



# Applied Behavior Analysis

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## Performance Standards

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## I. PURPOSE

Applied Behavior Analysis (ABA) refers to the scientific discipline and profession aimed at promoting socially significant changes in human behavior.<sup>1</sup> 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, 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) ABA Performance Standards is to ensure access to high-quality ABA services for children, adolescents, young adults (collectively referred to henceforth as “individuals”) 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.<sup>2</sup> All providers applying for ABA designation must first be in-network with CBH. The Performance Standards reflect the core values of the City of Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Practice Guidelines<sup>3</sup> and align with PA state regulations and the goals and recommendations of *The Mayor’s Blue Ribbon Commission on Children’s Behavioral Health (2007)*.<sup>4</sup> 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.

## II. APPLIED BEHAVIOR ANALYSIS (ABA)

ABA is a well-developed, evidence-based discipline that applies the principles of learning theory to produce practical, meaningful 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. ABA is a data-driven approach that measures the effectiveness of interventions by evaluating changes in behavior over time.

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<sup>1</sup> “About Behavior Analysis,” Association of Professional Behavior Analysts,

<http://www.apbahome.net/page/aboutba>

<sup>2</sup> “Application for ABA Designation,” Community Behavioral Health, <https://cbhphilly.org/cbh-providers/designation-applications/>

<sup>3</sup> “The Practice Guidelines for Resilience and Recovery Oriented Treatment,” Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), <https://dbhids.org/practice-guidelines>

<sup>4</sup> “The Mayor’s Blue Ribbon Commission on Children’s Behavioral Health Final Report,” Blue Ribbon Commission on Children’s Behavioral Health, January 2007, <http://dbhids.org/wp-content/uploads/2015/01/BlueRibbonCommission1.pdf>

The PA Department of Human Services Office of Mental Health and Substance Abuse (OMHSAS) 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.”<sup>5</sup> Further, Act 62 of 2008 defines 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 skill or function.”<sup>6</sup>

The Behavior Analyst Certification Board (BACB<sup>®</sup>) 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.”<sup>7</sup> ABA for ASD has been endorsed by multiple institutions, including the American Academy of Pediatrics<sup>8</sup> and the United States Surgeon General.<sup>9</sup> 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 transparency among the public, the BACB<sup>®</sup> further defined the core characteristics of ABA as:

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
2. Importance given to understanding the context of the 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 and ongoing objective assessment and data analysis to inform clinical decision-making<sup>6</sup>

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<sup>5</sup> “HealthChoices Program Standards and Requirements: Appendix S(2): Medical Necessity Guidelines Intensive Behavioral Health Services – Applied Behavior Analysis,” Pennsylvania Department of Human Services, January, 2018, [https://cbhphilly.org/wp-content/uploads/2021/03/CBH\\_MNC\\_Child\\_IBHS-ABA\\_2021-03-11.pdf](https://cbhphilly.org/wp-content/uploads/2021/03/CBH_MNC_Child_IBHS-ABA_2021-03-11.pdf)

<sup>6</sup> 2008 Act 62, INSURANCE COMPANY LAW OF 1921 – OMNIBUS AMENDMENTS Act of Jul. 9, 2008, P.L. 885, No. 62 Session of 2008 No. 2008-62  
<https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2008&sessInd=0&act=62>

<sup>7</sup> “Applied Behavior Analysis Treatment of Autism Spectrum Disorder,” Behavior Analyst Certification Board, 2014, [https://www.bacb.com/wp-content/uploads/2017/09/ABA\\_Guidelines\\_for\\_ASD.pdf](https://www.bacb.com/wp-content/uploads/2017/09/ABA_Guidelines_for_ASD.pdf)

<sup>8</sup> Scott M. Myers, Chris Plauché Johnson, The Council on Children with Disabilities, “Management of Children with Autism Spectrum Disorder,” *American Academy of Pediatrics* 120 (November 2007):5. doi: [10.1542/peds.2007-2362](https://doi.org/10.1542/peds.2007-2362)

<sup>9</sup> United States Office of the Surgeon General Center for Mental Health Services, “Mental Health: A Report of the Surgeon General,” National Institute of Mental Health, 1999, <https://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS>

### III. SCOPE OF SERVICES

These Performance Standards can be used to guide ABA assessment and 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 the capacity to deliver ABA through Intensive Behavioral Health Services (IBHS) per the HealthChoices Behavioral Health Program Standards and Requirements Medical Necessity Guidelines for Intensive Behavioral Health Services - Applied Behavior Analysis.<sup>10</sup> See section C. ABA Program Capacity and the ABA Designation Application, available on the CBH website.<sup>11</sup>

#### A. Objectives of ABA

The HealthChoices Behavioral Health Program Standards and Requirements Medical Necessity Guidelines for Intensive Behavioral Health Services - Applied Behavior Analysis (Appendix S(2)) 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.”<sup>10</sup> 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 (i.e., one's learning history), in conjunction with organic variables, such as genetic endowment and physiology
- To provide the least restrictive, most effective function-based intervention
- To ensure treatment integrity via proper implementation of intervention and systematic data collection of implementation fidelity
- To decrease challenging behavior while also increasing adaptive replacement skills
- To improve behavior while demonstrating a reliable, functional relationship between procedure and behavior change
- To increase communication and skills of daily living
- To promote generalization by training parents and others who work with the individual

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<sup>10</sup>“HealthChoices Program Standards and Requirements: Appendix S(2): Medical Necessity Guidelines Intensive Behavioral Health Services – Applied Behavior Analysis,” Pennsylvania Department of Human Services, January, 2018, [https://cbhphilly.org/wp-content/uploads/2021/03/CBH\\_MNC\\_Child\\_IBHS-ABA\\_2021-03-11.pdf](https://cbhphilly.org/wp-content/uploads/2021/03/CBH_MNC_Child_IBHS-ABA_2021-03-11.pdf)

<sup>11</sup>“Application for ABA Designation,” Community Behavioral Health, <https://cbhphilly.org/cbh-providers/designation-applications/>

## B. Target Population

Children, youth, or young adults with a behavioral health diagnosis are eligible to receive covered ABA under IBHS regulations through the day before that individual's 21<sup>st</sup> birthday. Most children referred for ABA have been diagnosed with a neurodevelopmental or behavioral disorder (e.g., ASD, intellectual developmental disorder) in accordance with the prevailing edition of the Diagnostic and Statistical Manual.<sup>12</sup> 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. Informed Consent

Consent for treatment should be obtained in accordance with state and federal regulations and guidelines for age and guardian consent and for authorization to release information. Verification of legal guardianship should be obtained for any young adult receiving services beyond their 18<sup>th</sup> birthday and for children residing in out-of-home placements.

State regulations require that a parent/legal 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.

## D. Program Capacity for ABA-Designated Providers under IBHS

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 under IBHS.

Following initial designation, it is expected that providers will begin to deliver services to individuals by accepting new cases referred by CBH or accept new admissions with Written Orders for ABA at an average of six to nine cases per month. By the one-year mark and ongoingly, each provider must have the capacity to achieve and maintain a minimum program census of approximately 80 to 100 members. Some agencies may have a slightly lower census, and CBH need will vary. Some other agencies may be significantly larger, and growth is limited only by need within the network and the ability of a provider to scale, while maintaining these standards and all regulatory requirements. Although the demand for ABA continues to increase, it is important for all providers to note that periodic lulls in referrals should be anticipated as a cost of doing business, and CBH is not able to assume responsibility for ensuring referrals.

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<sup>12</sup> American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®), Fifth Edition*. (Arlington, VA: American Psychiatric Publishing, 2013).

It is expected that many individuals with underlying neurodevelopmental disorders, and the presence of problematic or challenging behaviors, along with concomitant skill deficits, will be most appropriately served by an ABA-designated provider. However, individuals with ASD, I/DD and other behavioral health needs may also benefit from services authorized under IBHS-Individual (e.g., Mobile Therapy) or IBHS-Group Levels of Care (e.g., Social Skills IBHS Group). In these instances, the ABA-designated provider may contract with CBH to also offer these levels of care, so long as the provider has an approved service description on file with OMHSAS and has an active, current license that includes IBHS-ABA, as well as IBHS-Individual or IBHS-Group, accordingly.

Finally, providers must maintain adequate staffing levels on all assigned cases, as evidenced by a minimum of 90% of all cases being fully staffed at service levels specified in the ITP. Failure to meet or maintain minimal program capacity, and/or failure to adequately staff cases, as evidenced 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  $\geq$  10% for three or more consecutive months) may 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 Board Certified Behavior Analyst (BCBA<sup>®</sup>) and an appropriately credentialed Clinical Director, per IBHS Chap. 5240.81 (Staff qualifications for ABA services), should be reported to CBH immediately, along with 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**

### **Assessment**

#### **Diagnostic Assessment**

Prior to receiving an initial authorization for ABA assessment or treatment under IBHS, a child must have a behavioral health diagnosis per the most recent edition of the DSM or ICD, a Written Order from a licensed prescriber eligible to prescribe IBHS-ABA that specifies the types and amounts of ABA services requested, and the goals and objectives to be addressed via ABA treatment. Most Written Orders for IBHS-ABA are expected to come from CBH's network of ABA-designated Providers. A current list of ABA-designated providers is available on CBH's website.

Providers who are not ABA-designated may also complete an IBHS Written Order to request ABA Assessment and Initial Treatment. Families may take a valid Written Order to any CBH in-network, ABA-designated agency and request that they fulfill the request for

services. The provider must notify CBH within five business days of the initiation of IBHS treatment and services, and CBH will authorize services as indicated in the Written Order. The treating ABA-designated agency will then determine needs and complete an FBA, FA, and/or Skills Assessment, as clinically indicated.

Individuals referred for ABA may not have had a recent psychological evaluation, since it is not an explicit requirement for referral under IBHS. However, CBH recommends that any child receiving ABA have a psychological evaluation as close in time as possible to receiving a Written Order for ABA, and periodically thereafter, to ensure that the child's complete mental health status, adaptive functioning, and behavioral health needs are being adequately assessed and addressed. If a child referred for ABA under IBHS has never had a psychological evaluation, the ABA-designated agency may conduct a psychological evaluation at any time to support diagnostic clarity and case conceptualization.

When diagnosing ASD, prescribers are expected to follow best practice standards for their respective discipline (e.g., American Academy of Pediatrics, American Psychological Association), including use of norm-referenced structured tools, rating scales, and interviews. 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. Direct observation assessments using "gold standard" measures, such as the Autism Diagnostic Observation Schedule-2 (ADOS-2)<sup>13</sup> are preferred, but not required. 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 rule-out medical or biological influences, to collaborate with medical health care providers, and to coordinate comprehensive assessment and treatment.

Finally, collaboration and information sharing with school or Early Intervention (EI) providers is also part of a comprehensive evaluation. Teachers and educational personnel often contribute by completing rating scales to the assessment process or facilitate observations of the individual in their natural environment (e.g., schools and daycares). Likewise, school districts or EI providers may have completed their own diagnostic assessments to determine eligibility for Special Education or 504 Plan accommodations under the [Americans with Disability Act](#). If services are to be provided within the school or other structured setting, active collaboration on 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 individual and their natural supports to ensure least-restrictive services and environments.

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<sup>13</sup> Catherine Lord, Pamela C. DiLavore, Katherine Gotham, Whitney Guthrie, Rhiannon J. Luyster, *Autism Diagnostic Observation Schedule-2 (ADOS-2)*, (Los Angeles, CA: Western Psychological Services, 2012).



## Functional Behavior Assessment (FBA) and Skills Assessments

During the assessment phase for IBHS, a Functional Behavior Assessment (FBA), Functional Analysis (FA), and/or Skills Assessment (e.g., Verbal Behavior Milestones Assessment and Placement Program [VB-MAPP]<sup>14</sup>) should be completed. For individuals diagnosed with ASD, a Licensed Behavior Specialist who has completed the state’s required FBA training or a Licensed Psychologist who has completed the state’s required FBA training and who also possess the appropriate training and experience for the given referral concerns, may complete the FBA/FA. Preferably, an experienced Board-Certified Behavior Analyst (BCBA®) with licensure and completion of the state’s FBA training, and with appropriate training and experience in the stated referral concerns, will complete or supervise all FBAs. Board Certified Behavior Analysts qualified to deliver services under IBHS Behavior Analytic are required to coall FAs.

A standardized form and interview to guide the FBA is required. The Licensed Behavior Specialist, Licensed Psychologist, or BCBA® should assess for problem behaviors and skill deficits in conjunction with the parent or caregiver and any other professionals working with the individual. 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.

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

- Indirect assessment of the behavior(s) via a structured, or semi-structured interview with a parent, caregiver, or the individual
- An interview with the teacher, EI, daycare or other staff, if the challenging behavior(s) is/are occurring in school, EI, daycare, or other community setting
- Records review, including previous history of behavioral health and special education services, Initial Family Service Plan (IFSP), 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),<sup>15</sup> Questions About Behavioral Function (QABF),<sup>16</sup> or Functional Analysis Screening Tool (FAST),<sup>17</sup> with data summarized in graphic or chart form (i.e., average scores and hypothesized function), including at least one informant from each identified

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<sup>14</sup> Mark L. Sundberg, *Verbal Behavior Milestones Assessment and Placement Program: A Language and Social Skills Assessment Program for Children with Autism or Other Developmental Disabilities*, (Concord, CA: AVB Press, 2008).

<sup>15</sup> V. M., Durand & D.B. Crimmins, “Identifying the variables maintaining self-injurious behaviour,” *Journal of Autism and Developmental Disorders*, 18, (1988), 99–117.

<sup>16</sup> T.R. Paclawski, J.L. Matson, K.S. Rush, Y. Smalls, T.R. Vollmer, “Questions about behavioral function (QABF): a behavioral checklist for functional assessment of aberrant behavior,” *Research in Developmental Disabilities*, 21 (3) (2000), 223-9.

<sup>17</sup> B.A. Iwata, I.G. Deleon, E.M. Roscoe, “Reliability and validity of the functional analysis screening tool,” *Journal of Applied Behavior Analysis*, 46(1) (2013), 271-84.

- setting in which the behavior is likely to occur (e.g., home, school, and community)
- Direct observation and data collection, including observed setting events, antecedents, and consequences, 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, percent of opportunities)
- Summary of all assessment data, in tables or graphic 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 (i.e., consequent analysis)
- Hypothesis statements, or competing pathways, based on the results of the assessments describing conditions under which the target behavior(s) is/are more likely to occur

Please note: When an Experimental Functional Analysis (EFA)<sup>18</sup> can be conducted, such as those using Iwata (1982/1994) procedures; a Brief Functional Analysis (BFA), such as those summarized by Gardner, Spencer, Boelter, DuBard, and Jennett, 2012<sup>19</sup>; or procedures such as Interview-Informed Synthesized Contingency Analysis (IISCA; Jessel, Hanley, & Ghaemmaghami, 2016), the results may substitute for some of the FBA components indicated above. All FA's should include explicit parental informed consent and oversight by a seasoned BCBA<sup>®</sup> with significant FA training and experience.

## B. Authorization Requirements

1. An IBHS Written Order for ABA with the maximum amounts of each service requested per month, using IBHS level of care codes and descriptors (e.g., ABA-Behavior Consultation up to 20 hours per month (hpm) for 180 days; ABA-BHT up to 100 hours per month (hpm) for 180 days) is required.
2. An Individual Treatment Plan (ITP) that includes the interventions needed to address specific skills and targeted behaviors for improvement. The treatment plan must include measurable, achievable, and realistic goals for improving any identified behavioral challenges. The treatment plan must also include strategies for assessing and measuring the frequency of baseline deficits, adaptive behaviors, or skill development and use research-supported behavioral interventions.

<sup>18</sup> Brian A Iwata, Michael F Dorsey, Keith J Suifer, Kenneth F Bauman, and Gina S. Richman, "Toward a functional analysis of self-injury," *Journal of Applied Behavior Analysis*, 27 (1994), 197-209.

<sup>19</sup> Gardner, Spencer, Boelter, DuBard, and Jennett, "A systematic review of brief functional analysis methodology with typically developing children" (2012)

In addition to the Written Order and ITP, for all requests for **continued services** (i.e., concurrent review) of ABA treatment, designated providers should be able to produce data-based progress reviews at 90-day intervals and line graphs depicting treatment progress on every behavior targeted for reduction and every behavior targeted for acquisition/increase through a skill-building intervention (see Data Collection for further detail). CBH reserves the right to request supporting clinical documents either concurrently or through a process of retrospective review. CBH also may request that providers maintain within their clinical records only.

Authorizations for ABA treatment services are often requested in six-month increments, due to the changing needs and abilities of individuals served and the need to adjust services to the most appropriate, least restrictive amounts on an ongoing basis. When response to intervention is not yet established, or when current services do not result in significant improvement in behaviors or prevent regression, authorizations may be requested for shorter durations, and/or additional concurrent reviews of treatment data or progress monitoring discussions with CBH staff in attendance may be requested.

Requests for ABA treatment up to a duration of 365 days are appropriate for individuals in the presence of clear data showing positive, but slower or gradual response to ABA treatment and an appropriate treatment plan that includes measurable, achievable, and realistic goals supporting the frequency and duration of services.

## 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-behavior-analytic procedures should be the first-line interventions, with reliance on more didactic strategies only if/when 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 services over time. Generalization and maintenance of individual treatment outcomes should also be promoted by training in multiple settings, with multiple exemplars, and using mixed- and varied-stimuli.

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 FBA, FA, or Skills Assessment
- Informed by structured assessment of relevant skills and skill deficits including normative, curriculum-based, or criterion-referenced baseline data
- Individualized treatment goals, which are specific, objective, and measurable (including baseline data and change expected)
- Intervention targets that are socially significant for the individual and their family
- Intervention targets that reflect the strengths, needs, and preferences of the individual and their family
- Intervention methods and targets that are sensitive to cultural, religious, country of origin, or other differences that might impact care
- Behaviors identified for increase and/or decrease that are objectively defined and functionally equivalent
- Reliance on an antecedent-behavior-consequence framework
- Use of preference assessments to determine potential reinforcers
- Use of reinforcement to shape skill acquisition
- Child/individual-initiated teaching episodes
- Environmental manipulation to motivate the individual to initiate interactions
- Behavior intervention plans that are based on the results of an FBA or FA and directly related to the hypothesized function of the target behavior
- Manualized or structured behavioral interventions with clear instructions and criteria for treatment fidelity, data collection and analysis, and progress monitoring
- Systematic training of the intervention goals and strategies for Behavioral Health Technicians (BHTs), Registered Behavior Technicians (RBTs), education staff, parents, and caregivers
- Systematic prompting and prompt fading across sessions
- Broadening the attentional focus of the individual 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
- Systematic and frequent data collection and progress monitoring to inform treatment decisions, including analysis of IRR and the validity of all data collected
- Routine data analysis, facilitated by generating and examining line graphs for all treatment goals
- Review of graphs and progress data with members, parents/guardians, and other stakeholders on a regular basis

Many different approaches and treatment components have been empirically evaluated in the ABA literature. Further, formal classification systems for rating ABA interventions as either being established treatments, emerging treatments, or unestablished treatments have been developed to guide the public and promote national standards for evidence-

based practices (National Autism Center, 2015).<sup>20</sup> The National Clearinghouse on Autism Evidence and Practice (NCAEP, 2018) also released a report identifying EBPs in the ABA literature. ABA-designated providers are expected to remain current on these emerging models for classifying research support for interventions and modifying their clinical programming and areas of competence accordingly.

Although CBH does not emphasize specific models over others, all ABA programs are expected to use some combination of one or more of the following established approaches (this list is not exhaustive and subject to updating as the published literature evolves):

- Antecedent-Based Intervention Packages
- Behavioral Intervention Packages, which typically include combinations of two or more of the following components (not exhaustive):
  - a. Backward/forward chaining procedures
  - b. Behavioral momentum
  - c. Choice procedures
  - d. Count downs and timers
  - e. Differential reinforcement procedure
  - f. Direct instruction
  - g. Error correction procedures
  - h. Imitation training
  - i. Extinction procedures
  - j. Modeling
  - k. Pre-teaching expectations
  - l. Prompting and prompt fading
  - m. Reinforcement schedules
  - n. Scripts/social scripts
  - o. Signaled availability
  - p. Stimulus fading
  - q. Task analysis
  - r. Video modeling
- Cognitive Behavioral Intervention Programs
- Discrete Trial Training (DTT)
- Early Intensive Behavioral Intervention (EIBI)
- Precision Teaching (PT)
- Functional Communication Training (FCT)
- Incidental Teaching (IT)
- Natural Environment Teaching (NET) or Naturalistic Teaching Strategies
- Parent Training
- Pivotal Response Teaching/Training (PRT)
- Response Interruption and Redirection (RIRD)

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<sup>20</sup> National Autism Center, 2015, <https://www.nationalautismcenter.org/national-standards-project/phase-2/>

- Self-management Strategies
- Verbal Behavior Interventions (often referred to as VB programs)
- Visual Schedules

## Family/Caregiver Engagement

ABA programs have the ethical and clinical responsibility to include families as *active* participants in the individual'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 should begin from the moment of referral and continue throughout all subsequent treatment recommendations through discharge planning. It is also essential to gather parent/caregiver input to inform the assessment 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.

ABA providers are also expected to develop family goals for the treatment plan by following the lead from families regarding priorities, preferences, and socially valid family goals. CBH expects ABA ITPs to reflect and integrate family voice with the team's formulation of the relationships and dynamics, as well as treatment priorities. Cultural humility and respectful services that are sensitive to each family's unique culture, heritage, religion, family constellation, country of origin, and any other important aspects of the child and family's identity should be heard and integrated into each ITP.

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. Youth 14 years and older should also give informed consent, to the extent possible, to any direct service support in natural environments (e.g., ABA-BHT) and their response to having an adult with them in natural environments noted in their assessment summary and ITP. Generally speaking, the use of ABA-BHTs for youth ages 14 or older, especially in group settings or schools, should be evaluated as potentially restrictive, isolating, or embarrassing, and the benefits of continued service of this type should be carefully weighed against the risks of continued dependency and/or social stigma produced by the provision of this more restrictive intervention.

The team providing ABA should work with the family system to establish healthy relationship patterns, including appropriate adult-child hierarchies, boundaries, communication, and emotional expression so that the individual will be better prepared and supported to meet the demands across settings. Once again, cultural humility and sensitivity to different family constellations and dynamics should make this a unique and

individualized conversation with each family unit. ABA treatment can occur with the entire family, or with other members of the family without the individual present, as long as 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 the 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 utilization data.

### Cultural Competency

All IBHS providers are expected to support the development of cultural literacy regarding gender, age, race, ethnicity, spirituality/religion, gender identity, and sexual orientation. The provider must be prepared to treat and support families whose treatment needs are heavily impacted and informed by social determinants and risk factors, including health complications, substance use challenges, poverty, histories of homelessness/unstable or inadequate housing, and violence in their communities. Providers should also be affirming of LGBTQIA populations. The provider must ensure that services are delivered in a manner that is welcoming to people from diverse cultures and have the resources to work with individuals and families who speak languages other than English.

To support providers in offering culturally and linguistically appropriate services, we strongly encourage use of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care ([The National CLAS Standards](#)) through the U.S. Department of Health and Human Services- Office of Minority Health. Educational content for improving cultural competency for behavioral health professionals may be found [here](#).

The IBHS provider must ensure knowledge and skills to meet all special communication needs of the youth or family, including access to translation and interpretation services as needed. CBH supports interpretation requests for over 150+ languages and receiving services in one's preferred language should never be a barrier to access. Providers are expected to reach out to the broader community to increase their expertise and bring in natural support/peers/families with similar needs to support the individual youth and family.

### 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, psychiatrists or physicians prescribing psychotropic medications; and all educational staff, teachers, and EI, daycare or after-care providers. Results of any previous evaluations and/or skill assessments completed by any of these team members should be obtained and integrated into ABA assessment treatment, as clinically appropriate. For example, no child should have a verbal behavior program and Speech-Language Services in their IEP without coordination and collaboration across these disciplines (i.e., between treating BCBA and SLP). Further, all relevant team members should be ongoing and active participants in the ISPT process. CBH Clinical Management staff may participate in some ISPTs, as requested by either the individual, their parents or caregivers, or by the provider agency for purposes of information sharing or resource coordination. Data-based reviews of progress within teams should occur on a regular and recurring basis, (e.g., monthly or bi-monthly) and never greater than every 90 days, to assess progress toward treatment goals and any necessary modifications to strategies for reducing and/or eliminating unwanted behavior or strategies to teach, reinforce, generalize, and maintain skill acquisition targets. All ABA-designated providers are expected to maintain compliance with all governing state and federal laws and regulations, including those specified in Chap. 1155 and 5240 regarding the provision of IBHS.

#### D. Data Collection

Initial assessment and ongoing collection of structured data on all behavioral and skill acquisition targets is one of the most basic and fundamental aspects of ABA. Every staff at every ABA-designated provider should be able to produce and rely on graphed data for treatment decisions, including consultation to psychiatrists, physicians, or related services professionals (e.g., SLP, SpEd teachers). CBH may request current (last 90 days), last year, or all data to date (from baseline through current data) at any time. It is expected that complete and up-to-date data (within one week and updated to within one week) will be provided to CBH staff whenever requested when participating in progress monitoring for individuals, concurrent or retrospective chart reviews, ISPTs, or case consultation.

Baseline data should be collected during the initial assessment phase (i.e., IBHS assessment, FBA or FA) and prior to starting treatment. Data should subsequently be collected with each therapeutic encounter, including direct data collection by assigned direct care workers (e.g., ABA-BHTs or RBTs). Parents should also collect behavioral data systematically between therapy sessions, whenever possible. The form/type of data should be tailored to parent's abilities and availability. Data should be collected using a standardized form and measurement, as specified in the treatment plan, and the Licensed Behavior Specialist (LBS) or BCBA® should regularly graph data using line graphs or graphing software across all dates of treatment. It is further expected that the LBS or BCBA® will regularly monitor progress toward goals on a regular basis. This is typically performed weekly or no greater than biweekly. In no instance should more than 14 days pass without updating graphs and analyzing trends toward goals/objectives/target criteria.



ABA providers should be prepared to share treatment data on all treatment goals 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 demonstrating response to treatment 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 also occur during supervision sessions with ABA staff and utilized throughout the treatment authorization period to inform intervention efficacy, progress review, and/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 outcome data may be requested by CBH on an annual basis, or as part of a redesignation process. 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 treatment, achievement of community tenure, successful treatment and quality of life indicators, parent satisfaction, and successful discharges to lower levels of care through a variety of contacts, including ISPT participation, authorization requests, Quality Indicator (QI) data, and Utilization Management (UM) data.

## Clinical Outcomes

All IBHS Providers are responsible for the following desired treatment outcomes for ABA Services:

- Improvement in clinical symptoms, either as evidenced by lower symptomatology scores or higher skill profiles, on a structured tool or as evidenced through single subject data collection (as well as successful attainment of treatment plan goals and objectives)
- Community tenure, as evidenced by decreased utilization over time of high acuity behavioral health services (e.g., crisis services, inpatient, partial hospitalization services, RTF), allowing children to remain in their home communities and schools
- Enhanced parent, caregiver, teacher, and school staff sense of competency and self-efficacy to handle children's behavioral health concerns as reflected in applicable school and/or parent satisfaction surveys.

## E. Individual Treatment Plan (ITP)

The Individual Treatment Plans (ITP) for individuals receiving ABA services should be updated at least every 180 days, or sooner if clinically indicated, and may be requested by CBH with all requests for service re-authorization. Treatment plan templates may vary by provider, but must minimally adhere to all CBH, State, and Federal guidelines. Treatment

plans for individuals receiving ABA must include the following minimal components:

- Baseline data on all target behaviors and skill acquisition targets
- Results of any skill assessments attached and/or summarized for skill acquisition/maintenance plans
- Objectively defined behaviors targeted for decrease
- Replacement behaviors identified and objectively defined
- Specific, objective, and measurable treatment plan goals
- Method for collecting data for all behaviors
- Graphs of all behavior(s) (including baseline data)
- Interventions for target behaviors that are function-based and refer to the results of the FBA/FA
- 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 also 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 and consent to their own treatment. 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 and Medical Assistance documentation guidelines. Progress notes for ABA treatment should summarize the data collected at each contact. Reliance on narrative observations, subjective assessment/casual observation, and/or indirect methods is neither consistent, nor appropriate documentation of ABA treatment.

## H. Aftercare Plan/Discharge Planning

The aftercare and discharge planning process should begin during initial stages of treatment by identifying overall treatment goals and family preferences and priorities for what they hope to achieve by their child or family in order to feel that treatment is successfully complete. All ITP goals and objectives should therefore be individualized and necessary steps or pre-requisites

to long-term/discharge goals. The discharge planning process and plan should follow all CBH/Network Improvement and Accountability Collaborative (NIAC) standards and requirements. The Aftercare/Discharge Plan should include a description of caregiver-led interventions to be used ongoingly, aftercare appointments, and natural supports to assist the child and family in long-term maintenance of progress.

## V. STAFF REQUIREMENTS

### A. Qualifications and Credentials of Staff Who Provide ABA Services

1. The ABA-designated agency has an employed Administrative Director who meets one of the following:
  - a. A Bachelor's degree in ABA, psychology, social work, counseling, education, public administration, business administration, or related field (per 5240.81); OR
  - b. The qualifications for a clinical director outlined in 5240.81(b).
  
2. The ABA-designated agency has an employed Clinical Director who meets both of the following:
  - a. Licensure as a psychiatrist, psychologist, professional counselor, marriage and family therapist, certified registered nurse practitioner with a mental health certification, clinical social worker, behavior specialist, or other professional with a scope of practice that includes overseeing the provision of ABA, AND
  - b. Certification as a BCBA® or BCBA-D®.
  - c. **NOTE: CBH exceeds IBHS regulation for the credentials of the Clinical Director by requiring licensure AND BCBA® or BCBA-D® certification.**
  
3. All staff who provide Behavior Analytic services (whether employee or contractor) for an ABA-designated agency shall meet both of the following:
  - a. License as a psychologist, professional counselor, marriage and family therapist, certified registered nurse practitioner with a mental health certification, clinical social worker, social worker, behavior specialist, or other professional with a scope of practice that includes overseeing the provision of ABA, AND
  - b. Certification as a BCBA® or BCBA-D®.
  
4. All staff who provide Behavior Consultation-ABA (whether employee or contractor) for an ABA-designated agency shall meet one of the following (a or b):
  - a. Licensed as a psychologist, professional counselor, marriage and family therapist, certified registered nurse practitioner with a mental health certification, clinical social worker, social worker, behavior specialist, or other professional with a scope of practice that includes overseeing the provision of ABA, AND one of the following:
    - i. Certification as a BCaBA®
    - ii. Minimum of one-year full-time experience providing ABA and 12 college credits in ABA

- iii. Minimum of one-year full-time experience providing ABA under supervision of someone with a BCBA® or BCBA-D® and a minimum of 40 hours of training related to ABA and approved by the Department or by a continuing education provider approved by the Behavior Analyst Certification Board (BACB®), OR
  - b. Licensed as a psychologist and a minimum of one-year full-time experience providing ABA services and a minimum of 40 hours of training related to ABA and approved by the Department or by a continuing education provider approved by the Behavior Analyst Certification Board (BACB®).
5. All staff who provide Assistant Behavior Consultation-ABA (whether employee or contractor) for an ABA-designated agency shall meet one of the following:
- a. Certification as a BCaBA® or RBT, OR
  - b. Meet qualifications to for licensure as a behavior specialist, OR
  - c. Have a minimum of 6-months experience in provision of ABA services and a bachelor’s degree in psychology, social work, counseling, education, or related field, AND a minimum of 12 college credits in ABA
6. All staff who provide Behavioral Health Technician-ABA (ABA-BHT) are employees of the ABA-designated agency and must meet one of the following:
- a. Certification as a BCaBA®, OR
  - b. Certification as an RBT (or BCAT or other NCC qualified certification), OR
  - c. Have a high school diploma and have completed 40 hours of training covering the RBT task list, as evidenced by a training certification signed by a BCBA® or BCBA-D®, OR
  - d. Have a minimum of two-years of experience in providing ABA services and a minimum of 40 hours of training related to ABA approved by the Department or by a continuing education provider approved by the BACB®.

Additionally, CBH requires that all staff who provide ABA-BHT services must meet the following:

- a. Successful completion of a performance-based competency assessment, as rated by a BCBA® or BCBA-D® who has completed the eight-hour supervision training, as close to onboarding of the employee as possible, but no later than 90 days following date of employment with agency, AND
- b. The overseeing BCBA® or BCBA-D®, as well as the ABA-designated agency, bear responsibility for ensuring that the competency assessment is conducted in accordance with the BACB® requirements; that both parties have signed the Initial Competency Assessment; that the records of all assessments conducted are maintained by the agency and available to CBH for auditing or compliance purposes at any time requested; and that the assessment meets all quality standards in accordance with BACB® requirements.

**NOTE that attaining the RBT® credential is NOT required for all staff providing ABA-BHT services; however, completion of a 40-hour RBT training curriculum and successful completion of a competency-based assessment, as rated by a BCBA or BCBA-D, are both required by CBH.**

## B. Supervision of Staff who provide ABA services

1. All staff who provide Behavior Analytic Services shall receive supervision from a person who meets the CBH qualifications of a Clinical Director (Licensure and BCBA<sup>®</sup> or BCBA-D<sup>®</sup>) at the following ratios:

- a. One hour per month, face-to-face, individual supervision if no supervisees, OR
- b. Two hours per month, face-to-face, individual supervision if they supervise any assistant behavior consultation-ABA or ABA-BHT staff, AND
- c. 30 minutes of direct observation during the provision of services every six months.
- d. Supervision logs, including the date, start time, end time, location, modality, format, narrative, signature, and signature date, are completed for every supervision requirement listed above. Supervision logs are stored within the agency and are available to CBH staff for ABA designation chart reviews, compliance, or auditing purposes at any time.
- e. Each supervisor of ABA staff, at every level, has no more than 12 full-time equivalent staff, with a maximum of nine being ABA-BHTs.

2. All staff who provide Behavior Consultation-ABA services receive supervision from a person who meets the CBH qualifications of a Clinical Director (Licensure and BCBA<sup>®</sup> or BCBA-D<sup>®</sup>) in accordance with the prevailing supervision standards promulgated by the Behavior Analyst Certification Board (BACB<sup>®</sup>) for the accumulation of supervised experience/fieldwork hours.

Specifically, the Behavior Consultant-ABA who is NOT certified as a BCBA<sup>®</sup> or BCBA-D<sup>®</sup> must receive supervision from a BCBA<sup>®</sup> or BCBA-D<sup>®</sup> as if they were in the process of accruing supervised fieldwork hours toward eligibility for BCBA<sup>®</sup> certification.

- a. **NOTE: CBH exceeds IBHS regulations for the supervision of staff who provide behavior consultation-ABA.** CBH will adopt the most current version of supervision standards, as promulgated by the Behavior Analyst Certification Board (BACB<sup>®</sup>), to address needed capacity in our system.
- b. As of the time of this document publication, this requires anyone who is NOT a BCBA<sup>®</sup> or BCBA-D<sup>®</sup> to obtain supervision by a BCBA<sup>®</sup> or BCBA-D<sup>®</sup> who has completed a supervision training course and is in good standing to provide supervision.
- c. As of the time of this document publication, this would require anyone who is NOT a BCBA<sup>®</sup> to obtain supervision by a BCBA<sup>®</sup> or BCBA-D<sup>®</sup> for the equivalent of 5% of their total clinical hours worked per supervision period. The following additional specifications also apply:
  - i. 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.
  - ii. Supervisees must review each case they are working on at least once monthly during supervision sessions.
  - iii. All supervision should be documented on the most current version of the BACB<sup>®</sup> 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-ASD, and a copy will be kept by the supervising BCBA®.

iv. All supervision must be documented on the BCBA® Monthly Fieldwork Verification Form (or current version, if BCBA® documents are updated after the publication date of this document).

v. All supervisees must be observed working with a client in the natural environment during each supervisory period by the supervising BCBA® or BCBA-D®. In-person, on-site observation is preferred. However, the observation may be conducted using asynchronous (e.g., recorded video) or synchronous (e.g., live video conference) formats.

vi. Once a staff who provides behavior consultation-ABA has accumulated the required Supervised Experience/Fieldwork hours required for eligibility for the BCBA® or BCBA-D® credential, AND the supervisee has received Final Fieldwork Verification Form(s) attesting to the completion of all supervised hours required for BCBA eligibility, then the staff providing behavior consultation-ABA may reduce to the supervision requirements under IBHS, which are:

- a. One hour per month, face-to-face, individual supervision if no supervisees, OR
- b. Two hours per month, face-to-face, individual supervision if they supervise any assistant behavior consultation-ABA or BHT-ABA staff, AND
- c. 30 minutes of direct observation during the provision of services every six months.
- d. Supervision logs, including the date, start time, end time, location, modality, format, narrative, signature, and signature date, are completed for every supervision requirement listed above. Supervision logs are stored within the agency and are available to CBH staff for ABA designation chart reviews, compliance, or auditing purposes at any time.
- e. Each supervisor of ABA staff, at every level, has no more than 12 full-time equivalent staff, with a maximum of nine being BHT-ABAs.

3. All staff who provide Assistant Behavior Consultation-ABA services shall receive ongoing supervision in accordance with the prevailing Supervision standards for the BCaBA® credential, as promulgated by the Behavior Analyst Certification Board (BACB®).

a. **NOTE that CBH exceeds IBHS regulations for the supervision of staff who provide assistant behavior consultation-ABA.** CBH will adopt the most current version of supervision standards, as promulgated by the BACB®, in order to address needed capacity in our system.

b. As of the time of this document publication, this requires all BCaBA®'s to receive ongoing supervision by a BCBA® or BCBA-D® who has completed a supervision training course and is in good standing to provide supervision.

d. Supervision logs, including the date, start time, end time, location, modality, format, narrative, signature, and signature date, are completed for every supervision requirement listed above. The supervision logs are stored within the agency and are

available to CBH staff for ABA designation chart reviews, compliance, or auditing purposes at any time.

e. Each supervisor of ABA staff, at every level, has no more than 12 full-time equivalent staff, with a maximum of nine being BHT-ABA's.

4. All staff who provide ABA-BHT services shall be employees of the ABA-designated agency and receive supervision from a person who meets the qualifications of a Clinical Director, or is eligible to provide Behavior Analytic services, or Behavior Consultation-ABA at the following ratios:

a. One hour of individual, face-to-face supervision each week, if working 37.5 hours a week or more

b. One hour of individual, face-to-face supervision, twice per month, if working less than 37.5 hours a week

c. Six hours of on-site supervision during the provision of services before ever providing services independently

d. One hour of direct observation during the implementation of the ITP with a CBH member, every four months

e. One hour of direct observation during the implementation of the ITP every two months with a CBH member, if qualified to provide ABA-BHT with a high school diploma and RBT training only

f. NOTE: Additional group supervision may be provided to supplement BHT learning but may not replace any of the minimum supervision requirements described in the regulations and specified above.

g. Supervision logs, including the date, start time, end time, location, modality, format, narrative, signature, and signature date, are completed for every supervision requirement listed above. Supervision logs are stored within the agency, and are available to CBH staff for ABA designation chart reviews, compliance, or auditing purposes at any time.

h. Each supervisor of ABA staff, at every level, has no more than 12 full-time equivalent staff, with a maximum of nine being BHT-ABAs.

i. Each ABA-designated agency shall ensure that a clinical supervisor is available by phone to consult with all staff during the provision of all ABA services, including evenings and weekends, at any time that ABA services are being provided and billed by the agency.

### C. Ongoing Training/Continuing Education

All providers must ensure that all Staff providing ABA services complete all agency-specific, CBH-mandatory trainings, and IBHS regulated trainings.

1. All staff who provide ABA Services shall meet the following initial and annual training requirements:

a. For Clinical Directors, Behavior Analytic staff or Behavior Consultation-ABA staff,

i. At least 45 hours of training related to ABA approved by the Department or by

- a continuing-education provider approved by the BACB<sup>®</sup>, prior to independently providing services, AND
- ii. At least 16 hours annually approved by the Department or by a continuing education provider approved by the BACB<sup>®</sup>, AND
  - iii. Complete continuing-education units (CEUs) as required by the BACB<sup>®</sup> for each defined recertification cycle to maintain active certification. BCBA<sup>®</sup> and BCBA-D<sup>®</sup> certificants must adhere to the BACB<sup>®</sup>'s ethics requirements and self-reporting requirements and submit a complete recertification application and associated fees every two years prior to their recertification date. At the time of this document publication, all BCBA<sup>®</sup> and BCBA-D<sup>®</sup> certificants must obtain 32 CEUs within each two-year recertification cycle, including four CEUs in ethics and three CEUs in supervision (for supervisors).
- b. For Assistant Behavior Consultation-ABA staff, who are all required to hold the BCaBA<sup>®</sup> credential,
- i. 20 hours of training related to ABA approved by the Department or by a continuing-education provider approved by the Behavior Analyst Certification Board (BACB<sup>®</sup>), prior to independently providing services, AND
  - ii. At least 20 hours of training annually approved by the Department or by a continuing education provider approved by the Behavior Analyst Certification Board (BACB<sup>®</sup>), AND
  - iii. Complete continuing education units (CEUs) as required by the Behavior Analyst Certification Board for each defined recertification cycle to maintain active certification. BCaBA<sup>®</sup> certificants must adhere to the BACB<sup>®</sup>'s ethics requirements and self-reporting requirements and submit a complete recertification application and associated fees every two years prior to their recertification date. At the time of this document publication, all BCaBA<sup>®</sup>s must obtain 20 continuing education units (CEUs) within each two-year recertification cycle, including four CEUs in ethics and three CEUs in supervision (for supervisors).
- c. For Staff providing ABA-BHT services,
- i. 30 hours of Department-approved training on topics outlined in 5240.73(c) (e.g., crisis intervention, child and adolescent development) prior to independently providing services, AND
  - ii. An additional 24 hours of Department-approved training during the first six months of providing BHT-ABA on topics outlined in 5240.73(d) (e.g., systems of care, cultural considerations, conflict resolution), AND
  - iii. At least 20 hours of training annually approved by the Department or by a continuing education provider approved by the Behavior Analyst Certification Board (BACB<sup>®</sup>). Training hours to maintain certification or licensure may count.



## Appendix A. Practice guidelines for ABA-Group levels of care

Under IBHS regulations, provider agencies who have an IBHS license to deliver ABA and Group Services may offer small group ABA treatment to two to 10 individuals simultaneously. Small group instruction typically focuses on the development of adaptive, social, and behavioral skills where all children share the same (or very similar) goals and objectives and can benefit from instruction in dyads or small groups. All children in segregated, or non-inclusive, groups have an eligible diagnosis and all children are receiving IBHS treatment simultaneously as part of attending the program.

Indications for ABA-group services under IBHS may include:

- children who have demonstrated difficulty benefitting from community-based settings such as day care, Headstart, school, after school programs, and community recreational activities or
- children who have demonstrated skill deficits or behavior challenges that would benefit from ABA group treatment
- children for whom prior treatment from the children’s treatment continuum has been unsuccessful to support success in these settings.
- children who present with identified skill deficits and/or behaviors that would preclude them from participating in other treatments from the children’s treatment continuum (e.g., BHT support in an integrated program) may also be appropriate for IBHS groups.

For example, social skills groups may be used to teach individuals with ASD ways to appropriately interact with typically developing peers. Social skills groups typically involve small groups of children with ASD who attend a program in a community or community-like setting and receives services from someone qualified to deliver Behavior Analytic Services or Behavior Consultation Services. Most social skill sessions include a period of direct instruction/reviewing a lesson for the day, modeling, role-playing or practice with peers, coaching and prompting, and feedback to help participants acquire skills to promote positive social interactions with peers. Some manualized social skills curricula that are considered to have an “established” evidence-base in the literature include Social Skills Solutions (McKennon and Krimpa, 2002) and the Skillstreaming Series for Early Childhood, Elementary School-Aged Children, and Adolescents (McGinnis, 2011).

### Inclusive, evidence-based social skills groups

Another evidence-based approach to facilitate the development of appropriate play and social skills for children with ASD is the use of inclusive, peer-training packages. In these models,

learners with ASD are integrated with neurotypical, same-age peers who function as peer role models and interaction partners. This model may be preferred to more segregated models for those children who show a tendency to rely on adults for prompting, guidance, and have very low or no spontaneous play with peers their same age. The neurotypical peers should be consistently available, free of any significant behavioral concerns, willing to participate, generally friendly and prosocial, and with an age-appropriate level of compliance to adult instruction. These types of integrated social skills programs are typically offered in school or community settings, where children with behavioral health needs have greater access and incidental contact with their same-age peers. Some specific peer-training programs cited in the established treatment literature include: Project LEAP, peer networks, circle of friends, “best buddy” or buddy skills package, integrated play groups, peer initiation training, and peer-mediated social interaction training.

### Goals and Treatment Planning for ABA-Groups

The overarching goals of ABA-Group treatment under IBHS is to support the child to improve functioning so they can return to an age-appropriate, least-restrictive setting wherein there are age-appropriate opportunities to interact with typically developing same-aged peers. It is not expected that all behaviors associated with a child’s diagnosis will cease as a result of group treatment. Rather, strategies are established to ameliorate concerns and skills are being developed. Appropriate additional on-going treatment can be utilized to support that eventual transition back into the community as needed.

The ITPs developed for ABA-Group programs must reflect the same standards for the ITP, goals, and objectives as those for IBHS-ABA (See ABA Performance Standards). In other words, all goals should be specific, observable, measurable, and phrased in the positive as to what the child will be able to do versus what they will stop or cease to do. Further, it should be demonstrated that although each ITP is individualized to each child, more than one child should share common goals that are addressed through group treatment. For example, in an overall group of six children, two groups of three children may work with each of two group facilitators on shared goals (e.g., one group of three is working on conversation skills while the other group of three is working on turn-taking and sharing in the context of a game).

Common foci of goals and objectives may include the following (not exhaustive) list: perspective-taking, conversation skills, friendship skills, problem-solving, social competence, emotion recognition, theory of mind, and/or problem-solving. In addition, specific interaction skills such as initiation, responding, maintaining, greeting, giving/accepting compliments, turn taking, sharing, asking for help, offering help, and including others are commonly reported targets. Data on each child’s performance toward their goals should be collected at least once per encounter and graphed per ABA Performance Standards to demonstrate progress over time.

The literature supporting social skills groups typically involves treatment sessions of 15 to 90 minutes, one or more times per week, with shorter sessions of 15 to 30 minutes for young

children. Older youth may benefit from slightly longer sessions and the number of unique treatment plan goals and objectives should increase incrementally with the total duration of services per week. Most social skills groups will run one to three times per week for up to 90 minutes, and each child's ITP should typically include three to five specific goals. Some researchers have suggested that 30 hours of group treatment, delivered over 10 to 12 weeks was the minimum threshold for children to achieve meaningful clinical outcomes. Therefore, some programs may meet more frequently, as clinically indicated and approved by CBH during the contracting and Service Description process. Finally, most social skill programs are conducted as closed-ended groups with a fixed membership for a set number of sessions, typically between 12 to 20 weeks at a time, allowing open enrollment between these blocks of sessions. Many models in the literature aligned with school "semesters" and were offered either at the school location after regular school hours, or in the early evening hours in a community or community-like setting, such as a daycare or aftercare provider.

### Outcomes Measurement

ABA-Group Providers will be expected to adopt an outcomes measurement tool that allows for measurement of all participating children's progress on a standardized or norm-referenced assessment tool. Providers would be expected to utilize a repeated measure design to assess progress over time for the groups of children receiving ABA-Group services through their agency, in addition to tracking attainment of individual goals and objectives. Suggested assessment tools would include the Vineland Adaptive Behavior Scale (Sparrow, Balla, & Cicchetti, 1984)<sup>21</sup> or the Batelle Developmental Inventory (Newborg, Stock, Wnek, Guidubaldi, & Svinicki, 1984)<sup>22</sup>. Standardized instruments such as the Vineland or the Batelle are useful outcome measures because they allow providers and CBH to track progress over repeated assessments, but also allow for comparison to neurotypical peers or the general population of children with autism (Charlop-Christy & Kelso, 1996). This demonstration of response to intervention is essential for furthering the research base on group interventions for children with ASD and to demonstrate meaningful clinical outcomes to support the medical necessity of continued services.

### Group Therapy staffing

ABA-groups staffing models must follow the IBHS regulations regarding staff qualifications and staff supervision for group IBHS. A graduate level professional provides group therapy, designs psychoeducational group activities, and shall be present during all group activities. For groups in a community-like setting, the graduate level clinician also provides individual and family psychotherapy. The ABA-BHT may assist with conducting group psychotherapy, may facilitate psychoeducational group activities, and delivers interventions based upon the ITP.

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<sup>21</sup> Vineland Adaptive Behavioral Scale, Sparrow, Balla, & Cicchetti, 1984, <https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Behavior/Adaptive/Vineland-Adaptive-Behavior-Scales-%7C-Third-Edition/p/100001622.html>

<sup>22</sup> Batelle Developmental Inventory, Newborg, Stock, Wnek, Guidubaldi, & Svinicki, 1984, <https://info.riversideinsights.com/bdi-3>

## Group size

Consistent with MA regulations for group therapy, groups must include at least two and no more than 10 participants. For children under the age of 36 months, the group size is not to exceed six children as is consistent with PA Commonwealth regulations for center-based childcare centers. For groups of mixed age children that include children under 36 months as well as older children, the maximum number of children is also six.

For any ABA-Group IBHS program exceptions (e.g., those compensated in an Alternative Payment Model and not unit-based Fee-for-Service), staffing ratios should be determined by the individual clinical needs of the children participating in the group and provisions in the staffing pattern should be readily available to make adjustments as needed. Staffing ratios may never drop below the minimal ratios established and agreed upon by CBH in the contracting process and in the Service Description.