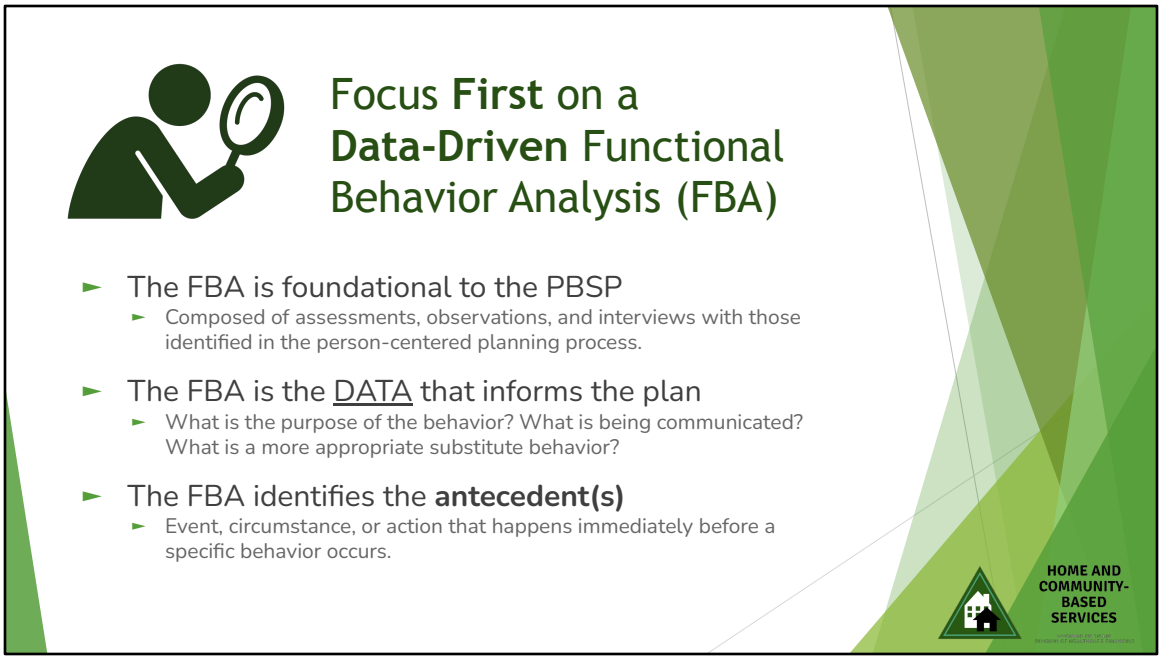
about you? Wouldn't you want the opportunity to give *your* input?

Focusing on the participant as the team's VIP helps to ensure the process is person-centered. Person-centered planning and positive behavior supports go together in that both represent a system of inclusivity, positivity, and growth. If a person-centered approach is taken, the participant's wants, needs, hopes, and dreams are at the center of both.

This meaning gets lost when plans become focused solely on what needs to be "fixed" rather than focusing on opportunities for enhancement, coaching and growth. Often we see PBSPs written in a manner that sound like they are trying to instruct the disability out of a person. Case managers may need to remind teams that behaviors are often *directly linked* to the individual's disability, and the PBSP team is there to ***support*** the participant, not to instruct or control them. A person-centered approach considers not just the individual participant, but what *makes* them an individual. Their age, culture, gender, beliefs, strengths, desires, dislikes, etc., as well as their diagnosis or disability.

A person-centered approach maintains the universal practices of dignity, choice, and respect. The process should enhance dignity, promote positive well-being, honor choice, and support independence. As a case manager, you can promote choice by

focusing on the participant's needs and wants rather than the provider's or LAR's. You can encourage self-expression by involving participants in the conversations and decisions about the plan and asking them direct questions to facilitate meaningful participation. This type of empowered environment will help keep the process person-centered and focused on the participant's preferences.



After coordinating the team and while maintaining a person-centered VIP approach, case managers can assist the team with a data-driven functional behavioral analysis (FBA).

It cannot be understated how foundational the Functional Behavioral Analysis is to a Positive Behavior Support Plan. If the team focuses on completing a comprehensive FBA, the plan development often falls into place. The FBA is the first step and is composed of assessments, observations, and interviews with those identified via the person-centered planning process through the team you formed. While the FBA's observations, assessments and data collection is often completed by providers, case managers must contribute and guide the process to ensure it is thorough, data-driven and person-centered.

The FBA is ultimately the ***data*** that informs the plan. It seeks to answer the questions: "What is the purpose (or function) of the behavior?", "What is being communicated?", and "What is a more appropriate substitute behavior?". During this phase, it is important to remember that in order to be truly person-centered, what is deemed "appropriate" should look different from one participant to another and one plan to another.

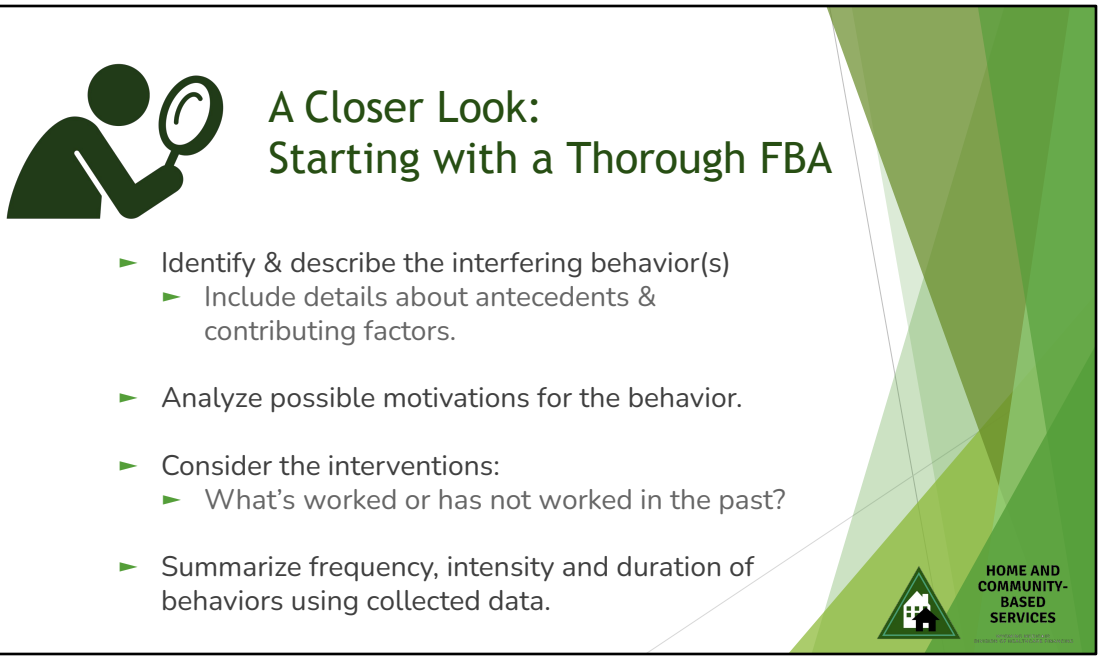
Through the FBA process, **antecedents** are identified. Antecedent are the events, circumstances, or actions that happen immediately before a specific behavior occurs. The antecedent is essentially the trigger or cue that makes the behavior more likely to happen; it's what happened just before a behavior takes place. Identifying the antecedent can shed light on what's being communicated and what the purpose of the behavior really is. By taking time to identify antecedents, the team can be PROACTIVE and anticipate when the participant might struggle, need more support or how providers can help the participant avoid the trigger altogether.

During the functional behavioral analysis, the team must go beyond the obvious antecedents and consider other possible contributing factors in the settings, events, persons and circumstances surrounding the behavior.

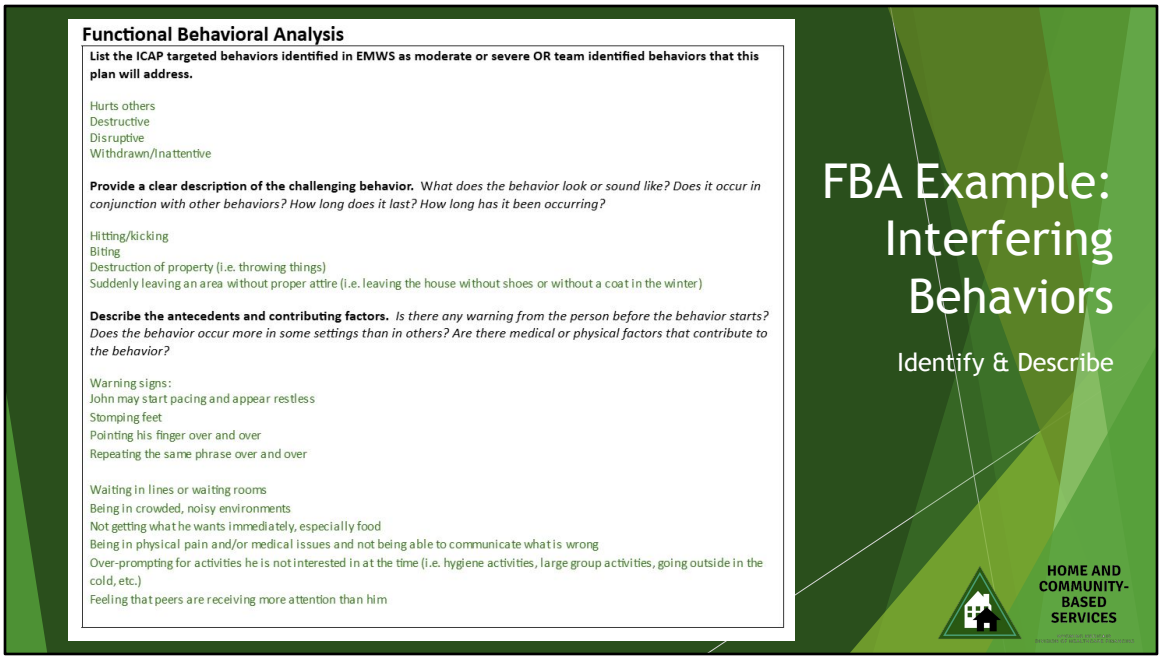
As a case manager, you can encourage providers to dive deeper in their questioning, observations and data collection on other factors that may contribute to the behavior. For example, when, where and with whom is the interfering behavior occurring? Does the behavior occur at a certain time of day? Before or after meals? Who is working? Are other participants around? What is the environment like? Are physical factors contributing? What is the motivation or purpose? What is being communicated and why? If the behavior typically occurs before a meal, could they be hungry? If the behavior occurs every time a specific staff member works, maybe there is a relational issue. Or maybe they don't like their roommate, or just don't like doing a specific activity.

Systematically examining all of these various aspects surrounding a behavior, collecting data about the circumstances and occurrences, and defining possible motivations for the behavior during a functional behavioral analysis will go a long way in determining what interventions will likely be most effective for the individual's

positive behavior support plan.



Before we move on with case manager responsibilities, let's pause and walk through an example of a well-written Functional Behavioral Analysis and Positive Behavior Support Plan. As mentioned, effective PBSPs always begin with a thorough FBA which describes the interfering (or targeted) behaviors, antecedents, and contributing factors. The FBA also looks at possible **motivations** for the interfering behavior, considers what interventions have or have not worked in the past, and provides a summary of the collected data by describing the frequency, intensity and duration of the behavior. Taken collectively, these items will help the team better understand WHY the interfering behavior is being expressed and how to address it in the PBSP.

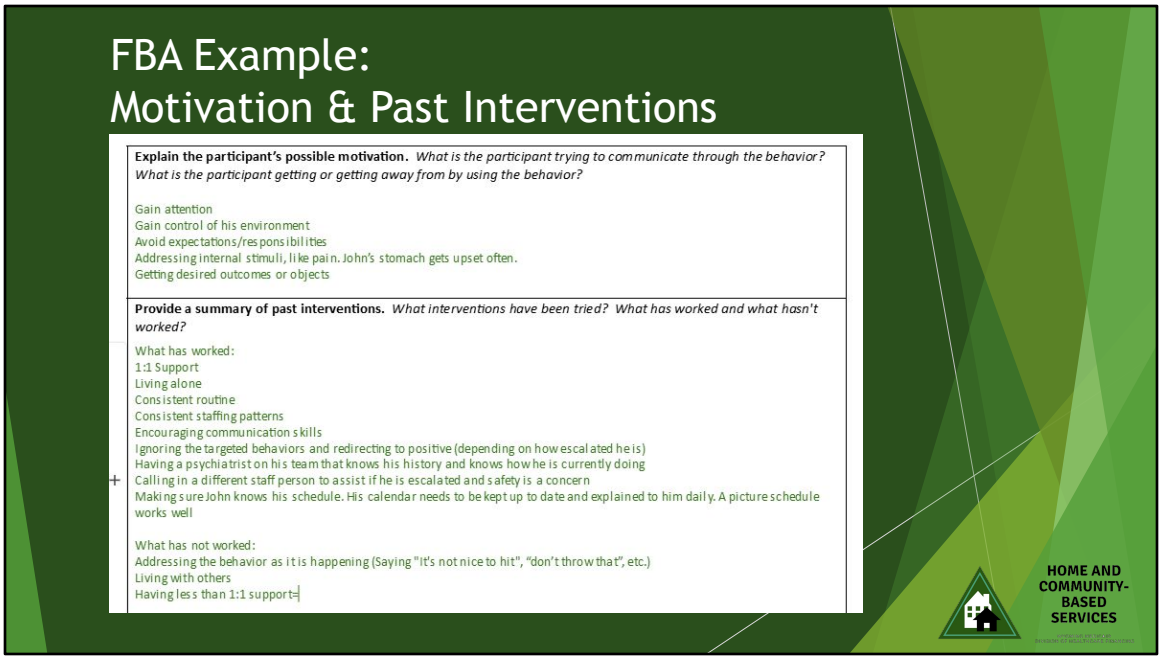


Keep in mind that the FBA form is designed to walk the team through the analysis one step at a time beginning with identifying and describing the interfering (or targeted) behaviors. Remember, for participants on the Comprehensive Waiver, the ICAP may be a tool that can help with this.

In this example, the **behaviors** are first identified as hurting others, being destructive, disruptive, and withdrawn or inattentive. The behaviors are then described in more detail. What does the behavior look or sound like? Does it occur in conjunction with other behaviors? How long does it last? How long has it been occurring? This may seem redundant, but it is important to look at these details as well as the big picture surrounding the behaviors in order to understand the purpose of the behavior.

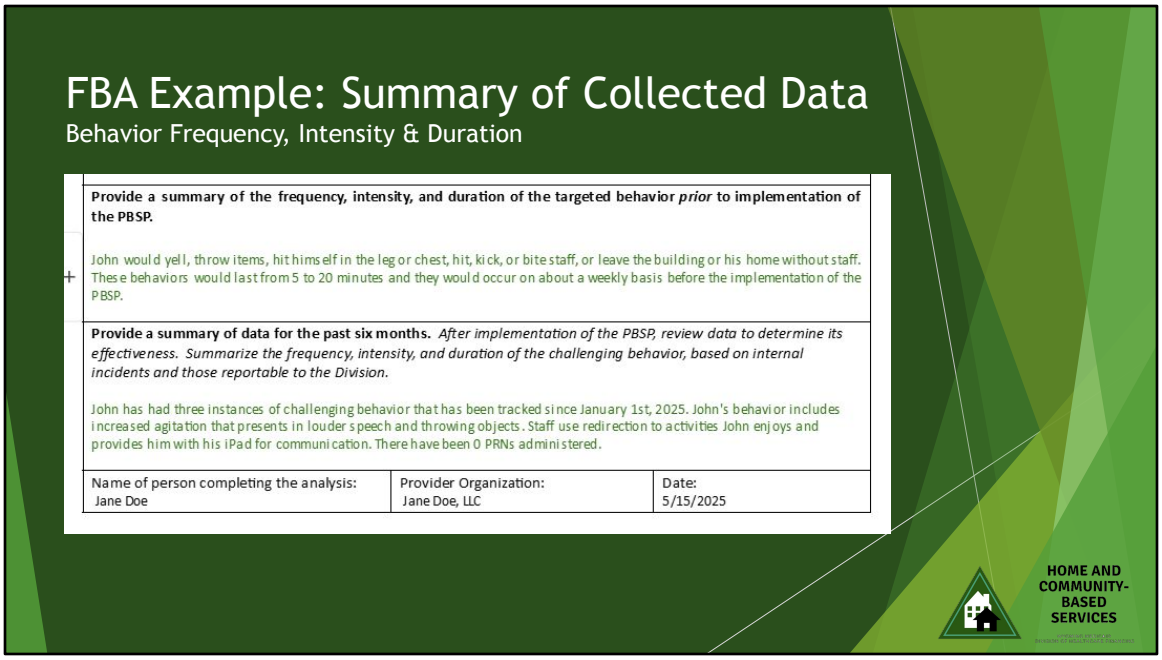
The form then asks for the team to describe the antecedents, warning signs, and other **contributing factors** or situations surrounding the behavior. This is where the thorough questioning mentioned earlier comes into play. Remember to encourage providers to look beyond the obvious and collect data. Does the behavior occur more in some settings than in others? Are there medical or physical factors that contribute to the behavior? In this example, the team lists several antecedents, warning signs

and contributing factors: pacing, restlessness, stomping feet, repeating phrases, waiting in lines, crowded or noisy environments, not getting immediate wants, pain, over-prompting, and the feeling that peers are getting more attention.



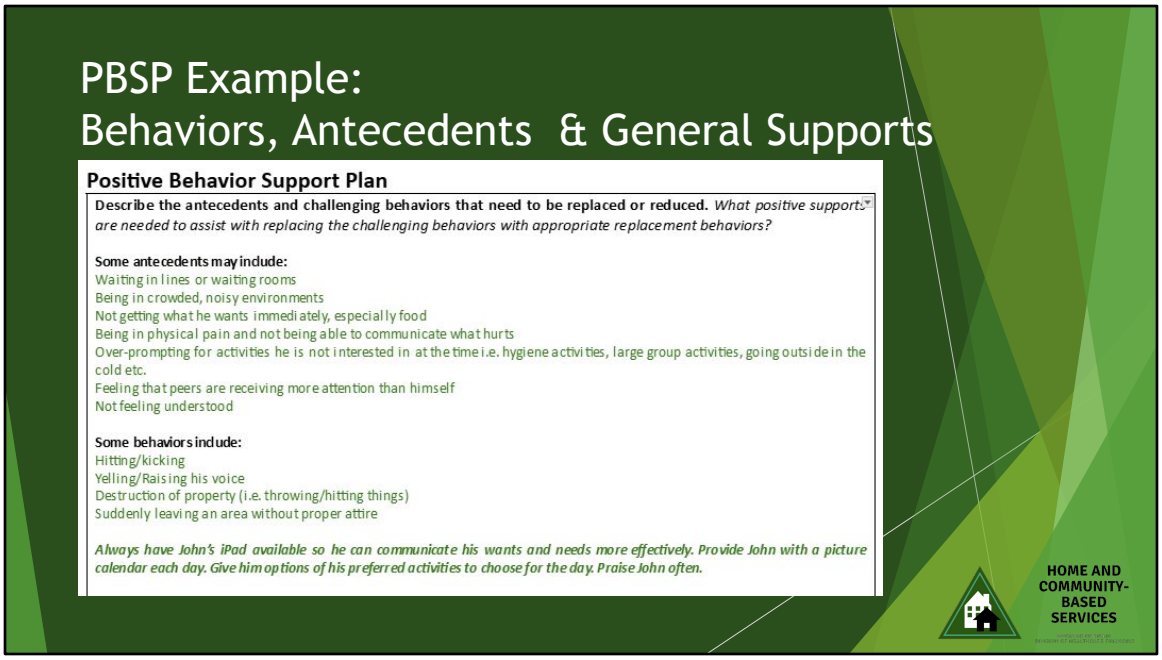
In the next section of the FBA, the team must consider what the participant is trying to communicate through the behaviors. What are the **possible motivations for the behavior**? What is the participant getting - or getting away from - by using the behavior? Remember to ASK the participant and include their input! In this example, the team listed that the participant may be seeking attention or control, avoiding responsibilities, coping with and internal stimuli like pain or attempting to get desired outcomes or objects.

Past interventions are listed next to determine what has been tried, and what has (or has not) worked for the participant. In this example 1:1 support, living alone, consistent staffing and routines have had positive results, but addressing the behavior as it happens, living with others, and having less than 1:1 support has **not** been successful. Recording these interventions helps to guide decisions about what future strategies should be included in the positive behavior support plan.



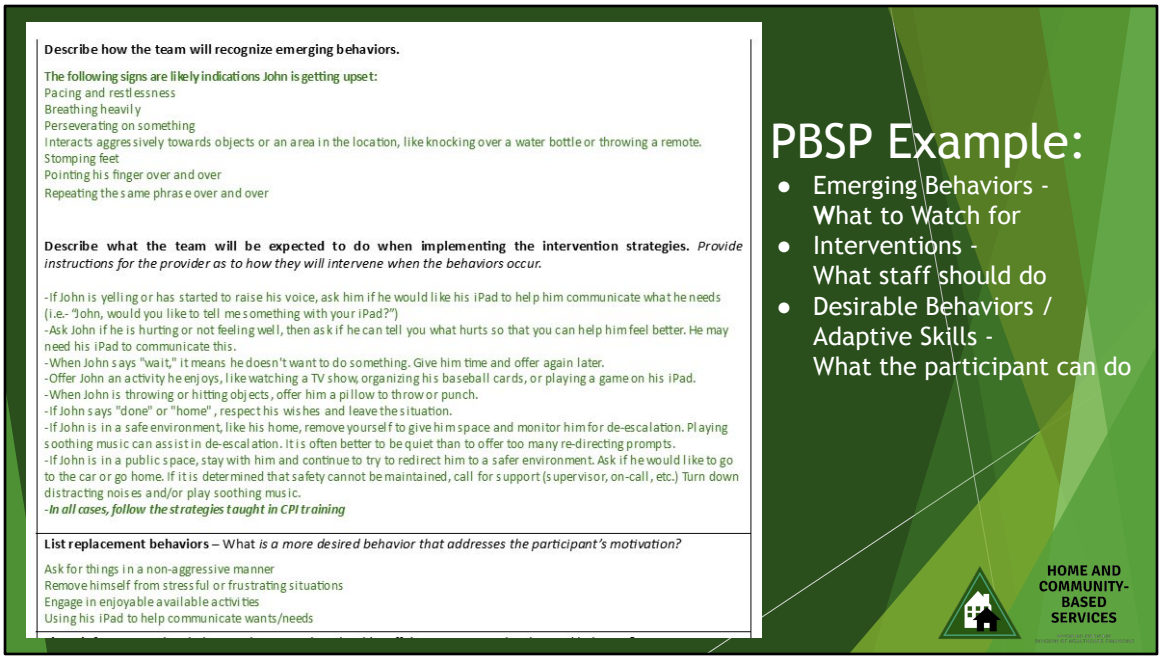
The summary section of the FBA form is where the data collected through documentation, incident reports, interviews and observations is summarized and recorded. The summary should describe the frequency, intensity and duration of the behavior ***prior*** to positive behavior interventions. This section provides a starting point or baseline from which to gauge the PBSP's effectiveness once implemented. In this example, behaviors occurred weekly, lasting 5-20 minutes before implementation of the PBSP.

The last section of the form is intended for ongoing reviews which should occur at least every six months. Here, data from documentation, incident reports and observations is again summarized to capture the current situation and address whether current interventions are effective. In this example, you can see that after the PBSP implementation, three instances were tracked.



Now building off the well-written, data-driven Functional Behavioral Analysis, let's look at the resulting Positive Behavior Support Plan. Although each subsection is vital, this first section connects the antecedents (or possible triggers) to the interfering behaviors and gives an overview of the general supports needed. In clear, concise language it lists the situations to watch for, behaviors to be replaced, and what proactive actions to take.

For example: "Always have the iPad available for communication of wants and needs. Offer a picture calendar. Give options on preferred activities. Offer praise often." Notice that although some information from the FBA is used in the PBSP, the PBSP is **not** meant to be a regurgitation or copy of the FBA.



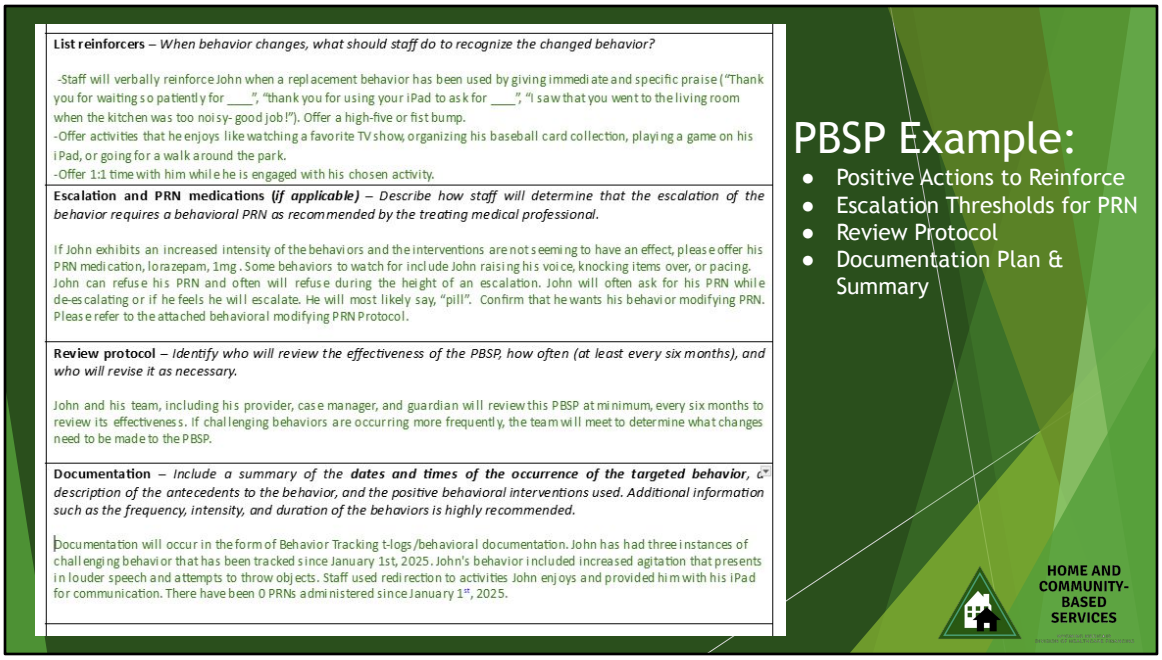
The PBSP goes on to describe emerging behaviors, what to watch for, what to do, and what the more desirable replacement behaviors should be. The plan should be detailed in it's explanation of how direct care staff will recognize emerging behaviors and identify early signs of escalation. Pacing, heavy breathing, stomping feet, etc are listed in this example.

In the next section, intervention strategies are included with clear instructions for staff on how to respond to behaviors so they know ***exactly*** what to do. "If that occurs, do this."; "If you notice this, offer this alternative."

In this example, "When John is throwing or hitting objects, offer him a pillow to throw or punch." "If John is in a public space, stay with him and continue to try to redirect him to a safer environment. Ask if he would like to go to the car or go home. If it is determined that safety cannot be maintained, call for support (supervisor, on-call, etc.) Turn down distracting noises and/or play soothing music." The plan includes explicit, highly-detailed directions on how to intervene.

In the replacement behaviors section, a list of more desirable behaviors is included. These alternative behaviors would still address the participant's motivation, but be

considered more acceptable. Asking for things in a non-aggressive manner; removing himself from stressful situations; engaging in enjoyable activities; and using the iPad to help communicate wants/needs are all examples of replacement behaviors this team included. It may be helpful to think about the three high-level goals of positive behavior support we touched on earlier when working with the team on this section. Does the replacement behavior increase quality of life, enhance overall well-being and teach an adaptive skill? If not, what other replacement behaviors would meet these goals?



Next, the reinforcers section outlines what actions staff can take to reinforce and reward the participant's use of a replacement behavior. This section gives clear participant-specific instruction for what staff can do (or ***add*** to the situation) to **recognize** the changed behavior and **reinforce** it. For this particular participant,

-Staff will verbally reinforce by giving immediate and specific praise: "Thank you for waiting so patiently for ____"; "Thank you for using your iPad to ask for ____"; "I notice you went to the living room when the kitchen was too noisy - good job!"

-Staff can offer specific activities the participant enjoys to reinforce the desired behavior: maybe watching a favorite TV show, organizing a card collection, playing a game on the iPad, going for a walk around the park, or having 1:1 time.

In the next section, detailed procedures for managing escalation, severe behaviors, and PRN medication administration are given. In this example, if John exhibits an increased intensity of the behaviors and interventions are ineffective, a 1 mg of lorazepam is offered. Antecedent behaviors and information about how the participant typically refuses or asks for medication should also be included. ***Any*** detail that give staff more context to better understand a participant's escalation thresholds

and patterns should be included here. In this example, the team included the participant's specific language: "John will often ask for his PRN while de-escalating…**He will most likely say, 'pill'."** This level of detail is is extremely helpful to staff - especially new staff that may be more unfamiliar with a participant.

Next, the review protocol section ensures that regular evaluation and updates are made to the PBSP. This area should specify who, how and when (or how often) the plan will be reviewed.

Finally, the documentation section includes a summary of occurrences and establishes how behavior incidents will be tracked and recorded. In this example, documentation will occur in the form of a Behavior Tracking t-log. The section includes the dates and times the interfering behavior occurred and summarizes the circumstances and use of PRN medications. In this example, "John has had three instances of challenging behavior that has been tracked since January 1st, 2025. John's behavior included increased agitation that presents in louder speech and attempts to throw objects. Staff used redirection to activities John enjoys and provided him with his iPad for communication. There have been 0 PRNs administered since January 1st, 2025."

To recap the highlights from this example, an effective PBSP begins with a **thorough FBA** that describes the behavior, antecedents and contributing factors in great detail after questioning, observing, discussing and documenting the data. The FBA helps answer **WHY** the interfering behavior is being expressed, what the motivations are, and what the participant is trying to communicate.

As shown, a well-written PBSP must also include a list of **POSITIVE support interventions and reinforcement techniques (or reinforcers)** that will assist the participant in replacing interfering behaviors with more desirable ones. Regarding interventions and reinforcers, it may be helpful to think of the word "positive" from an applied science standpoint where it refers to "**adding**" something to a situation – maybe more attention, a tangible item, etc., to increase or decrease a behavior. In the example we looked at, staff used specific phrases as reinforcers and offered more activity options. These ***additive*** supports and reinforcers work to ***increase*** the adaptive replacement behaviors. Encouraging and rewarding positive behaviors *frequently* leads to a reduction in interfering behaviors *naturally*.

Additionally, the support strategies in effective PBSPs must be person-centered and focus on *how the provider can accommodate the participant* rather than how the

participant is making life hard on the provider and what can be done to ease the provider's difficulties. In fact, a good PBSP is a tool that should ultimately make the provider's job ***easier*** if it's consistently followed and utilized.

Effective PBSPs also use **specific, person-centered language** consistently across all providers to make it it easier for the participant to know what to expect. Plans must be **written legibly, and give clear, concise directions** for staff. They must be accessible, specific and easily understood, so direct care staff can implement them appropriately and consistently. Providers often have a lot going on – sometimes supporting far more than one participant at a time. The more clear and concise a PBSP can be, the better.

Finally, effective plans utilize **input from all providers** on the participant's team (including the participant) with the understanding that different plans may need to be developed for providers. What works for the participant with one provider, may not work with another.

Please remember that a PBSP is **not** a regurgitation of the FBA. We often see copying and pasting between the two documents which indicates the process is NOT being followed as intended. Effective plans are NOT a documented set of consequences for the participant's non-compliance or reward systems that allows a participant to "earn" rewards. In fact, participant funds can never be used to purchase rewards. If receiving or not receiving something in the plan escalates behavior, it is NOT a good plan.

Like we mentioned, PBSPs are also **not** written for legally authorized representatives or provider convenience. Rights restriction rules for providers and LARs are very different; providers and LARs are in very different roles. Case managers may need to remind providers and LARs about these limits and nuances. And finally effective PBSPs do **not** utilize the same interventions for different participants. If they do, they are not truly person-centered.

Case managers and the team must also understand that PBSPs are not **approved for use**, but rather *reviewed*, by the Division. The Division only gets involved if the plan results in issues that require technical assistance or corrective action.

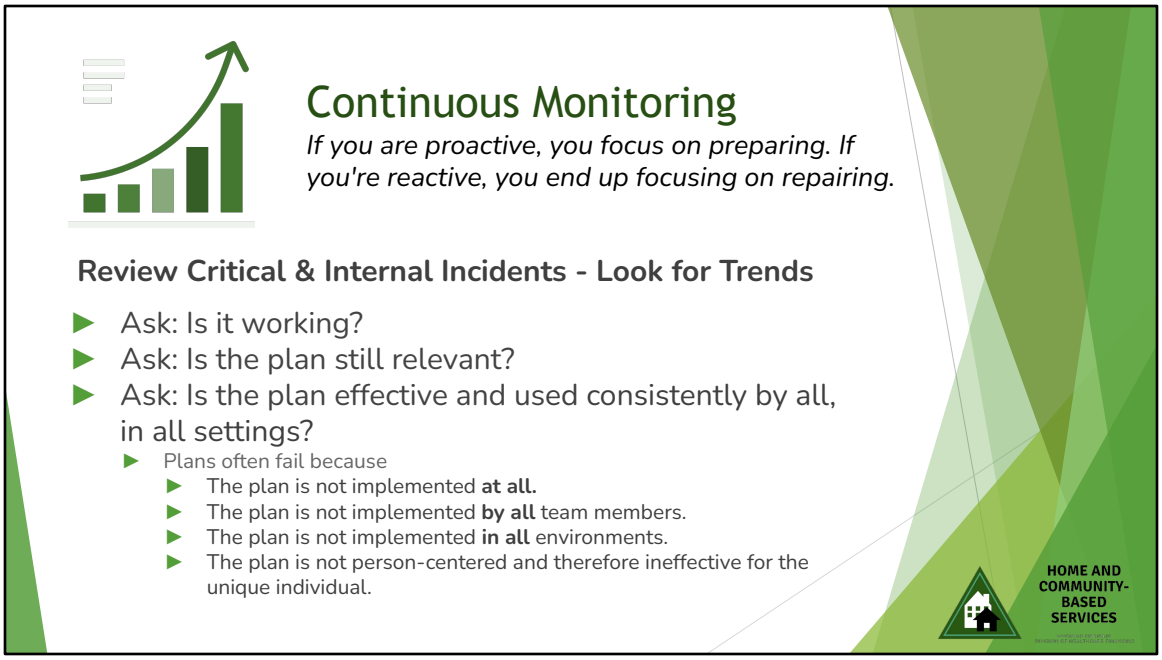
So taking all this into consideration, what strategies can case managers use to facilitate the creation of effective PBSPs when working with the team through the plan development process?

First, be a **resource**. Some providers may be more comfortable with applying the principles of Positive Behavior Support. Providers, especially small ones, may benefit from education & training resources that you might direct them to. Larger provider organizations may have opportunities for more formal training. However, be mindful that the physical techniques taught in some training programs skew towards what **providers** can do *after* escalation has already occurred**.** Well-written Positive Behavior Support Plans are a **pro-active**, **positive, action plan for *participants* to learn a replacement behavior.** They *add and enhance* rather than subtract or withhold through negative reinforcement techniques. Case managers can be a resource for the team to further their understanding of positive behavior support.

Secondly, case managers can be an **advocate**. Consider the participants' rights and know your team players. Like we said, there is sometimes a difference between what providers can or cannot do, and what LARs may want to do. As the case manager, you play an important role by advocating for the team to uphold a participant's rights and

keeping the whole process person-centered. Case managers can also be an advocate by encouraging ALL members of the care team to communicate openly and drive to identify UNIQUE, ***positive*** interventions and protocols that are the least restrictive and most effective for the specific individual.

Finally, be responsive. As a case manager, understand that a plan that works perfectly with one provider may not work well with another. This may be true with LARs, too! Case managers should not hesitate to initiate another plan, suggest alternative intervention techniques, or plan modifications if needed.



We've covered the case manager's role in coordinating the team, focusing on the participant to ensure a person-centred approach, the importance of starting with a thorough FBA, and effective plan development strategies. Now, we'll shift our time frame to look at what case managers are responsible for ***after*** a PBSP is implemented and in use - more specifically, continuous monitoring.

> *"If you are proactive, you focus on preparing. If you're reactive, you end up focusing on repairing."*

This quote summarizes why continuous monitoring of PBSPs is so important. Case managers must be proactive and monitor plans to help providers and participants prepare rather than repair. Case managers must review incident reports including *internal* incidents every month with the PBSP in mind in order to identify trends and answer the following questions:

1. Is it working?
    a. Case managers must be proactive 2nd-line monitors and pay attention to when the behavior occurs, who's around and if behavior modifying drugs are being used. Is there an increase in incidents? Has there been

    a. an increase in the usage of the behavior-modifying PRNs? Is there a common thread between incident reports?
2. Ask: Is the plan still relevant?
    a. Case managers should utilize resources and talk to directly to the staff responsible for implementing the plan to ensure that what is written in the PBSP is still feasible and attainable.
3. Ask: Is the plan still effective and is it being used consistently by all, in all settings?
    a. Plans often fail because
        - The plan is not implemented **at all**
        - The plan is not implemented **by all** team members
        - The plan is not implemented **in all** environments in which the participant interacts.
        - The plan is not person-centered and is therefore ineffective for the unique individual.

PBSP monitoring is an essential step for case managers and must be considered part of an ongoing PBSP process for each participant.

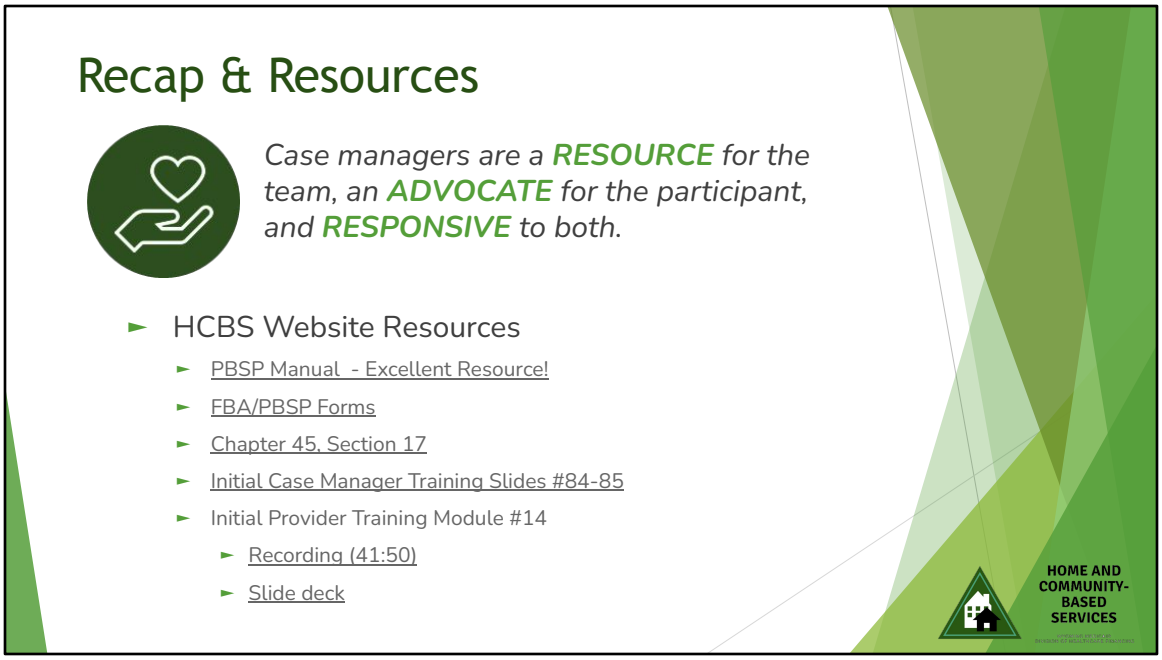
Along with monitoring, case managers must initiate formal plan reviews and possible revisions with the team on a regular basis. Even if it's the most perfect, well-written plan in the world, it won't make any difference if it's outdated, no one implements it, knows it's there, or ignores it. Regular reviews and revisions help the team keep the plan in mind and helps to determine if the plan is working. Case managers must upload plan documents and ensure that the participant, LAR and providers all have access to it. You may want to encourage providers to make sure that the PBSP is readily available for direct support staff to reference, too.

Chapter 45, Section 17 of Wyoming Administrative Rule ***requires*** that case managers review PBSPs (and other protocols) with providers at least every six (6) months to assess the plan's effectiveness. The rules also state the review must be documented and should occur "more frequently" if needed. Case managers should, at the very least, review PBSPs formally with the team at the participant's annual IPC meeting and sixth-month review meeting. Case managers should plan ahead and extend the meeting time if more time is needed to do a thorough review together as a team. The team should reflect on the the changes that have occurred with the participant since the last review. Case managers should be sure to include direct-care staff members who are responsible for implementing the plan as part of this required formal review.

Case managers can also ask about the plan during quarterly visits and in conversations with BOTH the participant and their direct care staff. Service observations, goal reviews and plan/protocol reviews go hand-in-hand with in-person visits and already occur quarterly for community support services (habilitative services with goals), and every six months for non-habilitative services. These conversations MUST BE DOCUMENTED and will be part of the case manager's certification renewal.

If the PBSP is ineffective, a critical incident occurs, law enforcement is called or restraints of any kind are used, a documented review must occur within 2 weeks.

We want to stress this requirement, the time frame, and the importance of documenting these reviews. Conversations had at the annual team meeting, during an in-person visit, or regarding an incident do not count as a formal review if they are not documented! As mentioned, the documentation is needed to satisfy the rule requirement and serves as evidence which will be reviewed during your HCBS case manager certification renewal.



To review, recall that we started by looking at the three basic goals of positive behavior support - to increase quality of life, decrease an interfering behavior, and teach more acceptable, replacement behaviors. Case Managers must follow the fundamentals to ensure the PBSP process is person-centered, positive, data driven and proactive. They do this more tangibly by:

- Coordinating the team and creating an inclusive environment that values input from all team members.
- Focusing on the participant and maintaining a person-centered approach in all aspects of the process.
- Pushing for a data-driven FBA, with thorough questioning, and the development of a plan that utilizes detailed, participant-specific, positive interventions.
- Monitoring plan outcomes, documenting regular reviews, and revising the plan as needed.

Ultimately, case managers are an invaluable RESOURCE for PBSP teams, an ADVOCATE for their participants, and RESPONSIVE to the needs of both - the participant and the team.

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For more information, we've listed the resources available on our HCBS website that you may find useful including

- The PBSP Manual
- FBA & PBSP Forms
- A link to Chapter 45, Section 17
- The Initial Case Manager Training Slides that cover this topic
- And the Initial Provider Training Module #14

We thank you for joining us today. At this time, I'm happy to answer any questions you may have.