

ALAMEDA ALLIANCE FOR HEALTH APPLIED BEHAVIOR ANALYSIS (ABA) TREATMENT PLAN (TP) REPORT GUIDELINES FOR PROVIDERS



Introduction

Welcome to the Alameda Alliance for Health (Alliance) provider network! We appreciate your partnership in helping fulfill our mission to improve the health and well-being of our members by collaborating with our provider and community partners to deliver high-quality and accessible services. Together, we can help make our community a healthier and safer place for all.

We created this Applied Behavior Analysis (ABA) Treatment Plan (TP) Report Guidelines for Providers to help provide key information for you and your staff in working with the Alliance. We aim to ensure that your relationship with us works well for you, your staff, and Alliance members. More information is available in your Alliance contract, the Alliance Provider Manual, and on our website www.alamedaalliance.org.

The information in this guideline is subject to change. For the most up-to-date information, please refer to the guideline available on the Alliance website. You can also send your inquiries to deptBHABA@alamedaalliance.org using the following subject line: *Treatment Plan Inquiry*.

For clarification, questions, or comments about your role as an Alliance provider, please call the Alliance Provider Services Department at **1.510.747.4510**.

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Welcome to the Alliance Provider Network!

Thank you for being a part of the Alliance provider network! The Alliance contracts with individual practitioners, medical groups, hospitals, and other non-hospital facilities to provide our members with high-quality health care and services.

The Alliance is a local, public, not-for-profit, managed care health plan committed to making high-quality health care services accessible and affordable to Alameda County residents. For over 25 years, the Alliance has worked to provide access to programs and services you can trust and count on. The Alliance is honored to serve more than 300,000 children and adults throughout Alameda County.

Our Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high-quality and accessible services.

Our Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of life.

We provide access to care and services through two (2) lines of business:

1. **Alliance Group Care:** An employer-sponsored group health plan for In-Home Supportive Services (IHSS) workers.
2. **Medi-Cal:** Affordable insurance for families, children, persons with disabilities, and seniors.

Section 1. Expectations/Helpful Hints

Below are expectations and helpful hints for the Initial Functional Behavior Assessment (FBA)/Treatment Plan (TP) and progress reports:

- Providers must offer the first date of service (DOS) within **10 calendar days** of the approved authorization (including the FBA authorization). Please document any challenges or barriers to providing the first DOS.
- Providers must submit the progress report **two (2) weeks** before the ABA service authorization ends. Please review the approval letter/notification that was faxed to you which will include procedure code H0032. This will allow the Alliance Behavioral Health (BH) Team sufficient time to review the progress report/recommendations and request additional information (if needed) before the current ABA service authorization ends.
- Providers must submit the completed FBA results/initial treatment plan before the FBA authorization ends.

Please allow the Alliance BH Team up to **five (5) business days** to make a determination. Providers will receive a notification letter via fax. The letter will indicate if your request was approved, denied, modified, or deferred due to a lack of information.

Contracted providers can check the status of their prior authorization (PA) requests in the Alliance Provider Portal or by calling:

Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**

Section 2. ABA Treatment Report Elements

A member should have a total of 12-15 goals (not including parent/caregiver training goals). Once met, new goals can be introduced. Please prioritize goals according to the member's needs and availability.

Behavior Reduction Goals

Please include graphs that depict behavior(s) targeted for decrease and replacement behavior(s). The graphs should depict the entire duration that the goal has been targeted even if it includes the prior authorization (PA) period.

Please include the following information in the behavioral reduction goals:

- Barriers to progress (if any).
- Comments that may help explain the variability in data (e.g., client cancellations, behavioral team change).
- If the data depicts an increasing trend **OR** no change in behavior, please include what the behavioral team will do to help make the intervention more effective in the next reporting period (please be specific).

Skill Acquisition Goals and Parent/Caregiver Training Goals

Please include graphs that depict the entire duration that the goal has been targeted even if it includes the PA period.

Please include the following information in the skill acquisition goals and parent/caregiver training goals:

- Barriers to progress (if any).
- Comments that may help to explain the variability in data (e.g., client cancellations, behavioral team change).
- If the data depicts a decreasing trend **OR** no change in behavior/targeted response(s), please include what the behavioral team will do to help make the intervention more effective in the next reporting period (please be specific).

Section 3. Case Supervision Guidelines

Typically, providers follow this ratio when determining the amount of supervision:

- **Two (2) hours** of supervision for every **10 hours** of direct treatment.

Please Note: Some of the items below may not apply to the initial assessment/treatment plan (e.g., progress data/graphs on goals).

For some of the sections below, providers can choose to present the requested information in a table format.

1. QAS Provider Information

Please provide the following Qualified Autism Service (QAS) provider information:

- QAS provider
 - i. Full name
 - ii. Credentials
 - iii. Phone number
 - iv. Email
- QAS professional
 - i. Full name
 - ii. Credentials (if any)
 - iii. Phone number
 - iv. Email
- QAS para-professional
 - i. Full name

2. Member Identifying Information

Please provide the following member identifying information:

- Full Name
- Date of birth
- Age
- Alliance member ID number
- Parent/caregiver name
- Caregiver's relationship to the member (e.g., the parent or legal guardian)
- Diagnosis, including date, and name and title of the professional (if applicable)
- Date of treatment plan/report

3. Basic Background Information

Please provide the following basic background information:

- Parent/caregiver’s primary concerns
- Medical and behavioral health history, including treatment and medication (if applicable)
- Current or prior services (e.g., ABA, speech, occupational, social skills group, etc.)
- Member’s strengths

4. Member and Family’s Availability for ABA Services

Please provide the member and family’s availability for ABA services as indicated in the table below. You can incorporate the table into the member’s treatment plan/report.

Instructions

- **Time:** Indicate the time range (e.g., 10 am – 11 am).
- **Setting:** Indicate the setting (e.g., clinic, home, etc.).

Member and Family’s Availability for ABA Services							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Time							
Current/Confirmed Schedule for ABA Services							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Time							
Setting							

5. Review of Prior Assessments/Documents

For the purposes of conducting this assessment, please provide the following information:

- Diagnostic reports/assessments
- Individualized education plan (IEP) (if applicable)
- Individual family service plan (IFSP) or individualized program plan (IPP) from a regional center (if applicable)
- Prior functional behavior assessment (FBA) or progress report
- Assessments/reports of other services provided (e.g., OT, ST, PT, etc.)
- Other (please specify)

6. Coordination of Care

Please provide information regarding the coordination of care. If you are unable to coordinate care or if it is not applicable, please explain why in the **Comments** column. You can incorporate the table below into the member’s treatment plan/report. Please add more rows as needed.

Date	Name/Person You Coordinated Care With	Purpose of Communication	Comments

7. School Information (if applicable)

Please provide the following school information:

- School name
- Class type/placement
- School schedule
- IEP services that the member is receiving at school (if any)

8. Assessment Methods

Please list all assessment methods that were used during the initial FBA and progress reports and provide a brief description of the methods or documents reviewed. You can incorporate the table below into the member’s treatment plan/report.

Assessment Method	Brief Description of Methods or Documents Reviewed
Record Review of Prior Assessments/Records	
Indirect Assessment	
Descriptive Assessment/ Direct Observation	
Functional Analysis (brief or standard)	
Baseline Data Collection	
Skills Assessment	
Direct Home Observation	
Direct School Observation	
Preference Assessment	
Other	

9. Preference Assessment and Established Reinforcers

Please provide the corresponding established reinforcers for each type of preference assessment. You can incorporate the table below into the member’s treatment plan/report.

Preference Assessment Type	Established Reinforcers
Paired Stimulus	
Single Stimulus	
Multiple Stimuli	
Free Operant	
Other	

10. Skills Assessment

Please conduct a formal skills assessment (e.g., Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), Vineland, Adaptive Behavior Assessment System (ABAS), etc.) no less than once every **six (6) months** and provide the results in the initial FBA and subsequent progress reports/re-assessments. For subsequent treatment plans/progress reports, please include previous results for comparison. If you were not able to conduct a skills assessment, please explain why.

11. Goals Met

Please provide all previously mastered goals for the last **12 months**. This will serve as a quick reference on the progress that the child has made over the last **12 months**. You can incorporate the table below into the member’s treatment plan/report. Please add more rows as needed.

Goals	Date Met

12. Behaviors Targeted for Decrease

Instructions

- **Goal #:** Include the goal number.
- **Behavior:** Include the onset and offset.
- **Indirect Assessment:** Describe what indirect assessment was used and what the results were.
- **Baseline of Target Behavior:** Include the measurement system.
- **Date:** Date of when this behavior was first targeted by your team.
- **Behavior Reduction Goal:** Include an observable/measurable goal with criteria for mastery.

- **Replacement Behavior & Baseline:** Include an observable/measurable goal with criteria for mastery and measurement system. At least one (1) replacement behavior should be named and targeted for each hypothesized function listed.

Please use the format below for all behavior reduction goals. You can incorporate the table below into the member’s treatment plan/report.

Behaviors Targeted for Decrease	
Goal #	
Behavior	
Observed Antecedents	
Observed Consequences	
Indirect Assessment	
Hypothesized Function (based on direct observation)	
Baseline of Target Behavior	
Date First Targeted	
Behavior Reduction Goal	
History of Problem Behavior	
Replacement Behavior & Baseline	
Antecedent-Based Interventions	
Consequence-Based Interventions	

Graph

Please include a graph depicting the data collected during the current authorization period, per goal, including baseline data.

Please Note: If a mastery criterion was defined as per session/week/month, then the data on the graph must be displayed as per session/week/month.

Progress summary and interpretation of progress data/graph

If there is an increase in maladaptive behavior, please provide a clinical rationale and a proposed plan to address the barriers to progress. Indicate the status of current goals (i.e., in progress, met, canceled, modified).

13. Skill acquisition/skill-building goals

If a task analysis is included, please list the steps, teaching method (e.g., forward/backward chaining, etc.), and mastery criteria. Please use the format below for each goal. You can incorporate the table below into the member’s treatment plan/report.

Instructions

- **Goal #:** Include criteria for mastery, e.g., 80% of opportunities across three (3) consecutive sessions for three (3) people and three (3) settings).
- **Baseline Data:** Include measurement system.
- **Teaching Strategies/Instructional Methods to Be Used:** Please be specific.

Skill Acquisition/Skill-Building Goals	
Domain	
Goal #	
Social Significance to Member	
Baseline Data	
Target/Goal Introduction Date	
Teaching Strategies/Instructional Methods to Be Used	

Graph

Please include a graph depicting the data collected during the current authorization period, per goal, including baseline data.

Please Note: If a mastery criterion was defined as per session/week/month, then the data on the graph must be displayed as per session/week/month.

Progress summary and interpretation of progress data/graph

Provide a clinical rationale for any decrease in performance and a proposed plan to address barriers to progress. Indicate the status of current goals (i.e., in progress, met, on hold, modified).

14. Parent/Caregiver Education Goals

Please use the format below for each goal. You can incorporate the table below into the member’s treatment plan/report.

Instructions

- **Goal #:** Include criteria for mastery, e.g., 80% of opportunities across three (3) consecutive sessions for three (3) people and three (3) settings).
- **Baseline Data:** Include measurement system.
- **Treatment Package:** List all strategies that will be used to support the parent’s acquisition of skill.
- **Training Setting:** Please clearly indicate where the parent training will take place (i.e., home, community, clinic, etc.).
- **Frequency of Parent Education Will Be Delivered for This Goal:** I.e., 30 minutes per week, 1 hour per month.

Parent/Caregiver Education Goals	
Goal #	
Purpose of Goal	
Baseline Data	
Target/Goal Introduction Date	
Treatment Package	
Data Collection Method	
Training Setting	
Frequency of Parent Education Will Be Delivered for This Goal	
Graphs	
Progress Summary	

Graph

Please include a graph depicting the data collected during the current authorization period, per goal, including baseline data.

Please Note: If a mastery criterion was defined as per session/week/month, then the data on the graph must be displayed as per session/week/month.

Progress summary and interpretation of progress data/graph

Provide a clinical rationale for any decrease in performance and a proposed plan to address barriers to progress. Indicate the status of current goals (i.e., in progress, on hold, modified).

15. Crisis Plan

Please provide a detailed crisis plan should the member have any maladaptive behaviors that could result in any potential physical harm/injury to the member and/or others involved.

16. Generalization Plan: Please indicate how your team will target generalization of goals/skills .

17. Discharge Plan and Criteria

Providers should consider the following when planning for discharge:

- Has the member achieved treatment goals?
- Does the member demonstrate progress towards goals for successive authorization periods?
- Are the family/caregivers interested in discontinuing services?
- Are members and family able to generalize skills across multiple settings?
- Are there any Issues in treatment planning and delivery that cannot be reconciled?
- Is the member ready to move from the current level of service to a lower level of service (i.e., social skills group therapy, community resources, parent consultation)

17. Significant Barriers to Progress

Please provide significant barriers to progress. Please be specific.

18. Service Utilization Chart (direct ABA/H2019):

Providers are required to provide a service utilization chart in each progress report/subsequent treatment plans. You can incorporate the table below into the member’s treatment plan/report.

	PR #1	PR #2	PR #3	PR #4	PR #5
	Reporting period date range:	Reporting period date range:	Reporting period date range:	Reporting period date range:	Reporting period date range:
Total # of direct hours authorized					
# Of hours canceled by the caregiver					
# Of hours canceled by the provider:					
# Of hours made up					
% Utilized $\left(\frac{\# \text{ hours used}}{\# \text{ of hours approved}} \right) \times 100$					
If % utilization is less than 60%, please provide justification by selecting one of the options in the table.	<input type="checkbox"/> Excessive cancellations by family <input type="checkbox"/> Excessive cancellations by staff <input type="checkbox"/> Family preference <input type="checkbox"/> Lack of staffing <input type="checkbox"/> Other				
# Of sessions in which a caregiver(s) actively participated in the child’s ABA programming during this reporting period:					

19. Summary and Recommendations

Please indicate the clinical team’s recommended treatment intensity based solely on the member’s medical necessity (i.e., based solely on the severity of the child’s deficits and behavioral symptoms). Please include the actual hours being requested for the upcoming authorization when considering the family’s availability.

Example: “We recommend that Amy receives 40 hours a month of H2019, 8 hours a month of H2012, and 5 hours a month of S5111. However, due to the family’s/member’s availability, we will be requesting the hours and procedure codes listed below.” Please use the format below for each recommendation. You can incorporate the table below into the member’s treatment plan/report.

Procedure Codes	Description	# Of Hours/Month (hours must be whole numbers)
H2019	Direct ABA with the member present. Typically provided in the member’s home.	
H2012	Direct and indirect supervision.	
H2014	Small group social skills training. Usually, there will be four (4) clients/children to one (1) adult.	
S5111	Parent/caregiver training. The member may or may not be present.	

Board Certified Behavior Analyst (BCBA) Information	
Name of BCBA:	
Signature of BCBA:	
Date:	
Email Address:	
Phone Number:	

20. Parents/Caregiver’s Consent for Treatment Plan/Report

Please indicate if the treatment plan/report was shared and reviewed with the member’s parents/caregivers. If yes, please indicate the date and whether parents/caregivers agreed with the proposed treatment plan. If not, please explain why not.

We Are Here to Help You

We hope that you have found the information and resources in this guide to be useful and helpful.

If you have any questions or concerns, please contact:

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Phone Number: **1.510.747.4510**
Email: **providerservices@alamedaalliance.org**

Thank you for joining the Alliance provider network! We look forward to continued partnership with you to provide quality and affordable healthcare. Together, we are creating a healthier community for all.