DEPARTMENT OF VERMONT HEALTH ACCESS
APPLIED BEHAVIOR ANALYSIS
Clinical Practice Guidelines

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CONTENTS

INTRODUCTION

Purpose:

The *Vermont Applied Behavior Analysis Guidelines* were created to provide Vermont practitioners with a consolidated set of recommendations and best practice suggestions for the treatment of Applied Behavior Analysis (ABA) for individuals diagnosed with Autism Spectrum Disorder (ASD). Although literature has shown some effectiveness with the use of ABA based procedures to reduce problem behavior and to increase appropriate skills for individuals with other childhood developmental disorders, evidence-based research and clinical studies are incomplete. Given the lack of evidence-based research regarding the effectiveness of ABA for other childhood developmental disorders, this document will primarily focus on ABA treatment for individuals specifically diagnosed with ASD. The content of these *Guidelines* is based on scientific evidence, best practice guidelines from nationally recognized organizations, professional standards of care, and expert clinical opinions.This document is intended to supply ABA providers with a user-friendly guide to the application of ABA as an effective behavior health treatment procedure for individuals diagnosed with ASD.

Considerations:

This document is meant exclusively as guidance for providers of ABA services and is intended to provide recommendations and best practice suggestions. An individualized treatment plan is a defining feature of ABA aswell as an integral component of successful treatment for those diagnosed with ASD and other neurodevelopmental disorders. Additional behavioral health treatment techniques often used in conjunction with ABA for the treatment of ASD are not addressed within this manual.

Autism Spectrum Disorders (ASD):

As defined in the Diagnostic and Statistical Manual (DSM-5) of the American Psychiatric Association, ASD is a neurodevelopmental disorder characterized by persistent impairment in reciprocal social communication and social interaction, and restricted, repetitive patterns of behavior, interests, or activities. These symptoms are present from early childhood and limit or impair everyday functioning. Manifestations of the disorder vary greatlydepending on the severity of the autistic condition, developmental level, and chronological age; hence, the term spectrum. Recent reported frequencies for ASD in the United States have approached 1% of the population.
Symptoms of ASD are typically recognized during the second year of life (12-24 months of age) but may be seenearlier than 12 months if developmental delays are severe or noted later than 24 months if symptoms are more subtle. Improved reliability of diagnosis can be influenced by the availability of standardized behavioral diagnostic instruments with good psychometric properties, including caregiver interviews, questionnaires, and child observation measures (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Health, 5th Edition).

Applied Behavior Analysis (ABA):

Applied behavior analysis (ABA) is a scientific approach for discovering environmental variables that reliably influence socially significant behavior and for developing a technology of behavior change that takes practice advantage of those discoveries (Applied Behavior Analysis; Cooper, Heron, Heward 2014). The ABA treatment process begins by evaluating an individual's past and current environment in relation to genetics and ongoing physiological variables. An individualized ABA treatment plan is created using observation, measurement, and functional analysis by identifying changes in environmental events through specialized assessment methods.
ABA focuses on treating behavioral difficulties as well as supporting skill acquisition and maintenance through changing the environment rather than focusing on variables that are unlikely to change. Therefore, ABA evaluates antecedents, behaviors, and consequences to change an individual's environment.

Policy

Legislation:

Act 158 (8 V.S.A. § 4088i.) requires private and Medicaid insurance plans to cover evidence-based diagnosis and treatment of early childhood developmental disorders including applied behavioral analysis supervised by nationally board- certified behavior analysts, for children birth until the age of 21 years.

As defined in Act 158, "applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes direct observation, measurement, and functional analysis of the relationship between environment and behavior. ABA includes a wide variety of evidence-based strategies to impact behavior.

The act further indicates that "behavioral health treatment" means evidence-based counseling and treatment programs, including applied behavior analysis, that are necessary to develop skills and abilities for the maximum reduction of physical or mental disability and for restoration of an individual to his or her best functional level, or to ensure that an individual under the age of 21 achieves proper growth and development. Please refer to: http://www.leg.state.vt.us/docs/2012/Acts/ACT158.pdf

Medicaid Rule/ABA Medical Policy:

Medical Necessity

Prior Authorization Determination

Supervised Billing

Medicaid Rules

Developmental Screening for Young Children | Department of Vermont Health Access

STANDARDS FOR SERVICE DELIVERY

ABA Provider Responsibilities (http://bacb.com/credentials/)

Within ABA treatment there are four levels of treatment providers: **Board Certified Behavior Analyst (BCBA)**;**Board Certified Behavior Analyst-Doctorate (BCBA-D); Board Certified Assistant Behavior Analyst (BCaBA); and Behavior Technician (BT)**.

- A **BCBA** holds a graduate level certification. They design and supervise behavior interventions and effectively develop and implement appropriate assessments and intervention methods for use in varied situations and for a range of cases. The BCBA teaches others to carry out ethical and effective behavior analytic interventions based on published research and designs and delivers instruction in behavior analysis. BCBAs also supervise the work of others providing interventions of behavior analysis.

- A **BCBA-D** is required to have the credentials of a BCBA along with a degree from a doctoral programaccredited by the Association for Behavior Analysis International (at the time the degree was earned), or has earned a doctoral degree from an accredited university in which he or she conducted a behavior- analytic dissertation; and passed at least two behavior analytic courses as part of the doctoral program of study; and met all the BCBA coursework requirements prior to receiving the doctoral degree. A BCBA-D is certified through the BACB and must be free from sanctions or disciplinary actions on their certification and/or license, as well as no Medicare/Medicaid sanctions or federal exclusions. This individual must be covered by professional liability insurance. A BCBA-D has the same responsibilities as a BCBA

- A **BCaBA** conducts descriptive behavioral assessments, interprets the results, and designs ethical andeffective behavior analytic interventions for members. The BCaBA may teach others to carry out interventions and supervise behavioral technicians once the BCaBA has demonstrated competency with the procedures involved under the direct supervision of a BCBA.

- A **BTs** primary responsibility is for the direct implementation of skill-acquisition and behavior-reduction plans developed by the supervisor (BCBA or BCBA-D). BTs do not design intervention or assessment plans but may collect data. The supervisor of the BT is responsible for determining which tasks the BT may perform based onhis/her training, experience, and competence. The BTs supervisor is ultimately responsible for the work performed by the BT. BTs should receive specific, formal training before providing treatment. One way to ensure such training is through the Registered Behavior Technician (RBTs) Credentialing process. Information regarding RBTs can be found on the Behavior Analyst Certification Board website: https://www.bacb.com/wp-content/uploads/2017/09/ABA_Guidelines_for_ASD.pdf

Caseload Recommendations:

BCBAs should carry a caseload that allows them to provide appropriate case supervision and to facilitate effective treatment delivery safely. Caseload size for the BCBA is typically determined by the following factors: complexity and needs of the members in the caseload; total treatment hours delivered to the members in the caseload; total case supervision and clinical direction required by caseload (i.e. 2 hours of supervision/monitoring of direct service of the BT with the member by the BCBA for every 10 hours of direct service provided by the BT); location and modality of supervision and treatment (e.g., treatment facility verses home); and availability of support staff for the BCBAs (e.g., a BCaBA).

ABA Assessment:

ABA assessments are completed by a BCBA. One of the following assessment tools are required by DVHA to be administered at a minimum of every 6 months; PEAK, VB-MAPP or ESDM and should be incorporated into the treatment plan goals. The assessment should identify members' strengths and weaknesses across domains as well as potential barriers to progress. The information obtained during the assessment is the basis for development of the individualized treatment plan. An assessment should utilize information gathered from multiple methods and multiple sources including, file review, interviews and rating scales, direct observation, and assessments from other professionals. File reviews may include review of prior assessments, such as intellectual and achievement tests, developmental assessments, and evaluations of family functioning and needs. BCBAs should use interviews, rating scales and social validity measures to assess the perceptions of the member's skill deficit and behavioral excesses and how these deficits and excesses impact the member and the family. Direct observation by the BCBA should be used to help identify levels of function and subsequently develop, implement and modify treatment protocols on an ongoing basis, as well as for evaluating the members' response to treatment and progress towards meeting treatment goals. Observation should occur in a variety of environments, including naturally occurring settings as well as in structured interactions. Assessments from other professionals can be helpful in guiding treatment and assessing progress. Information obtained through all of the methods listed above should be incorporated into the development of treatment goals and interventions.

Treatment Plan Requirements:

ABA treatment plans are developed by BCBAs and should be based on completed ABA assessments that determine baseline skills. ABA treatment plans must be individualized and should include specific and measurable goals, objectives and outcomes. DVHA requires that a treatment plan contain a list of staff members and their credentialing who will be working directly with the member. The plan must be updated at a minimum of every six months or sooner if clinically appropriate. One of the following assessment tools are required by DVHA to be administered at a minimum of every 6 months; PEAK, VB-MAPP or ESDM and should be incorporated into the treatment plan goals. Other assessment tools may be used if clinically appropriate but should not be substituted. If the provider determines that none of the above-mentioned authorized assessment tools is not clinically indicated for a member, they should notify the DVHA Autism Specialist and document clinical rationale. Rationale should explain if one of the above clinical tools was attempted, and why it was unsuccessful. Clinical rationale should be determined on a member-by-member basis and should not be because the provider does not have access to these assessment tools or because the provider is not trained in the administration of the tools. The BCBA is responsible for summarizing and analyzing data, evaluating member progress towards treatment goals, adjusting treatment protocols based on data, monitoring treatment integrity, training and consulting with caregivers and other professionals, evaluating risk management and crisis management, ensuring satisfactory

implementation of treatment protocols, reporting progress towards treatment goals and developing and overseeing of a transition/discharge plan. Best practice states that this is done through *direct* and *indirect* supervision. *Direct supervision* activities include observing treatment implementation for potential program revisions, monitoring treatment integrity to ensure satisfactory implementation of prescribed protocols and directing staff and/or caregivers in the implementation of new or revised treatment protocols with member present (coaching). *Indirect supervision* activities include developing individualized treatment goals, protocols, and data collection systems, summarizing, and analyzing data, evaluating the member's progress towards goals and adjusting interventions based on data. Indirect supervision activities also include coordination of care with other professionals and reporting progress toward treatment goals and interventions in place. Other indirect supervision activities include reviewing member progress with staff to refine treatment protocols and meeting with staff and caregivers to discuss how to implement new or revised treatment protocols without the member present.

Treatment Plans Should Consider

- Evidence of parent/guardian and member's involvement in the development of the plan.
- Parent/guardian and caregiver training, support, and participation.
- Development of member's individualized goals that consider the specific member's age; adaptive functioning; and intellectual functioning.
- Interventions should be designed that are culturally sensitive and appropriate.
- Goals should be prioritized based on implications for the member's health and well-being, the impact on member, family and community safety, and contribution to functional independence.
- Service setting and hours of treatment.
- Measurable objectives based on clinical observation and assessment of outcome measures.
- Detail of behaviors and skills targeted for modification and/or improvement methods to be used.
- Goals of the family/guardian(s).
- Target date for introduction of goal and attainment of goal(s).
- Care coordination which includes the member's parent(s)/guardian(s), caregivers, school, mental health providers, medical providers, and any applicable parties.
- Interventions which emphasize generalization of skills and focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors.

Documentation requirements:

The member's file should contain a minimum of one progress note per month that summarizes ABA treatment provided. Progress notes must document the service modality and describe contact, purpose, intervention used, supports used, observations, and member's response. Progress notes must also be individualized to the member's service interactions within a specific day/week or month and should not contain excessive repetition over time. If a provider chooses to write daily or weekly notes rather than monthly notes, documentation should be detailed regarding the encounter(s). Treatment/progress notes must be signed by the individual responsible for completion and include date, and degree and/or credentialing. A member's file must also contain a proactive crisis plan that is member specific, if appropriate.

Examples of behavioral targets:

The ABA treatment plan should specify the behavioral targets that are to be addressed. Behavioral targets should be individualized and measurable with clear goals, objectives, and anticipated outcomes. The following are behavioral targets often identified as needing assistance.

- Generalizing skills acquired in treatment settings into the natural environments (home and community).
- Reducing or replacing self-injurious or aggressive behaviors.
- Training in functional communication.
- Participating in routines that reinforce physical and emotional health.
- Developing daily living skills.
- Reducing ritualistic or preservative behaviors.

Treatment delivery setting:

ABA strives to promote generalization of therapeutic benefits in a variety of settings. Treatment can happen in homes, institutions, group homes, hospitals, business offices, and via telemedicine. When possible, members under the age of three should receive some treatment in their home environments. ABA treatment plans should specify where delivery of service will happen. Treatment plans should incorporate service delivery within the member's home in addition to natural environments (i.e., the community) where the skills are intended to be utilized.

Treatment duration:

Treatment duration is based on an evaluation of the members' response to treatment. Various empirical studies have suggested that early, intensive ABA treatment may have a significant impact on intellectual functioning, language development, social functioning, daily living skills acquisition, and language-related outcomes. DVHA requires that a treatment plan be updated every 6 months, and within this assessment, the provider evaluates and reports on the progress made, appropriateness of goals, the continued need for treatment, and medical necessity. The following should be considered when determining treatment duration:

- The member continues to achieve treatment goals.
- The member continues to meet the diagnostic criteria for ASD (as measured by appropriate standardized protocols).
- The member continues to demonstrate progress towards goals over successive authorization periods. If progress towards treatment goals is not being demonstrated, there must be evidence that the treatment plan is being adjusted. Progress is defined as: Change that is durable over time and is demonstrated outside of treatment sessions across the member's natural environments which include home, school and community settings.
- Treatment does not appear to be negatively impacting the member or causing symptoms to become persistently worse.
- The member receiving services demonstrates the ability to maintain long-term gains from the proposed plan of treatment.
- The parent(s)/caretaker(s) are interested in continuing services.

- The parent(s)/caretaker(s) and the provider agree regarding treatment planning and delivery.

Use of restraint and seclusion:

According to The Association for Behavior Analysis International (ABAI) website (https://www.abainternational.org/about-us/policies-and-positions/restraint-and-seclusion,-2010.aspx) ABAI and its members "strongly oppose the inappropriate or unnecessary use of seclusion, restraint, or other intrusive interventions. Although many persons with severe behavior problems can be effectively treated without the use of any restrictive interventions, restraint may be necessary on some rare occasions with meticulous clinical oversight and controls. In addition, a carefully planned and monitored use of time-out from reinforcement can beacceptable under restricted circumstances. Seclusion is sometimes necessary or needed, but behavior analysts would support only the most highly monitored and ethical practices associated with such use." It further states, "This Position Statement on Restraint and Seclusion summarizes critical guiding principles. With a strong adherence to professional judgment and best practice, it also describes the conditions under which seclusion and restraint may be necessary and outlines proper strategy to implement these procedures appropriately andsafely. This statement is consistent with ABAI's 1989 Position Statement on the Right to Effective Behavioral Treatment, which asserts numerous rights, including access to the most effective treatments available, while emphasizing extensive procedural safeguards."

The Association of Professional Behavior Analysts (APBA), "Position Statement on the Use of Restraint and Seclusion as Interventions for Dangerous and Destructive Behaviors: Supporting Research and Practice Guidelines", discusses the use of restraint and seclusion as a means of intervention for individuals who displayself-injurious behavior (SIB). Research has demonstrated that individuals with the most severe behavior problems can be helped with interventions developed by the discipline of applied behavior analysis (ABA). The APBA's "The Use of Restraint and Seclusion as Intervention for Dangerous and Destructive Behaviors" positionstatement reads, "Some individuals diagnosed with developmental disabilities and mental health disorders exhibit severe and dangerous problem behaviors that can pose significant risks to theirown safety and health and the safety and health of people around them. Examples include self-injurious behavior and physical aggression towards others, which can result in severe injuries, even death. Research and practice in applied behavior analysis (ABA) over the past five decades have produced safe, humane, positive, and effective methods for preventing or decreasing the occurrence of such behaviors. Whenthose methods are implemented correctly as part of a professionally designed and comprehensive intervention plan, they have been shown to result in dramatic improvements in severe problem behavior as well as the quality of individuals' lives". Please refer to the following websites for more information:

Position Statement on the Use of Restraint and Seclusion

DVHA's stance on the use of restraint and seclusion is in alignment with ABAI's statement above. All lesser restrictive interventions should be utilized first. Restraint and/or seclusion should be used only as a last resort.Clinical judgment and best practice need to be highly regarded in making the decision to utilize restraint and/orseclusion.

Parents, caregivers, and family members:

ABA treatment plans should include parent and caregiver training that involves the parent(s)/caretaker(s) receiving direct and indirect coaching, and with the emphasis on developing skills and support. ABA services assist parent(s)/caretaker(s) in the development of skills to support, prompt, and reinforce when appropriate; and when modeling an intervention, the child should be present. When reviewing a new protocol, the child should not be present. Guidance for determining the need and adjustment of the natural environments (home and community) is also provided. Training for parents and caretakers should be individualized and customized and may include modeling, skill demonstration, educational presentations, coaching, and support for problem solving and strategy implementation. ABA treatment plans should clearly identify how the parent(s) and/or caregiver(s) will be trained in the skills necessary to support their child in meeting treatment goals. It is recommended that parent training happen on a weekly basis, to keep the parent(s)/caretaker(s) current on interventions and treatment approaches.

Supervision:

ABA treatment requires high levels of case supervision to ensure effective outcomes because of the individualized nature of treatment, the reliance on frequent collection and analysis of member data, and the need for adjustments to the treatment plan. Supervision should include both *direct* and *indirect* activities as theyare critical to producing best treatment outcomes concurrently with the delivery of direct treatment to the member. *Direct supervision* includes directly observing BT implementing interventions with member, monitoringtreatment integrity to ensure the programs are implemented with fidelity and directing staff and/or parent(s)/caregiver(s) in the implementation of treatment protocols. *Indirect supervision* includes developing individualized programming and data collection systems, summarizing and analyzing data, evaluating membersprogress towards goals, adjusting treatment protocols based on data, coordinating with related service providers, crisis intervention, reporting progress, developing and overseeing transition/discharge plans, reviewing members progress with staff without the member present to refine individualized programs/protocols,reviewing and directing staff and/or caregivers in the implementation of a new or revised treatment protocol (without the member present).

Coordination with other health/mental health providers:

ABA providers should consult and coordinate care with other health/mental health providers to ensure themember's progress, regardless of the other providers' treatment modality. Coordination among the health/mental health providers who are involved in the member's treatment increases the probability that the member will achieve his/her treatment goals. ABA treatment plans should identify treatment providers involved, specify existing services, and outline a strategy for continued communication and coordination of future services to be provided. It is recommended that collaboration between related service providers should happen on a monthly basis or more frequently if needed. Pediatricians and Primary Care Physicians are key partners whose involvement is integral to the member's successful ongoing treatment. Collaboration needs to be thoroughly documented within treatment notes, i.e., progress notes. There may be situations in which cotreatment (multiple services being provided simultaneously) may be medically necessary and best practice. ABA treatment must be occurring in all cotreatment situations. Transporting to and from an appointment or observing treatment/therapy would not be considered medically necessary. Examples could include:

- A member has a speech generating device and the ABA provider wants to cotreat with the SLP to be sure that they are using the device properly during an ABA session,
- The ABA provider and OT are working together to help a member with a plan for an Activity of Daily Living, such as handwashing, to problem solve both the behavioral and fine motor aspects of the task,
- The ABA provider and PT are working together to help a member who uses a wheelchair to problem solve how to safely transfer to the toilet during the ABA session.

Transition/discharge:

Transition and discharge planning from ABA treatment should include specific reasons as to why ABA treatment is no longer required or needed. The plan should include recommendations for follow-up services for the member and the family. Discharge planning from ABA treatment should be gradual and initiated at a minimum of three months prior to discharge to best prepare the member and his/her care providers/family. Transition and discharge planning from ABA services should begin when at least one of the following occurs:

- The member has achieved treatment goals,
- The member no longer meets diagnostic criteria for ASD (as measured by appropriatestandardized protocols),
- The member has not demonstrated progress toward goals following modification to the treatment plan over successive authorization periods. Progress, for this document, is defined as: a change in behavior that is durable over time and exists outside of treatment sessions. The changes should be noticed in the member's residence, school, and community settings, (hours may need to be adjusted if a member is not making adequate progress prior to discharging due to lack of progress toward goals),
- Treatment appears to be negatively impacting the member and is causing symptoms to becomepersistently worse,
- The member or family are consistently not engaging in treatment or responding to outreach resulting in several no-show appointments,
- The member demonstrates an inability to maintain long-term gains from the treatment provided.

A discharge summary is required upon discharging a member from ABA services. Documentation is required indicating the rationale of discharge. If clinical services are warranted post-discharge, it is the provider's responsibility to make referrals to ensure continuity of care. Providers should document referrals made. If a provider discharges a member because of lack of engagement in treatment or no-shows, the provider must provide adequate notice, at least a month's notice prior to the discharge date.