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CLINICAL PERFORMANCE STANDARDS

Applied Behavior Analysis (ABA) – Early Childhood (EC) Programs

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Community Behavioral Health

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1. PURPOSE

Applied Behavior Analysis (ABA) refers to the scientific discipline and profession aimed at promoting socially significant changes in human behavior. Interventions based on ABA have proven effective in supporting children with neurodevelopmental differences in acquiring new skills to maximize meaningful developmental functioning and to achieve mutually agreed upon goals developed in partnership with parents, caregivers, educators, healthcare and rehabilitative professionals, and other system partners involved in the lives of children. Research articles published over the last 50 years, combined with case law and national credentialing standards, verify ABA as a best practice treatment for the myriad symptoms and skill deficits commonly associated with autism spectrum disorder (ASD) and other neurodevelopmental and behavioral disorders, particularly when those children are still within early childhood.[1]**Error! Reference source not found.Error! Reference source not found.**

Therefore, the purpose of these ABA – Early Childhood (EC) performance standards is to ensure access to high-quality ABA services for young children so that they may maximize functioning related to identified skill acquisition and behavior reduction goals while their parents become more prepared and empowered partners to support progress. Additionally, these performance standards are to guide treatment providers in delivering intensive ABA interventions to young children that are least restrictive, maximally effective, and culturally and linguistically sensitive. These performance standards reflect the core values of the City of Philadelphia's Department of Behavioral Health and Intellectual Disability Services (DBHIDS) **Practice Guidelines** and align with Pennsylvania state regulations and the goals and recommendations **of The Mayor's Blue Ribbon Commission on Children's Behavioral Health (2007)**. The performance standards serve as a tool to promote continuous quality improvement and best practices in ABA for early childhood populations, increase the consistency of service delivery, and improve outcomes for children receiving treatment and their families.

The overarching goal of ABA-EC programs is to support the child to improve functioning so they can return to an age-appropriate, least-restrictive setting where they are maximally integrated with same-aged peers in natural environments. Therefore, ABA-EC programs must ensure meaningful access to same-aged, neurotypical peers, including opportunities for structured and spontaneous interactions. This is consistent with both established special education laws and the **Behavior Analyst Certification Board (BACB) Ethics Code**. Both the BACB and the **Council of Autism Service Providers (CASP)** emphasize treatment within naturalistic or in vivo environments to increase motivation and skills generalization.

Also consistent with the BACB Ethics Code and the **CASP ABA Practice Guidelines** is including parents and caregivers in the selection, design, and implementation of behavior-change interventions with opportunities to receive training and consultation throughout treatment. Thus, robust parent/caregiver training is expected to serve as a centerpiece and is required for all children receiving ABA-EC treatment. This could include daily communication or data logs, weekly parent/caregiver coaching or training, or group parent training for parents of enrolled children. Consistent with the literature and ideas put forth by designated pilot providers, caregiver training sessions should be offered on a robust schedule, best practices would

[1] ***Early Intensive Behavioral Intervention (EIBI) for Young Children with Autism Spectrum Disorders (ASD)***

suggest biweekly to monthly sessions, and CBH will require at least one session per quarter to be conducted in the home settings to support generalization and skills transfer. Parents/caregivers shall be screened by the provider for their ability to fully participate in their child's ABA-EC treatment, and CBH reserves the right to request an interagency service planning team (ISPT) or evaluate child progress related to parent participation at any time.

It is not expected that all behaviors associated with a child's diagnosis will cease as a result of ABA-EC treatment. Rather, children and their families are expected to acquire strategies to ameliorate their greatest concerns and challenging behaviors while skills are being developed, maintained, and generalized across environments. Appropriate additional ongoing treatment can be utilized to support the necessary transition in an appropriate timeframe back into maximally integrated and least restrictive environments.

2. ABA-EC PROGRAMS LICENSING REQUIREMENTS

A provider agency desiring to offer ABA-EC programs must:

1. Be licensed as an Intensive Behavioral Health Services (IBHS) agency in accordance with **55 Pa. Code § 20** (Licensure or Approval of Facilities and Agencies) and **55 Pa. Code § 5240** (IBHS)
2. Enter into a written provider agreement with PA DHS
3. Be enrolled in the Medical Assistance (MA) program by PA DHS
4. Operate the ABA-EC program within the city limits of Philadelphia, with a preference for centers located within ZIP codes associated with the highest incidence of ASD, per CBH enrollment data.

   NOTE: *Not all centers will need to accommodate all children and referrals will be made based on proximal ZIP codes to support access and transportation arrangements with the School District of Philadelphia.*
5. Providers shall meet one of the following:

   - Are licensed to operate a childcare facility in accordance with applicable regulations issued by the **Office of Child Development and Early Learning** (OCDEL)

     OR

   - Are co-located within a childcare facility and have developed a memorandum of understanding (MoU) regarding the services and support to be provided

3. PROGRAM OPERATIONS

ABA-EC programs shall operate over the full calendar year and are expected to accept admissions and discharge children on a rolling basis. Each program day should include a minimum of four program hours of intensive ABA treatment per child. Although ABA-EC programs may observe agency-wide holidays, it is expected that children receiving this intensive level of care will be provided ongoing services with minimal gaps in treatment (i.e., no more than five consecutive weekdays of program closure) throughout the year, with rolling admissions and discharges per each child's individual progress and consideration of least restrictive environment (LRE). Programs must offer a minimum of 240 program days per calendar year. All ABA-EC centers must be Americans with Disabilities Act (ADA)-compliant and accessible to children and families.

Program hours should be designed to support the developmental needs of young children, including their physical needs, capacities, and limitations (e.g., naps, attention span, meals). Program hours should maximize child attendance and family engagement. ABA-EC programs are expected to provide flexible parent sessions to accommodate various work schedules, needs, and preferences of families served. It is expected that ABA-EC programs will also support young children to receive other needed services or treatments, such as early intervention services. These services may be integrated into the ABA-EC treatment environment, extending the program day beyond the minimum of four hours of ABA intensive treatment (e.g., ABA-EC program with occupational therapy and speech push-in may operate for 5-6 hours per day). Due to transportation coordination and the developmental needs of preschool children, ABA-EC programs are not expected to run for more than six hours per day. Parents retain responsibility for providing all care items (e.g., alternate clothing and diapers). ***NOTE:*** *Dually enrolled children in ABA-EC and other childcare programs offered at the center may stay for extended or after-care hours per concurrent childcare agreement with family and funders.*

ABA-EC programs are expected to implement evidence-based procedures within the program. ABA-EC programs shall also structure their program rooms and group sizes in accordance with the literature and assess the developmental and behavioral needs of the children in each group. On average, group sizes are expected to be one staff member for every three children and a maximum "group" or room size of nine children. One staff member per room must meet the requirement to deliver ABA-Behavior Analytic (BA) or ABA-Behavior Consultation (BC), per the IBHS requirements. ABA-EC programs must also be able to program for individual child needs and use staff flexibly to meet the needs of children who may require 1:1 instruction or behavior support for some portion of their ABA-EC treatment. In fact, some children are expected to experience non-linear progress and fluctuating needs wherein 1:1 or 1:2 support may be necessary as part of a comprehensive ABA-EC program. Staffing should also accommodate the generalization of skills, including rotating staff across children and rooms and maximizing opportunities for interactions with neurotypical peers.

4. ADMISSION REQUIREMENTS

ABA-EC programs are designed to admit children ages 3-5 who have not yet entered kindergarten and require intensive intervention that cannot be implemented in a less restrictive setting. This determination of need is assessed and prescribed during a level of care (LOC) assessment or psychological evaluation by an

appropriately licensed staff person in the ABA-EC program. Each child's individual needs and goals will then be more thoroughly assessed during the first 30 days of enrollment, in alignment with the IBHS assessment process as required by IBHS-ABA regulations. The IBHS assessment shall minimally include a cross-setting functional behavior assessment, skills assessment, and the domains required in regulation. The IBHS assessment may be completed by a graduate-level clinician qualified to deliver ABA-BA services or by a clinician qualified to deliver ABA-BC under the supervision of a clinical director. The assessment must include direct observation of the child in all settings (i.e., home, community, and center) and conclude that center-based services are the least restrictive location likely to be effective for this child's current individual needs. ***NOTE:*** *Assessment in the home and center would be acceptable for children not yet enrolled in any formal placement.*

Children appropriate for ABA-EC programs must demonstrate significant difficulty interacting successfully with same-aged peers due to measured significant skill deficits and disruptive or dangerous behaviors. Observed behaviors must be of a frequency/intensity/duration/rate that is widely discrepant from developmentally expected behaviors. Children must demonstrate an inability to be successful in less restrictive settings and with less intensive levels of behavioral health treatment. Children must have a primary behavioral health disorder diagnosis of ASD, with Level 2 or 3 severity for either the social communication or restricted, repetitive behaviors and interests domains, or likely both. Children may be admitted with or without co-occurring intellectual/developmental disorders or medical conditions, although they must be assessed as reasonably likely to benefit from interventions delivered in groups and to reasonably be able to generalize skills to natural environments.

More specifically, children appropriate for ABA-EC programs may display measured difficulty with both verbal and nonverbal communication, engage in frequent repetitive behaviors, have narrow and specific or restricted interests, struggle with change, demonstrate limited interest in social situations or interactions, and learn or develop more slowly than their same-aged peers such that they require substantial, comprehensive, and structured support and treatment intervention. Behaviors resulting from skill deficits may include refusal, tantrums, self-injurious behaviors, aggression, property destruction, elopement, or significantly diminished attention span, and none may be disqualifying or exclusionary criteria for ABA-EC programs. Children with co-occurring conditions are also appropriate for participation. Children who are appropriate for ABA-EC programs will exhibit behaviors and limited skills, including group readiness skills, and it is expected that flexible staffing be provided and that ABA interventions be individually modified to meet those needs.

4.1. Monitoring of Standard

- Acceptance of all CBH-referred children who meet admission requirements, pending program openings
- Start date offered within seven business days of referral
- Actual start date (in days) from the date of referral

5. ACCESS FOR NEW MEMBERS

All ABA-EC providers shall be contracted at an expected maximum census. ABA-EC providers are expected to accept referrals directly from CBH for any children who meet the admission requirements, so long as the provider has program openings. CBH will track acceptance percentages and may implement specific standards or P4P targets in future years. New referrals who are determined to be clinically appropriate shall be offered admission to the program within 7 business days of the date of referral. The actual start date may be longer, as arrangements of transportation and/or other logistics may delay an individual child's start date. 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 or maintaining a minimum census.

6. ACCESS FOR EXISTING MEMBERS

In alignment with the IBHS regulations, ABA-EC providers shall evaluate each child's progress towards stated goals in the Individual Treatment Plan (ITP) every 90 days. Use of the **CBH Progress Monitoring Form**[2] is required. Care coordination reviews will occur with CBH critical care managers and psychologists for any individuals not making demonstrated, data-driven progress to discuss barriers, results of updated assessments such as a functional behavior assessment (FBA) or skills assessment, response to interventions, collaboration with child and family supports, stakeholders, and research-based modifications to interventions to support progress. For children requiring crisis evaluation or for children referred to acute levels of care, additional longitudinal care management strategies will be required.

7. PARENT/CAREGIVER ENGAGEMENT

Active engagement of the parents, family, legal guardians, or caregivers is essential to the success of any service to early childhood populations. ABA-EC providers shall screen families for their ability, willingness, and availability to fully participate in their child's ABA treatment program, including attending regular parent/caregiver training sessions and other opportunities to obtain skills and learn new strategies to support their children. Only those families who provide informed consent and sign a participation agreement will be offered admission. ABA-EC providers are also expected to develop child and family goals in the ITP by explicitly asking parents/families about their child's priorities, preferences, and goals. At least one parent/caregiver training or skills goal must be included in every ITP.

The ITP for children enrolled in ABA-EC programs must include at least one active parent training goal, with documented and data-based progress reviews every 90 days. To achieve parent training goals, it is expected that ABA-EC programs will offer parent training sessions on a bi-weekly basis and ensure a minimum of monthly parent/caregiver training sessions throughout the child's entire course of treatment. Half of all family sessions may occur at the center and may occur in small groups when discussing content beneficial to more than one family, but at least one session per quarter shall occur in the natural environment

[2] ***CBH Provider Bulletin 20-02***

of the child's home to facilitate generalization and skills transfer. Home sessions may be facilitated by a Behavioral Health Technician-ABA (BHT-ABA) inclusive of the requirement that they are first assessed competent in implementing all components of the child's treatment plan via treatment fidelity measures by a supervising Board-Certified Behavioral Analyst® (BCBA®) and are able to successfully demonstrate, explain and transfer skills to others. This could be an opportunity to utilize Assistant BCs, Registered Behavior Technicians (RBTs), or BHT-ABA staff enrolled in graduate programs in ABA or similar fields. Extended family members, such as non-custodial parents, siblings, aunts/uncles, or grandparents, are encouraged to participate in sessions if they regularly interact with the child and would benefit from this training.

Explicit engagement with families regarding child de-escalation and crisis plans should occur as frequently as is clinically indicated. Those activities should include development of plans consistent with the family's identified goals and needs, the child's preferences and skill capacity, psychoeducation, and guided practice. Likewise, as Medicaid-funded entities, all ABA-EC providers must have a language access plan and be able to offer all communication (both verbal and written) and parent training sessions in the language of a family's request.

8. CULTURAL COMPETENCY

All CBH providers are expected to support the development of cultural competency 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.

Use the **National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care**, developed through the U.S. Department of Health and Human Services Office of Minority Health, to support providers in offering culturally and linguistically appropriate services. The **Improving Cultural Competency for Behavioral Health Professionals** online program is strongly encouraged.

ABA-EC providers must also ensure knowledge and skills to meet all special communication needs of the child or family, including access to translation and interpretation services as needed. Although children may be instructed primarily in English, all parent training and family sessions shall occur in the family's preferred language and should never be a barrier to access. ABA-EC providers are expected to have a language access plan independent of CBH. 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.

8.1. Alignment with the BACB Ethics Code

Alignment with the **BACB Ethics Code** for BAs related to cultural responsiveness, diversity, and non-discrimination:

- BAs actively engage in professional development activities to acquire knowledge and skills related to cultural responsiveness and diversity. They evaluate their own biases and ability to address the needs of individuals with diverse needs/ backgrounds (e.g., age, disability, ethnicity, gender expression/identity, immigration status, marital/relationship status, national origin, race, religion, sexual orientation, socioeconomic status). BAs also evaluate the biases of their supervisees and trainees and their supervisees' and trainees' ability to address the needs of individuals with diverse needs/backgrounds. (§ 1.07)

- BAs do not discriminate against others. They behave toward others in an equitable and inclusive manner regardless of age, disability, ethnicity, gender expression/identity, immigration status, marital/relationship status, national origin, race, religion, sexual orientation, socioeconomic status, or any other basis proscribed by law. (§ 1.08)

9. LINKAGES/COORDINATION OF CARE

ABA-EC programs are expected to be comprehensive, stand-alone programs, and it is not anticipated that most enrolled children will need other behavioral health services while enrolled in ABA-EC programs. Children enrolled in ABA-EC programs may not concurrently receive other forms of IBHS or ABA services from another provider while enrolled in an ABA-EC program.

Children enrolled in ABA-EC programs may still receive the following concurrently with ABA-EC:

- Psychiatric Services or medication management

- Family-Based Services or other behavioral health treatment for siblings or other identified children in the family

- Blended Case Management

- Intellectual Disabilities Services Supports Coordinator

In all cases of concurrent services, the ABA-EC provider is responsible for referral, coordination, and regular collaboration. CBH may require a stated schedule of interdisciplinary team meetings and/or to be present in said meetings if clinically indicated or if barriers to consistent and effective collaboration are identified.

As it is anticipated that most children enrolled in ABA-EC programs will be dually eligible for Early Intervention (EI) or special education and likely to receive specialized healthcare services, each ABA-EC program must have a plan for coordinating care and integrating treatment approaches with other service providers. ABA-EC providers shall assess for child's eligibility for EI or special education services and ensure ongoing collaboration of ABA-EC staff with any related services professionals, such as specialized instruction, speech, occupational, and/or physical therapies included in a child's Individualized Family Service Plan (IFSP), for those children who recently turned three years of age, or Individualized Education Plan (IEP), for those children ages 3-5. There should be a plan for ongoing collaboration to ensure consistency of approaches towards congruent treatment goals. The same expectations would apply to any medically necessary healthcare, psychiatric services, or specialists involved in the child's care.

Results of any previous evaluations and/or skill assessments completed by any of these team members should be obtained and integrated into ABA-EC 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 ABA-EC staff and treating speech and language pathologists). Further, all team members should be ongoing and active participants in the Interagency Service Planning Team (ISPT) process, as needed. CBH Clinical Management staff may participate in some ISPTs, as requested by either the child, parents, or family, or by the provider agency for purposes of information sharing, care coordination, or when children are not making measurable progress towards identified treatment goals. Data-based progress reviews within teams should occur regularly (e.g., every 90 days as part of the progress review requirement in ABA-EC programs).

It is not expected that ABA-EC will remediate all skill deficits or reduce all problem behaviors to zero rates. Rather, ongoing assessment of the least restrictive, most effective environment is expected to be a part of ongoing progress monitoring and lead to individualized discharge planning for each child. ABA-EC programs are expected to assist families with identifying appropriate discharge settings and services to support continued progress in that setting. The ABA-EC program is also expected to collaborate with aftercare/discharge settings to support the child's transition.

10. ASSESSMENT

Consistent with IBHS regulations and best practices in ABA, each child will receive a comprehensive assessment at the beginning of and periodically throughout their enrollment in an ABA-EC program. Assessments should be completed by a graduate-level professional qualified to deliver ABA-BA services. The staff person who completed the assessment shall sign and date the assessment and all updates.

Although the exact format of the assessment is not dictated by CBH, the assessment must minimally address each of the following domains and be used to inform the ITP:

- The strengths and needs across developmental and behavioral domains of the child
- The strengths and needs of the family system in relation to the child
- Existing and needed natural and formal supports
- Social Determinants of Health (SDOH) using **OneCare Vermont's Self-Sufficiency Outcomes Matrix**
- Clinical information that includes the following:
  - Survey data gathered from a parent, legal guardian, or caregiver
  - Treatment history
  - Medical history
  - Developmental history

- Family structure and history
- Educational history
- Social history
- Trauma history
- Adaptive skills assessment
- Other relevant clinical information

- Standardized behavioral assessment tools, including completion of a functional behavior assessment (FBA), if the reduction of behaviors of concern is a goal in the ITP
- Compilation of observational data to identify developmental, cognitive, communicative, behavioral, and adaptive functioning across the home, school, and other community settings, in addition to observation in the center-based environment
- Identification and analysis of skill deficits, such as through commercially available, evidence-based skills assessment or curriculum-based assessment tools
- The cultural, language, or communication needs and preferences of the child and their parent, legal guardian, or caregiver
- A summary of the treatment recommendations received from other/related health care providers, schools, or other service providers involved with the child

The assessment shall be reviewed and updated at least every 12 months or if any of the following occurs:

- A parent, legal guardian, or caregiver of the child requests an update
- The child requests an update
- The child experiences a change in living situation that results in a change of their primary caregivers
- The child has made sufficient progress to require an updated assessment
- The child has not made significant progress towards the goals identified in the ITP within 90 days of the services' initiation
- The child experiences a crisis event, including any activation of children's mobile crisis services, presentation to a Crisis Response Center (CRC) or the emergency department of any hospital, or referral/admission to any higher LOC, including Acute Partial Hospitalization Services or Acute Inpatient Services

- A staff person, primary care physician, other treating clinician, case manager or other professional involved in the child's services provides a reason an update is needed

Linkage to a qualified psycho-diagnostic evaluation is required to clarify the child's behavioral health diagnosis, eligibility for program participation, or consideration of complex treatment needs. A qualified psychologist or psychiatrist may complete a psycho-diagnostic evaluation within the provider agency or via an MoU with a qualified evaluation professional.

10.1. Alignment with the BACB Ethics Code

Alignment with the **BACB Ethics Code** for BAs related to selecting, designing, and implementing assessments:

- Before selecting or designing behavior-change interventions, BAs select and design assessments that are conceptually consistent with behavioral principles that are based on scientific evidence and that best meet the diverse needs, context, and resources of the client and stakeholders. They select, design, and implement assessments with a focus on maximizing benefits and minimizing the risk of harm to the client and stakeholders. They summarize the procedures and results in writing. (§ 2.13)

11. TREATMENT PLANNING

ABA-EC treatment should take place as much as possible in naturalistic or "community-like" settings that mirror environments the child would experience if not in need of intensive ABA services. Program schedules shall be based on naturally reinforcing activities and developmentally appropriate for enrolled children. ABA-EC programs should emphasize skill acquisition as the primary strategy to reduce or replace interfering or challenging behaviors with more desirable and functionally equivalent replacement behaviors. ABA-EC treatment should include strategies to promote generalization by training parents, extended family, and other natural supports, along with a plan to support the eventual transition from the ABA-EC program into more natural environments, such as an integrated daycare or school placements. Generalization and maintenance of individual treatment outcomes should also be explicitly promoted by training in multiple settings, with multiple staff, with multiple exemplars, and using mixed and varied stimuli.

A written ITP shall be completed by an individual qualified to provide ABA-BA services within 45 days after the initiation of ABA-EC Services, so long as a treatment plan is in place. The ITP shall be developed in collaboration with the child and their parent, legal guardian, or caregiver of the child or youth. The ITP for children enrolled in ABA-EC programs must include at least one active parent training goal, on which there are documented and data-based reviews of progress no less than every 90 days. The ITP must include the recommendations from the licensed professional who completed the written order for the ABA-EC program and incorporate the results of the IBHS-ABA assessment, including integration of FBA and skills assessment data. The ITP must be strength-based with socially significant, individualized goals/objectives. Distinct goals/objectives should be developed to address each of the identified skill deficits and targeted behaviors, as well as specific, measurable goals to achieve generalization and maintenance of acquired skills across all anticipated discharge environments (e.g., home, school, community). Given the comprehensive

and intensive nature of ABA-EC programs, it is expected that ITPs will include an average of 10-12 individualized goals for each child.

ABA-EC treatment is not expected to remediate all skill deficits or reduce all problem behaviors to zero rates. Rather, repeated assessment of the least restrictive, most effective environment is expected to be a part of ongoing progress monitoring and lead to individualized discharge planning at each child's readiness. It is expected that ABA-EC programs will assist families with identifying appropriate discharge settings and services to support continued progress in new, less restrictive environments. Ideally, ABA-EC providers also deliver IBHS-ABA Services in the home, school, and community, and the children can continue to receive services from the same provider agency as they transition out of ABA-EC programming. ABA-EC programs aim to deliver intensive services for a limited period to reduce high-risk behaviors and build pivotal skills that will support children's success in less restrictive environments with continued treatment support. The ABA-EC program is also expected to collaborate with aftercare/discharge settings to support the child's transition. Therefore, it is anticipated that the average length of stay (LoS) for most children in ABA-EC programs will be 12-18 months, while it is also anticipated that some children will require continued ABA treatment in the home, school, and community upon discharge.

The ITP must include the following:

- Service array, service locations, and number of hours per month anticipated for each service (e.g., center-based hours, home and community-based hours, parent psychoeducation, and training)
- Specific, measurable short-term, intermediate, and long-term goals and objectives to address socially significant behaviors, skill deficits, or both
- Delineation of the frequency/intensity/duration/rate of baseline behaviors from the FBA, the specific interventions planned to address behaviors, skill deficits, or both, and the frequency at which the child's progress in achieving each goal will be measured
- Expected timeframes to complete each goal, including the timeframe to achieve maintenance and generalization
- Specific and measurable goals for parent/caregiver training and the level of support and participation expected to achieve the identified goals and objectives
- Expected course of treatment and anticipated discharge dates and plan
- ABA interventions that are tailored to achieving the child's goals and objectives
- A safety plan to prevent a crisis, a crisis intervention plan, and a transition plan (this must include documentation that the safety plan was developed in collaboration with the family and is periodically reviewed with the family and updated, as clinically indicated)

The ITP shall be reviewed and updated at least every six months or if any of the following occurs:

- The child has made sufficient progress to require that the ITP be updated

- The child has not made significant progress towards the goals identified in the ITP within 90 days from the initiation of ABA-EC Services
- The child requests an update
- A parent, legal guardian, or caregiver of the child requests an update
- The child experiences a crisis event, including any activation of children's mobile crisis services, presentation to the Crisis Response Center (CRC) or the emergency department of any hospital, or referral/admission to any higher level of care, including Acute Partial Hospitalization Services or Acute Inpatient Services
- The ITP is no longer clinically appropriate for the child
- A staff member, primary care physician, other treating clinician, case manager, or other professional involved in the child's services provides a reason an update is needed
- The child experiences a change in living situation that results in a change in their primary caregivers

In the event of an ITP update, the update must address the following:

- A description of progress or lack of progress toward previously identified goals and objectives
- A description of any new goals, objectives, and interventions
- A description of any changes made to previously identified goals, objectives, or interventions
- A description of any new interventions to be used to reach previously identified goals and objectives

The ITP and all updates shall be reviewed, signed, and dated by the parent or legal guardian of a child and the staff member who completed the ITP. They shall also be reviewed, signed, and dated by an individual who meets the qualifications of an ABA-EC program Clinical Director.

Providers must adhere to all internal policies required by CBH surrounding creating and maintaining an evidence-based treatment linkage policy.

11.1. Alignment with the BACB Ethics Code

Alignment with the **BACB Ethics Code** for BAs related to progress monitoring and continual evaluation of the behavior change interventions:

- BAs engage in continual monitoring and evaluation of behavior-change interventions. If data indicate that desired outcomes are not being realized, they actively assess the situation and take appropriate corrective action. When a BA is concerned that services concurrently delivered by

another professional are negatively impacting the behavior-change intervention, they take appropriate steps to review and address the issue with the other professional. (§ 2.18)

12. TREATMENT PROVISIONS

The benefit of treatment provision in a least restrictive environment (LRE) or least restrictive alternative (LRA) has long been established.[3,4,5]. It is expected that ABA-EC center-based treatment will be provided within a setting that supports opportunities for children to interact with neurotypical peers via structured and semi-structured activities in an individually determined and clinically appropriate manner. In the case of ABA-EC treatment, LRE settings provide the occasion for rehearsing newly acquired skills and taking advantage of natural reinforcement contingencies. Within ABA center-based treatment, participating children will benefit from natural environment teaching strategies and observational learning of behaviors modeled by their neurotypical peers. The inclusion of neurodiverse and neurotypical peers will increase motivation, engagement, and interest in developmentally appropriate activities, such as play, communication, socialization, self-regulation, and varied interests, as well as enhanced support for skill generalization and maintenance. As children's skills increase and when clinically indicated, participation in activities within maximally integrated environments (such as within the larger, licensed daycare facility or community) should occur. These shall be addressed via explicit generalization and maintenance goals, including demonstration of skill with multiple staff, with multiple exemplars, and within multiple environments.

ABA treatment is an evidence-based best-practice treatment for autism and related disorders endorsed by the U.S. Surgeon General, the **American Psychological Association**, and the **National Institutes for Health**. The literature supports the effectiveness of several different early childhood treatment models, and ABA-EC programs are expected to deliver evidence-based treatment interventions. It is also expected that ABA-EC programs will obtain EBP designation through CBH's **Evidence-Based Practice and Innovation Center (EPIC)** within six months of contracting (if not already ABA-designated). Following initial designation, ABA-EC programs shall continue to provide ABA treatment consistent with those standards and maintain annual designation. Failure to maintain designation may result in termination of the provider contract.

Consistent with the global evidence-based ABA treatment with young children, well-established behavior change procedures are expected to be incorporated into most children's ITP. Those include, but are not limited to:

- Antecedent-based procedures
- Backward/forward chaining procedures

[3] ***Education for All Handicapped Children Act (Public Law 94-142)***

[4] ***American with Disabilities Act of 1990***

[5] ***Olmstead v. L.C.***

- Behavioral momentum strategies
- Choice procedures
- Countdowns and timers
- Differential reinforcement procedures
- Direct instruction
- Discrete trial training
- Emotion regulations strategies
- Error correction procedures
- Extinction procedures
- Functional communication training
- Imitation training
- Incidental teaching procedures
- Modeling
- Natural environment teaching (NET) or naturalistic teaching strategies
- Pivotal response teaching/training (PRT)
- Pre-teaching expectations
- Prompting and prompt fading
- Reinforcement contingencies and schedules
- Response interruption and redirection (RIRD)
- Scripts/social scripts
- Self-management strategies
- Signaled availability
- Stimulus fading
- Task analysis

- Verbal behavior programs
- Video modeling
- Visual schedules

In isolation, the use of one or more of the specific interventions and/or teaching strategies listed above does not encompass adherence to the provision of ABA. Rather, the provision of ABA requires multiple components, including skills assessment via structured tools (e.g., Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic Language and Learning Skills (ABLLS™-R)), functional behavior assessment/functional analysis, application of research-based intervention procedures, ongoing data collection with graphing and frequent data analysis, and data-informed systematic shifts to interventions to promote skill development, maintenance, and generalization. The targeted behaviors and skills must be socially valid, significant, and meaningful to the child and their family, and the child's natural supports must be integrated into the treatment.

Individual children and their families are expected to make treatment progress and will be monitored every 90 days by the treatment team in alignment with the IBHS-ABA progress monitoring regulations. Goals and procedures will be systematically modified to support skill generalization and maintenance, and if progress is not being achieved, goals and intervention procedures will be modified using research-based interventions to support success. Treatment modification will also include additional FBA, preference evaluation, skill assessment, and assessment of family goals, priorities, and strengths, as is clinically indicated to inform new treatment goals and interventions. Staffing will be adjusted to provide targeted intervention to support stabilization and progress.

12.1. Alignment with the BACB Ethics Code

Alignment with the **BACB Ethics Code** for BAs related to providing effective treatment:

- BAs prioritize clients' rights and needs in service delivery. They provide services that are conceptually consistent with behavioral principles, based on scientific evidence, and designed to maximize desired outcomes for and protect all clients, stakeholders, supervisees, trainees, and research participants from harm. BAs implement nonbehavioral services with clients only if they have the required education, formal training, and professional credentials to deliver such services. (§ 2.01)

13. AFTERCARE PLANNING AND DISCHARGE

Data collection on all behavioral and skill acquisition targets is one of ABA's most basic and fundamental aspects. Therefore, ABA-EC providers are expected to have robust data collection in support of the medical necessity for continued authorization of the ABA-EC programs as the LRE in which the child is likely to make progress. Children's progress toward goals identified in the ITP shall be formally reviewed and documented in the child's chart every 90 days utilizing the **CBH Progress Monitoring Form**. CBH may request one or more progress reviews at any time and in support of continued stay UR decisions and discharge/aftercare planning. It is expected that complete and up-to-date graphed data on all ITP goals and

data-based progress monitoring forms will be provided to CBH staff whenever requested. For selected children, CBH may also request progress review meetings, concurrent or retrospective chart reviews, ISPTs, case consultations, or crisis consultations.

ABA-EC providers are expected to determine when a child has met the individual and family goals defined in the ITP. When it is determined that a child has met their goals and could be successful in an LRE, such as a pre-K or a daycare slot, discharge planning should begin. The dual enrollment of children in ABA-EC and pre-K classrooms is expected to facilitate a seamless transition on a rolling schedule and at the child's readiness.

In addition to analyzing individual member data, ABA-EC providers are also expected to aggregate data across members using structured outcomes tools. Each ABA-EC provider should select, collect, analyze, and be able to quantify the effectiveness of their program or the challenges they are encountering, including how they are responding to these challenges. In addition, CBH may monitor clinical key performance indicators (KPIs) such as lengths of treatment, community tenure, 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. CBH reserves the right to amend the list of required assessment or outcome measures or clinical KPIs or to introduce new care management strategies at any future point in time, with a minimum of 30-day notification to ABA-EC providers.

13.1. Alignment with the BACB Ethics Code

Alignment with the **BACB Ethics Code** for BAs related to collecting and using data:

- BAs actively ensure the appropriate selection and correct implementation of data collection procedures. They graphically display, summarize, and use the data to make decisions about continuing, modifying, or terminating services. (§ 2.17)

14. STAFFING REQUIREMENTS

All ABA-EC programs shall have an Administrative Director who meets one of the following:

- A bachelor's degree in ABA, psychology, social work, counseling, education, public administration, business administration, or related field (per **55 Pa. Code § 5240**.81);

  OR

- The qualifications for a Clinical Director outlined in § 5240.81(b) and below (In this instance, the same person may fulfill both roles.).

All ABA-EC programs shall also employ a Clinical Director who meets both of the following:

- Licensure as a psychiatrist, psychologist, professional counselor, marriage and family therapist, certified registered nurse practitioner with a mental health certification, clinical social worker, or other professional with a scope of practice that includes overseeing the provision of ABA,

AND

- Certification as a BCBA® or Board-Certified Behavior Analyst-Doctoral (BCBA-D®).

All staff who provide ABA-BA services for an ABA-EC program shall meet both of the following:

- Licensure 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

- Certification as a BCBA® or BCBA-D®.

All staff who provide BC for an ABA-EC program shall meet one of the following:

- 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:

- Certification as a Board-Certified Assistant Behavior Analyst (BCaBA®),
- Minimum of one year full-time experience providing ABA AND 12 college credits in ABA
- Minimum of one year full-time experience providing ABA under the supervision of someone with a BCBA® or BCBA-D® and a minimum of 40 hours of training related to ABA and approved by PA DHS or by a continuing education provider approved by the BACB®,

  OR

- Licensed as a psychologist and a minimum of one year of full-time experience providing ABA services and a minimum of 40 hours of training related to ABA and approved by PA DHS or by a continuing education provider approved by the BACB®.

All staff who provide Assistant ABA-BC for an ABA-EC program shall meet one of the following:

- Certification as a BCaBA® or RBT,

  OR

- Meet qualifications for licensure as a behavior specialist,

  OR

- Have a minimum of six months experience in the provision of ABA services and a bachelor's degree in psychology, social work, counseling, education, or a related field, AND a minimum of 12 college credits in ABA.

All staff who provide Behavioral Health Technician-ABA (ABA-BHT) for an ABA-EC program shall meet one of the following:

- Certification as a BCaBA®,

  OR

- Certification as an RBT (or Board-Certified Autism Technician (BCAT) or other National Commission for Certifying Agencies (NCCA)-qualified certification),

  OR

- 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

- 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 PA DHS or by a continuing education provider approved by the BACB®.

Please Note: *The overseeing BCBA® or BCBA-D®, as well as the ABA-EC provider agency, bear responsibility for ensuring that all staff are trained to competency on each child's ITP and all planned interventions. Competency assessment shall be conducted in accordance with the prevailing BACB® requirements, including each party's signatures on the competency assessment, records of all assessments maintained by the agency and available to CBH for auditing or compliance purposes at any time requested, and that the assessment meets all the quality standards in accordance with prevailing BACB® requirements.*

15. KEY PERFORMANCE INDICATORS (KPI)S

- Acceptance of referrals
- Timely admission offers (within seven business days)
- Length of stay
- Community tenure
- Successful discharge to natural environment/lower level of care
- Change in SDOH
- Parent/family satisfaction
- Number of parent/caregiver training sessions

- Future utilization (types, amounts, and cost) of behavioral health services
- EPIC designation and maintenance in ABA