Applied Behavior Analysis

Performance Standards

Updated October 2018

Contents

Disclaimer:
CBH is in the process of updating the Applied Behavior Analysis (ABA) Performance Standards. The updates reflect recent changes with the Behavior Analyst Certification Board (BACB) guidelines (https://www.bacb.com/), changes at the state level, and updates that will help promote access to quality ABA services. CBH is interested in feedback from providers, stakeholders, and families regarding the updated Performance Standards in its current stage; feedback is being collected through SurveyMonkey via this link- https://www.surveymonkey.com/r/CBHABAPS2018UpdatesFB between **October 15, 2018 and October 29, 2018.**

Applied Behavior Analysis: Performance Standards

I. PURPOSE

Applied Behavior Analysis (ABA) refers to the scientific discipline and profession aimed at promoting socially significant changes in human behavior.[1] Interventions based in ABA have been effective in supporting children and adults with disruptive behavior disorders, attention deficit/ hyperactivity disorder, acquired and traumatic brain injury, neurodevelopmental disorders, feeding disorders, and movement disorders, just to name a few. Hundreds of research articles published over the last 50 years, combined with case law and national credentialing standards, verify ABA as the best practice treatment for the myriad symptoms and skill deficits commonly associated with autism spectrum disorder (ASD) and other neurodevelopmental and behavioral disorders.

The purpose of the Community Behavioral Health (CBH) Performance Standards is to ensure access to high-quality ABA services for children, adolescents, young adults and their families so they may achieve success and build capacity in their living, working, and learning communities. Additionally, these Performance Standards are to guide treatment providers in attaining and maintaining ABA Designation in the CBH network.[2] The Performance Standards reflect the core values of the City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Practice Guidelines, in alignment with PA state regulations and goals and recommendations of *The Mayor's Blue Ribbon Commission on Children's Behavioral Health (2007)*.[3] The Performance Standards serve as a tool to promote continuous quality improvement and best practices in ABA, increase the consistency of service delivery, and improve outcomes for individuals receiving treatment and their families.

[1] http://www.apbahome.net/page/aboutba
[2] https://dbhids.org/providers-seeking-information/community-behavioral-health/cbh-provider-manual/
[3] The Mayor's Blue Ribbon Commission on Children's Behavioral Health, *Final Report*, January 2007, http://dbhids.org/wp-content/uploads/2015/01/BlueRibbonCommission1.pdf

II. APPLIED BEHAVIOR ANALYSIS (ABA)

ABA is a well-developed, evidence-based discipline that applies the principles of learning theory to produce practical, socially significant changes in behavior. ABA includes the use of direct observation, measurement, and functional assessment of the interaction between environment and behavior. ABA manipulates environmental events, including setting events, antecedent stimuli, and consequences, to change behavior. A data-driven approach, ABA measures the effectiveness of intervention by evaluating changes in behavior over time.

The PA Department of Human Services Office of Mental Health and Substance Abuse Services Bulletin (OMHSAS-17-01), *Medical Necessity Guidelines for Applied Behavior(al) Analysis*, describes ABA as a treatment to develop needed skills (e.g., behavioral, social, communicative, and adaptive functioning) through the use of reinforcement, prompting, fading, task analysis, or other interventions to help a child, adolescent, or young adult master each step necessary to achieve a targeted behavior.

The Behavior Analyst Certification Board (BACB®) indicates that "the successful remediation of core deficits of ASD and the development or restoration of abilities, documented in hundreds of peer-reviewed studies published over the past 50 years, has made ABA the standard of care for the treatment of ASD."[4] ABA for ASD has been endorsed by multiple institutions, including the American Academy of Pediatrics[5] and the United States Surgeon General.[6] It is important to note that although ABA is the prevailing best practice for individuals with ASD, ABA can also benefit individuals with other diagnoses and presenting concerns (e.g., traumatic brain injury, intellectual and developmental disorders, anxiety, pediatric feeding disorders).

To promote uniformity of practice and inform the public, the BACB® further defined the core characteristics of ABA to promote transparency with all stakeholders, including the individual served, parents/guardians and other natural supports, educational system partners, agencies, consumers, and funders. These core characteristics are:

1. An objective assessment and analysis of the client's condition by observing how the environment affects the client's behavior as evidenced through appropriate data collection

[4] Behavior Analyst Certification Board. (2014). *Applied Behavior Analysis Treatment of Autism Spectrum Disorder*. Retrieved from http://bacb.com/wp-content/uploads/2016/08/ABA_Guidelines_for_ASD.pdf

[5] Scott M. Myers, Chris Plauché Johnson, the Council on Children With Disabilitie.s (2014). *Management of Children with Autism Spectrum Disorders* Content reaffirmed by AAP https://www.autismspeaks.org/blog/2012/06/27/aba-coverage-tide-turning

[6] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999

2. Importance given to understanding the context of behavior and the behavior's value to the individual, the family, and the community
3. Utilization of the principles and procedures of behavior analysis such that the client's health, independence, and quality of life are improved
4. Consistent, ongoing, objective assessment and data analysis to inform clinical decision-making[7]

III. SCOPE OF SERVICES

These Performance Standards should be used to guide ABA treatment delivered in any setting that is clinically suited to the individual's needs; it is important to note, however, that CBH issues ABA Designation status to providers with capacity to deliver ABA through Behavioral Health Rehabilitative Services (BHRS) as per The HealthChoices Behavioral Health Program Standards and Requirements Medical Necessity Guidelines for Applied Behavior(al) Analysis. See section C. ABA Program Capacity and the ABA Designation Application.[8]

A. Objectives of ABA

The HealthChoices Behavioral Health Program Standards and Requirements Medical Necessity Guidelines for Applied Behavior(al) Analysis describe ABA as "the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, or to prevent loss of attained skills or function." [9] ABA may be implemented to reduce or mitigate impairment from challenging or interfering behavior, and to help individuals develop needed skills (adaptive, social, communicative). As such, the following are major objectives of ABA:

- To use direct observation, measurement, and functional assessment of the relationship between environment and behavior
- To use changes in environmental events, including setting events, antecedent stimuli and consequences, to produce practical and socially significant changes in behavior
- To intervene from the perspective that an individual's behavior is determined by past and current environmental events (learning history) in conjunction with organic variables, such as genetic endowment and physiological variables
- To provide the least restrictive, most effective function-based intervention

[7] Behavior Analyst Certification Board. (2014). *Applied Behavior Analysis Treatment of Autism Spectrum Disorder*. Retrieved from http://bacb.com/wp-content/uploads/2016/08/ABA_Guidelines_for_ASD.pdf
[8] https://dbhids.org/providers-seeking-information/community-behavioral-health/cbh-provider-manual/
[9] Appendix S, HC BH Program Standards- January 1, 2018

- To decrease challenging behavior while also increasing adaptive replacement skills
- To ensure treatment integrity via proper implementation of intervention and systematic data collection of implementation fidelity
- To improve behavior while demonstrating a reliable, functional relationship between procedure and behavior change
- To increase communication and skills of daily living
- To ensure behavioral changes are clinically and socially significant and make a meaningful difference in the individual's life
- To promote generalization by training parents and others who work with the child, adolescent, or young adult

B. Target Population

These Performance Standards address ABA for individuals age 2-21 who have a diagnosed neurodevelopmental or behavioral disorder (e.g., ASD, intellectual developmental disorder) in accordance with the prevailing edition of the Diagnostic and Statistical Manual.[10] As stated above, it is important to note that although ABA is the prevailing best practice for individuals with ASD, ABA can also benefit individuals with other diagnoses and presenting concerns (e.g., traumatic brain injury, intellectual and developmental disorders, anxiety, pediatric feeding disorders).

C. ABA Program Capacity

To ensure each provider's commitment to developing and maintaining an ABA service line that is robust and sustainable beyond the skillset of any single staff member, CBH has adopted minimal program capacity expectations for ABA Designated Providers. Following initial designation, it is expected that providers will begin to provide services to children/ adolescents/ young adults on the available case list, or transition (e.g., from traditional BHRS to ABA), an average of 8 cases per month. By the 1-year re-designation mark, it is expected that each provider will achieve and maintain a program census of approximately 100 members. It is further expected that the majority of children/ adolescents/ young adults with an ASD diagnosis within any existing program will be transitioned to ABA services by the 1-year re-designation mark. Finally, it is expected that providers maintain adequate staffing levels on all assigned cases, as evidenced by 90% of all cases being fully staffed at authorized levels.

Failure to meet or maintain minimal program capacity, and/or failure to adequately staff cases, as evidence by 10% or higher unstaffed or partially unstaffed cases in any month, may result in an action plan being requested by CBH, additional monitoring, and/or involuntary stoppage of new case availability from the case assignment list. A pattern of program instability (e.g., unstaffed cases > 10% for 3 or more consecutive months) may

[10] American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®), Fifth Edition.* Arlington, VA: American Psychiatric Publishing.

warrant closure to any new cases and/or revocation of ABA Designation status. Any inability of a provider to ensure ongoing program oversight and supervision by a BCBA, per these Performance Standards, must notify CBH immediately and implement an interim plan for compliance with these standards. Failure to do so may result in revocation of ABA Designation status.

IV. ABA PLANNING AND DELIVERY

A. Assessment

Comprehensive Biopsychosocial Evaluation/Re-evaluation (CBE/CBR)

When ABA is sought, the child/adolescent/young adult must receive a Comprehensive Biopsychosocial Evaluation (CBE) or Re-evaluation (CBR) to provide a current diagnosis and treatment recommendations. When diagnosing ASD, prescribers are expected to follow best practice standards for their respective discipline (e.g., American Academy of Pediatrics, American Psychological Association). The diagnosis of ASD must clearly describe the persistent deficits in social communication and social interaction across multiple contexts, the restricted, repetitive patterns of behavior, interests, or activities, the age of onset of symptoms, and the consideration of intellectual functioning. Given the high rate of medical co-morbidity with ASD, and the impact of medical conditions on behaviors of individuals with ASD, providers are also expected to collaborate with medical health care providers to coordinate comprehensive assessment. Finally, collaboration and information sharing with the school or Early Intervention provider is also a part of a comprehensive evaluation. Teachers and educational personnel often contribute rating scales to the assessment process or host observations of the child/adolescent/young adult in the natural environment. If services are to be provided within the school or other structured setting, active collaboration of interventions and partnership within that setting must be facilitated early and their input maintained throughout the course of treatment. A consistent goal of ABA treatment is to transfer skills to the child/adolescent/young adult natural supports to ensure least restrictive services and environments.

Functional Behavior Assessment (FBA) and Skills Assessments

When ABA is being requested, an FBA and/or Skills Assessment (e.g., Verbal Behavior Milestones Assessment and Placement Program [VB-MAPP], Assessment For Learning [ASL]) must be requested and completed as early in the treatment planning process as possible. A Licensed Behavioral Specialist Consultant with FBA certification, or preferably a Board-Certified Behavior Analyst (BCBA®), must complete the FBA. When there is a strong indication that ABA treatment would be beneficial, a non-ABA provider may complete a CBE/CBR to request an FBA and Skills Assessment to be completed upon referral to an ABA-Designated Provider.

A standardized form and interview to guide the FBA is required. The therapist should identify a plan for addressing problem behaviors and skill acquisition in conjunction with

the parent or caregiver and other professionals working with the child/ adolescent/young adult. Target behaviors must be clearly and operationally defined in a way that two people could agree that the behavior occurred. Operational definitions must be clear, objective, and complete. The FBA itself must be signed by the developing staff, at a minimum. If a FBA Summary is being submitted to prescribe ABA treatment, the Addendum must also be signed by a licensed prescriber.

Although a specific format is not dictated, a FBA should minimally include the following components:

- Indirect assessment of the behavior via structured interview with a parent, caregiver, or the individual
- An interview with the teacher, if the challenging behavior is occurring in the school
- An interview with Early Intervention (EI) staff, if the challenging behavior is occurring in an EI setting
- Records review, including previous history of behavioral health services, Initial Family Service Plan or Individual Education Plan (IEP) services and supports, and utilization and impact of less restrictive treatments
- Indirect rating scales, such as Motivational Assessment Scale (MAS), Questions about Behavioral Function (QABF), or Functional Analysis Screening Tool (FAST), with data summarized in graphic or chart form (i.e., average scores and hypothesized function), including at least one informant from each identified setting in which the behavior is likely to occur
- Direct observation and data collection of the behavior including observed setting events, antecedents, and consequences that may be maintaining the behavior
- Direct observation and data collection in all locations and settings in which the behavior has been reported as likely to occur, based on the results of the parent/caregiver interview
- Line graphs of baseline data, in whatever measurement form collected (e.g., frequency, rate, duration)
- Summary of all assessment data, in table or graph form, including but not limited to data identifying the percentage of time the behavior occurred during particular activities, percentage of times the behavior occurred after each antecedent (i.e., antecedent analysis), and/or percentage of time the behavior occurred followed by each identified consequence
- Hypothesis statements based on the results of the assessments and conditions under which the target behavior is more likely to occur
- When an Experimental Functional Analysis (FA) or Brief FA are able to be conducted, with explicit parental informed consent and oversight by a seasoned BCBA with significant FA experience, the results of the FA may substitute for the FBA components indicated above

B. Authorization

When there is indication that ABA treatment would be beneficial, non-ABA providers may complete a CBE/CBR and request that an FBA and/or Skills Assessment be completed upon referral to an ABA-Designated Provider. To request authorization for an initial FBA or ABA treatment, a provider should submit the CBE/R which provides the current diagnosis and recommendations for ABA treatment, as well as an updated Plan of Care, Treatment Plan, and Interagency Service Planning Team Meeting summary and sign-in sheets. If the child/adolescent/young adult meets medical necessity for ABA services (as defined by HealthChoices Appendix S), services will be authorized. If the referring agency is not designated as an ABA provider, the child/adolescent/young adult will be referred to an ABA designated provider by CBH.

Organizations designated as ABA Providers may request FBA and/or Skills Assessments using the set of billing codes for ABA-specific services (e.g., ABA-FBA).

Authorizations for ABA treatment services are typically approved in 6-month increments; individuals with behavioral health needs and/or intellectual/developmental disorders, may be authorized for ABA services for up to 6 months. Authorizations for individuals with ASD may be requested for 6 months when increased progress monitoring or response to intervention is indicated. Requests for up to one year will be considered.[11] ABA-Designated Providers may request ABA treatment using the ABA-specific billing codes (e.g., ABA-BSC or ABA-TSS-NS).

C. Treatment

ABA Treatment

ABA treatment is based on the principles of learning, should take place as much as possible in natural settings and be based in activities that are naturally reinforcing to the individual. Evidence-based, naturalistic, applied behavioral analytic procedures should be the first-line interventions, with reliance on more didactic strategies only when/if these strategies are not successful. ABA treatment should emphasize skill acquisition and replacing interfering behaviors with more desirable, functionally-equivalent behaviors. Treatment should include strategies to promote generalization by training families/caregivers/teachers/aides and other natural supports, along with a schedule of titration of ABA support over time. Generalization and maintenance of individual treatment goals should also be addressed by training in multiple settings, with multiple exemplars, and using mixed and varied stimuli.

[11] Commonwealth of PA. (2005). *Medical Assistance Bulletin: Psychological/Psychiatric/Clinical Re-Evaluations and Re-Authorizations for Behavioral Health Rehabilitation (BHR) Services for Children and Adolescents with Behavioral Health Needs Compounded by Developmental Disorders,* http://dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_004080.pdf

ABA programs may range from highly structured, didactic approaches (e.g., Verbal Behavior programs or Discrete Trial Training) to more child-led naturalistic approaches, such as Incidental Teaching, Natural Environment Teaching, or Pivotal Response Training. ABA programs may also include instruction in daily routines and language acquisition training. ABA programs generally share a set of common elements, including but not limited to:

- Informed by the results of a Functional Behavior Assessment or Functional Analysis
- Informed by structured assessment of relevant skills including normative baseline data
- Individualized treatment goals, which are objective and measurable (including baseline data)
- Intervention targets that are socially significant and functionally relevant for the individual and his/her family
- Behaviors identified for increase and/or decrease that are objectively defined and functionally equivalent
- Reliance on an antecedent-behavior-consequence framework
- Use of reinforcement to shape skill acquisition
- Use of preference assessments to determine potential reinforcers
- Child-initiated teaching episodes
- Environmental manipulation to motivate the child/adolescent/young adult to initiate interactions
- Systematic and frequent data collection and progress monitoring to inform treatment decisions
- Routine data analysis
- Systematic prompting and prompt fading
- Broadening the attentional focus of the child/adolescent/young adult by using mixed and varied stimuli during treatment sessions
- Incorporation of turn-taking, modeling, and imitation
- Intervention targets across several developmental domains that are precursors of developmental achievements
- Embedding intervention in meaningful social interactions and in everyday activities
- Behavior intervention plans that are based on the results of a FBA or FA and directly related to the hypothesized function of the target behavior
- Manualized or structured behavior plan with clear instructions and criteria for treatment fidelity, data collection and analysis, and progress measurement
- Systematic training of the intervention goals and strategies for parents and caregivers

Although not all ABA programs use the following approaches, many ABA programs may provide treatment using one or more of the following approaches (this list is not exhaustive):

- Discrete Trial Training (DTT)

- Early Intensive Behavioral Intervention (EIBI)
- Pivotal Response Training (PRT)
- Verbal Behavior Interventions (often referred to as VB programs)
- Natural Environment Teaching (NET)
- Incidental Teaching (IT)
- Precision Teaching (PT)
- Functional Communication Training (FCT)

Family/Caregiver Engagement

ABA programs have the ethical responsibility to include families as *active* participants in the child/ adolescent/ young adult's treatment. The provider's role includes engaging families to assist in their understanding of the diagnosis and the scope of ABA services, and to promote the caregiver/family's collaboration with the provider. This collaboration is essential to gather needed information to inform the evaluation, re-evaluation, and treatment planning process, as well as to facilitate communication with other behavioral health treatment providers, medical providers, and the schools. ABA providers must make accommodations to engage families and include them in all aspects of treatment.

Providers are expected to develop family goals for the treatment plan by following the lead from families regarding priorities, thus integrating family voice with the team's formulation of the relationships and dynamics. ABA treatment focuses on the reduction of behavior problems and/or the acquisition of skills within the natural context in which those skills and behaviors should occur. Thus, active and ongoing family/caregiver participation in treatment is essential for these changes to occur. Engagement activities should include explicit discussion about planned service titration to support generalization once mastery is achieved, and explicit transition planning for youth ages 14 and older.

The team providing ABA should work with the family system to establish healthy relationship patterns, including appropriate hierarchy, boundaries, communication, and emotional expression so that the child/ adolescent/ young adult will be better prepared and supported to meet the demands across settings. ABA treatment can occur with the entire family, or with other members of the family without the child/adolescent/ young adult present, as long these modalities are specified in the treatment plan and relate to the treatment goals (e.g., parent training with grandmother who provides after-school support to a young child, followed by rehearsal with child while receiving feedback).

Providers should inform CBH immediately whenever treatment teams encounter barriers to family engagement to allow for assistance with engaging family members and/or determining appropriate next steps. Since positive outcomes of ABA, including generalization and maintenance, can only occur with active parental input and transfer of skills, ongoing disengagement or extenuating circumstances that preclude family involvement may warrant discharge from ABA services and/or referrals for other, appropriate behavioral health services and supports. CBH may monitor engagement

through member satisfaction surveys, complaints and grievances, and paid-to-authorized calculations for service delivery.

Coordination

In addition to family involvement, a plan should be developed for coordinating care and integrating treatment approaches with other service providers, including related therapies such as speech, occupational, and physical therapies, pediatricians and medical specialists, physicians prescribing psychotropic medications, teachers/EI/day care providers, and Therapeutic Support Staff (TSS). All relevant team members should be ongoing and active participants in the ISPT process. Results of prior evaluations and/or skill assessments completed by these professionals must be obtained and integrated into ABA treatment. Data-based reviews of progress should occur on a regular and recurring basis (e.g., monthly, bimonthly) to assess progress towards treatment goals, strategies for reducing and/or eliminating unwanted behavior, and strategies to teach, reinforce, generalize and maintain skill acquisition targets.

D. Data Collection

Initial and ongoing collection of structured data on all behavioral and skill acquisition targets is one of the most basic and fundamental aspects of ABA. Baseline data should be collected during the initial evaluation (i.e., during CBE and/or Functional Behavior Assessment) and prior to starting treatment. Data should be collected with each therapeutic encounter, including direct data collection by assigned Therapeutic Support Staff (TSS) workers. Parents should also collect behavioral data systematically between therapy sessions, whenever possible. Data should be collected using a standardized form specified in the treatment plan, and the Behavioral Specialist Consultant-ASD (BSC-ASD) or BCBA should regularly graph data using line graphs across all dates of treatment. It is further expected that the BSC-ASD or BCBA progress toward goals on a regular basis. This is typically performed weekly or no greater than biweekly. In no instances should more than a month pass without updating graphs and analyzing trends toward target criteria.

Summary data on all goals should be shared with CBH and all treatment team members any time reauthorization of ABA treatment is being requested. Data should demonstrate that the treatment plan, planning process, and therapy adhere to the requirements above, and include information about direct training of family members and other involved caregivers and school personnel. Data should be used as the rationale for continued treatment or modifications to interventions to promote mastery (i.e., generalization training, natural environment teaching). Regular data review should occur during supervision and utilized throughout the treatment authorization period to inform intervention efficacy or the need to modify interventions.

In addition to analyzing individual member data, providers of ABA services are also expected to aggregate data across members. Aggregate outcomes data will be submitted to CBH with each annual re-designation application. Each ABA provider should be able to speak to what the data says about the effectiveness of their program or the challenges they are encountering,

including how they are responding to these challenges. Although CBH allows providers to select assessment measures and outcome metrics most meaningful to their individual programs and reflective of available resources, CBH will monitor metrics such as lengths of stay, paid-to-authorized ratios, successful treatment and discharges through a variety of contacts, including ISPT participation, packet submissions, Quality Indicator (QI) data, and Utilization Management (UM) data.

E. Treatment Plan

Treatment plans for individuals receiving ABA services should be updated every 180 days and submitted to CBH with requests for service re-authorization at a minimum of every 12 months. Treatment plans templates may vary by provider, but must minimally adhere to all State, CBH, and provider guidelines. Treatment plans for children/adolescents/young adults receiving ABA must include the following components (items can be attached as appropriate):

- Baseline data on all target behaviors and skill acquisition targets
- Results of any skill assessments attached and/or summarized for skill acquisition/ maintenance plans
- Behaviors targeted for decrease objectively defined
- Replacement behaviors identified and objectively defined
- Specific, objective, and measurable treatment plan goals
- Method for collecting data for all behaviors
- Graphs of behavior (including baseline data)
- Interventions for target behaviors that are function-based and refer to the results of the FBA
- Methods of instruction/reinforcement clearly described for skill acquisition programs and refer to the results of the skill assessment (e.g. VB-MAPP, AFLs)
- Preference assessment summary, indicating how potential reinforcers were selected, as appropriate
- Selected reinforcers and the reinforcement schedule
- Consequences for the occurrence of target behavior
- De-escalation and safety plans for any target behaviors that risk harm or injury to self or others
- Criteria and schedule for determining when a goal should be revised specified clearly (i.e., advancement and regression criteria)

State regulations require that a parent/ guardian sign the treatment plan, including a de-escalation and safety plan, for children under 14. Children 14 and over must sign their own treatment plans. It is best practice for treatment plans to be signed by all parties who participated in the development or updating of the plan.

G. Progress notes

ABA providers shall complete a progress note for each billed service, adhering to CBH documentation guidelines. Progress notes for ABA should summarize the data collected at each contact.

H. Aftercare Planning

The aftercare planning process begins during initial stages of treatment. The aftercare planning process will include, but not be limited to:

- The development of an aftercare plan that is concise, complete, and comprehensive to ensure a smooth transition into the next level of care and/or supportive services
- Authorizations for current services and any referrals being coordinated
- Inclusion of coordination with the following supports and agencies:
    - Family members and / or identified community support system
    - Clinical Management
    - Member Services
    - Case manager, when applicable
    - Any involved county agencies, including the Department of Human Services, Community Umbrella Agencies, Juvenile Justice System, Probation and Parole Officers
    - Treatment program social worker, Utilization Review staff, or case manager
    - Medical HMO, when physical health is compromised
    - Department of Drug and Alcohol Programs, including Behavioral Health Special Initiative

The Aftercare Plan

The Aftercare Plan must be a concise and comprehensive document driven by the child/ adolescent/ young adult and the family. It must specifically identify the following when applicable (aging out youth may need all these areas addressed while children/youth in a stable placement may not):

- Name of next level of care provider, date and time of appointment
- Supports needed, identified by type, provider, date that supports will be provided and name of contact person for each supportive service identified. Though not an exhaustive list, these may include:
    - Housing (such as Community Residential Rehabilitation Host Home, Recovery House), location, date of placement, contact person, and phone number
    - Name of case manager, or if referral made, when it was made, status, and contact person to verify application was completed
    - Vocational/ educational services
    - Specialized services such as interpreter service, home care, mental health, etc.

along with dates, location, and primary contacts
- Medical supports including the name of the primary care physician, phone number, and appointment date/location, if applicable
- Medications, including dosages, and date/time of next medication appointment with physician and/or psychiatrist
- Family/significant others who will be providing support, with addresses and phone numbers to allow for discharge follow-up from CBH Member Services and respective case management units, if applicable
- Post-discharge goals with timeframes
- A description of the services that can be provided by the provider(s) after discharge including the specific services, provider of such services, contact person(s), and phone numbers where applicable
- The method and frequency of continuing contact to provide the child/individual/family with support
- Meaningful daily activities

V. STAFF REQUIREMENTS

A. Credentialing

Board Certified Behavior Analyst (BCBA®), providing ABA services

- **Board Certified Behavior Analyst (BCBA®)** is the preferred credential for ABA services, in conjunction with one of the licenses listed below.

Licensed Behavior Specialist Consultant for ASD (BSC-ASD), providing ABA services

- **Licensed Behavior Specialist Consultant (BSC-ASD)** with at least one year, full time equivalent, post-master's degree experience implementing ABA programs for individuals with ASD less than 21 years of age. All BSC-ASDs must complete the state FBA training.

OR

- **Other licensed professionals** (e.g., psychologists, social workers, clinical social workers, marriage and family therapists, and professional counselors) will not require dual licensure and may therefore perform these services.

Therapeutic Support Staff (TSS), providing ABA services

-

Pursuant to MA Bulletin 01-01-05, the following are the minimal requirements for a TSS staff to provide ABA services:

- Persons with a bachelor's degree in psychology, social work, counseling, sociology, education, criminal justice, or similar human service field, with no previous work experience;
- Persons with a bachelor's degree in any other field, with the equivalent of at least 1 year of full-time paid work experience in a job that involved direct contact with children or adolescents;
- Licensed registered nurses, with the equivalent of at least 1 year of full-time paid work experience in a job that involved direct contact with children or adolescents;
- Persons with an associate's degree, or 60 credits toward a bachelor's degree, with the equivalent of at least 1 year of full-time paid work experience as a TSS Aide;
- Persons with an associate's degree, or 60 credits toward a bachelor's degree, with the equivalent of at least 3 years of full-time paid work experience in a job that involved direct contact with children or adolescents, other than as a TSS Aide;
- Licensed practical nurses, with the equivalent of at least 3 years of full-time paid work experience in a job that involved direct contact with children or adolescents.
- In addition, CBH requires that all TSS workers providing ABA complete the following:
    - 40 hour Registered Behavior Technician (RBT) certification training curriculum within 6 months of employment *RBT certification is not currently required

AND

    - Completed the RBT Competency Assessment, under the supervision of a qualified BCBA® within 12 months of employment *RBT certification is not currently required

OR

    - **Registered Behavior Technician (RBT®)** certified by the BACB. The RBT training curriculum can satisfy some of the training outlined in OMHSAS Bulletin 01-01-05[12]; however, the TSS must complete all training as described in OMHSAS Bulletin 01-01-05 and in the CBH Manual for Review of Provider Personnel Files and Supplemental Manual for Review of Provider Personnel Files [13].

NOTE. Although not currently a requirement, due to insufficient capacity within the Commonwealth, providers are encouraged to implement professional development plans for all staff providing ABA services to pursue certification as a BCBA or RBT. These credentials are currently required by most commercial carriers and may be required by CBH in future revisions of these standards.

[12] Commonwealth of PA. (2001). *Psychological/Psychiatric/Clinical Re-Evaluations and Re-Authorizations for Behavioral Health Rehabilitation (BHR) Services for Children and Adolescents with Behavioral Health Needs Compounded by Developmental Disorders*
http://dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_004080.pdf

[13] https://dbhids.org/providers-seeking-information/community-behavioral-health/cbh-compliance/

B. Supervision

BCBA®, providing ABA services

When the assigned clinician overseeing ABA services is also a BCBA® or BCBA-D (doctoral level)®, they are not subject to any enhanced supervision or consultation standards beyond that which is invoked in the current Professional and Ethical Compliance Code of the BACB (2016). Specifically:

- All behavior analysts provide services, teach, and conduct research only within the boundaries of their competence, defined as being commensurate with their education, training, and supervised experience.
- Behavior analysts provide services, teach, or conduct research in new areas (e.g., populations, techniques, behaviors) only after first undertaking appropriate study, training, supervision, and/or consultation from persons who are competent in those areas (BACB, 2016).

BSC-ASD, providing ABA services

The BSC-ASD providing ABA services, who is not also certified as a BCBA, will abide by the BACB's supervision structure as if they were in the process of obtaining BCBA certification. CBH will adopt the most current version of supervision standards, as promulgated by the Behavior Analyst Certification Board (BACB™). Currently, this requires a non-certified BSC-ASD to obtain supervision by a BCBA® or BCBA-D®, with supervision credentialing by the BACB. BSC-ASDs must receive supervision for the equivalent of 5% of their direct clinical hours worked per supervision period. At least 50% of these hours must be in-person, individual supervision. The remaining 50% may be in small groups of no more than 10 people. The BSC-ASD must review each case that they are working on at least once monthly during supervision sessions.

All BSC-ASD supervision will be documented on the most current version of the BACB Experience Supervision Form, or an equivalent form that includes all necessary information and fields (e.g., date of supervision, stop time/end time, cases discussed, relevant Task List objectives). Original documentation of all supervision should be kept by the BSC and a copy will be kept by the supervising BCBA® and a copy filed in the staff's personnel file. Clinicians who are both a licensed BSC and a BCBA® do not require this enhanced supervision model.

Example: A BSC-ASD working 20 direct clinical hours per week, 80 hours per month, would require 4 hours of documented supervision per month by a BCBA® or BCBA-D®. Two hours can be in small groups, and two hours must be individual supervision. Only direct clinical hours count toward the percentage of hours which must be supervised. Providers are directed to the BACB.com website for current prevailing standards.

TSS, providing ABA services

BSC-ASDs or BCBAs providing ABA services will be responsible to provide clinical case consultation to each TSS who is working on a mutual case at a minimum of once monthly. The BSC-ASD/BCBA must track and document each supervision encounter, including the content of the encounters, ensuring that all cases are discussed monthly.

TSS workers providing ABA services must receive supervision by a qualified TSS Supervisor (as defined in OMHSAS Bulletin 01-01-05), as well as on-site, in-situ, clinical case consultation by the BSC-ASD/BCBA overseeing the case at the following rates:

- TSS workers employed 20 hours per week or more must receive at least 1 hour of supervision per week plus 1 hour of on-site clinical case consultation by the BSC-ASD managing the case.
- TSS workers employed less than 20 hours per week must receive at least 30 minutes of supervision per week plus 30 minutes of on-site clinical case consultation by the BSC-ASD managing the case.

These are the minimum rates of supervision that are required. BSC-ASDs/BCBAs must ensure that each TSS working on cases that they oversee receive case consultation at least once per month per case.

All supervision encounters will be tracked in a format in compliance with the requirements in OMHSAS Bulletin 01-01-05 and a copy will be kept in the personnel file.

C. Ongoing Training/Continuing Education

All providers must ensure that staff complete all agency-specific and CBH mandatory trainings.

Licensed BSC-ASD, providing ABA services

BSC-ASDs will follow the most current BACB™ guidelines regarding Continuing Education Units (CEUs), as if they were certified as a BCBA®, as well as follow their agency's policies and procedures regarding additional trainings as required. This is currently at a level of 32 BACB™-approved CEUs in a 2-year period. This will meet CBH's requirement for 8 CEU hours annually. Services providers are directed to the BACB.com website for current prevailing standards.

Professionals licensed by another licensing entity must also follow their respective CEU requirements to maintain a license in good standing. They will ensure that they follow all CBH, state, and agency specific policies on training and CEUs. All professionals providing BSC-ASD services are encouraged to obtain as many CEUs as possible through the BACB™ and/or CEUs related to ABA, while maintaining their specific credential to remain current in best practice and the current literature in ABA.

TSS

TSSs providing ABA treatment will obtain 10 hours of BACB™-approved CEUs annually and follow their agency and CBH's policies and procedures regarding other trainings as required. OMHSAS Bulletin 01-01-05 requires 20 hours of training annually; these 10 hours may count towards that requirement.

- AND complete the RBT Competency Assessment, under the supervision of a BCBA® annually.