2016 U.S. APPLIED BEHAVIOR ANALYSIS
TRENDS IN CLINICAL QUALITY, EMPLOYEE ENGAGEMENT & CONSUMER SATISFACTION

Behavioral Health Center of Excellence
2016 ANNUAL REPORT
The Behavioral Health Center of Excellence (BHCOE) is a trusted source that recognizes top-performing behavioral health providers. BHCOE offers a third-party measurement system that differentiates top service providers from exceptional service providers. The BHCOE criteria feature standards that subject-matter experts developed to measure state-of-the-art behavioral health services.
LETTER FROM OUR CEO

Since its founding in 2015, BHCOE has been focused on shaping the future of applied behavior analysis (ABA) by driving innovation in practice – through technology, through peer-review, and through quality assurance evaluations.

We are extremely pleased to announce that the Behavioral Health Center of Excellence (BHCOE) is entering into our second year of service. Since our first year, we have surveyed more than 7,000 caregivers and staff. We have also entered 25 different states within the first year of our newly launched pilot program and have identified 20 states with Centers of Excellence.

The true power of this program lies in the on-the-ground partnerships between our organization and our existing Centers of Excellence (CoEs) across the United States. Our CoEs work with hundreds of school districts, insurance providers, and non-profit community partners every day to continue delivering quality services to customers across the United States.

I cannot overstate my gratitude to the hundreds of clinicians who have lent their time and expertise to coordinate these efforts as well as the many behavioral organizations that have taken a chance on a new program with a lofty vision. I am also appreciative of our founding advisory board that is engaging with their communities about the importance of quality evaluations and regular monitoring of the behavioral services they provide.

Our advisory board members have instilled within our behavior analytic community culture the driving ethos of our community philosophy, which is that when our providers succeed in providing ethical and effective treatment, the behavioral organization thrives as well. Our resolve to close this divide in clinical quality is stronger than ever, and we invite everyone who shares that vision to work with us to create even more opportunities in the year ahead.

Sincerely,

Sara Gershfeld Litvak, MA, BCBA
Chief Executive Officer
The Behavioral Health Center of Excellence has been a tremendous success by any measure. In the first year, we are proud to say that we have grown to be a key private sector behavioral health quality assurance organization.

In the beginning of 2015, we opened our doors with a 5-Agency pilot program, and as we close 2016, we now have 57 participating organizations from 25 different states, and two different countries.

Our goal has remained: Ensure quality service delivery for all families impacted by developmental disabilities.

We present this report as a measure of our accomplishments and as an opportunity to reflect on the standards our evaluation tool stands by, and the challenges we face going forward. We are thrilled to continue our work together, providing invaluable feedback for any organization that cares about providing quality services.
The Department of Developmental Services funded a Quality Improvement and Assurance (QIA) project through a local Regional Center in Los Angeles aimed at identifying quality indicators in ABA service delivery. Five years of QIA analysis resulted in meaningful data that allowed for ABA providers to understand the state of their practice services in comparison to other organizations in their region.

Northwestern University Kellogg School of Management conducted an Access to Care Market Research Analysis to understand the challenges that parents of special needs children have with identifying and selecting quality ABA service providers. They determined that access to quality providers was increasingly challenging.

California’s SB 946, effective July 1, 2012, required health care service plan contracts and health insurance policies to provide coverage for behavioral health treatment for individuals with autism or other pervasive developmental disorders (PDD).

Due to the growing demand of consumers searching for quality providers, members from the QIA Team established the Behavioral Health Center of Excellence to formalize quality assurance standards and pilot a national quality assurance evaluation tool.
QUALITY STANDARDS
The standards established by the Behavioral Health Center of Excellence reflect best practice documents that are readily discussed in the field of applied behavior analysis. Our evaluation tool measures these standards. Some of the documents we use to guide our assessment are:

1. Consumer Guidelines for Identifying, Selecting and Evaluating Behavior Analysts Working with Individuals with Autism Spectrum Disorders
   Authors: Autism Special Interest Group, Association for Behavior Analysis, International

   Authors: Behavior Analyst Certification Board (2014)

3. Code of Ethics for Behavior Organizations
   Authors: COEBO

In the following quality standards, the acronym “BHCOE” refers an organization that has received the Behavioral Health Center of Excellence distinction.

1. Staff Qualifications & Training

1.1 Staff Qualifications

- A BHCOE will retain clinical director-level staff who holds adequate education and training in line with the Consumer Guidelines for Identifying, Selecting and Evaluating Behavior Analysts Working with Individuals with Autism Spectrum Disorders, page 4.
- A BHCOE will retain supervisor-level staff who holds adequate education and training in line with the Consumer Guidelines for Identifying, Selecting and Evaluating Behavior Analysts Working with Individuals with Autism Spectrum Disorders, page 6.
- A BHCOE will retain direct service staff who hold adequate education and training in line with the Registered Behavior Technician Competency Assessment.

1.2 Staff Training

- A BHCOE will provide training to supervisory staff to ensure competency in clinical tasks (e.g., assessment processes, goal creation, intervention design, progress reporting, etc.) and administrative tasks (e.g., staff training, feedback delivery, BACB supervision standards, ethical billing practice, etc.).
- A BHCOE will provide direct service staff at least 40 hours of evidence-based staff training.
- A BHCOE will test for clinical competence prior to staff providing treatment to clients.
- A BHCOE will provide staff with continuing education in line with their areas of need.
- A BHCOE will ensure consistency of treatment across staff members through staff overlap, data collection, and/or team meetings.
- A BHCOE will utilize feedback mechanisms as outlined by Parsons and Reid (1995).


2. Treatment Program & Planning

2.1 Assessment & Treatment

• A BHCOE utilizes standardized assessments to evaluate client outcome annually, or more frequently if needed.
• A BHCOE utilizes evidence-based curricula when developing client goals.
• A BHCOE utilizes research-based skill-acquisition procedures.
• A BHCOE utilizes research-based behavior-reduction procedures.
• A BHCOE trains for and measures generalization throughout treatment.
• A BHCOE ensures skills are age-appropriate based on the developmental order in which skills are acquired in individuals with typical development.
• A BHCOE has resources available to service non-verbal/non-vocal children.

2.2 Data Collection

• A BHCOE utilizes electronic medical records (EMRs) to increase communication between clinical team and ensure safe keeping of client data.
• If BHCOE does not utilize an EMR, appropriate precautions are taken to ensure that data are analyzed daily, collected weekly, and safely stored.

2.3 Treatment Recommendations

• A BHCOE determines treatment dosage (hours) based on professional judgment, research, and standard of care.
• A BHCOE does not alter recommendations for treatment dosage based on any person, policy, or problem.
• A BHCOE does not alter recommendations for treatment dosage based on health plan recommendations.
• A BHCOE does not alter recommendations for treatment dosage based on location.
• A BHCOE does not alter recommendations for treatment dosage based on client availability.
• A BHCOE provides caregiver education and training regarding the impact of treatment intensity on client progress.
• A BHCOE clearly communicates criteria for fade out to caregivers at onset of treatment.

3. Collaboration

• A BHCOE requires caregiver participation in treatment sessions.
• A BHCOE requires caregiver training.
• A BHCOE requires caregiver involvement in treatment planning.
• A BHCOE ensures eLearning opportunities are easily accessible to caregivers.
• A BHCOE makes reasonable effort to collaborate with other professionals (e.g., speech-language pathologists, occupational therapists, school staff, physicians, etc.) to maximize clients' progress.
• A BHCOE clearly communicates policy to clients on collaboration with non-evidence-based practices.

4. Access to Services

• A BHCOE clearly communicates expectations of waitlist time to families.
• A BHCOE provides families with resources if unable to provide services within 1 month of contact.
• A BHCOE provides families with peer-referral options if unable to provide services within 1 month of contact.
• A BHCOE maintains close supervision over wait list times and caregiver needs.
5. Social Media & Marketing Practices

- A BHCOE accurately represents the services they provide.
- A BHCOE does not engage in misleading, false, or deceptive statements.
- A BHCOE does not exploit consumers of their services for marketing purposes.
- A BHCOE does not solicit testimonials and/or post testimonials in any format.

6. Caregiver Satisfaction

A BHCOE practices in a manner that results in caregiver satisfaction at 80% or higher in the following areas:

- Treatment Programming
- Scheduling
- Staff
- Caregiver Involvement
- Child Progress

7. Employee Satisfaction

A BHCOE practices in a manner that results in employee satisfaction at 80% or higher in the following areas:

- Career Development
- Compensation
- Work Engagement
- Relationship Management
- Benefits
- Work Environment

Evaluation Report & Passing Score

Results are compared against the BHCOE Benchmark outlined above. A due diligence report is sent to the Community Advisory Board (CAB) for review. The CAB is blind to the identity of the organization undergoing review. The CAB votes in agreement or disagreement with the auditor’s recommendation to distinguish the provider as a Behavioral Health Center of Excellence. Each organization is provided with a comprehensive report, which outlines raw data, recognition in observed areas of excellence, and suggestions for improvement.

Quality Improvement Plan

If the CAB does not vote in favor of distinguishing the provider, the BHCOE provides a Quality Improvement Plan (QIP) to assist the provider in adjusting their organizational practices. It is requested that these adjustments be made within 90 days following the receipt of the plan. After 90 days, the provider is then re-assessed in the areas addressed in the QIP. It is understood that some adjustments, such as the employment of under-qualified staff, cannot be completed within 90-days. If adjustments cannot be made within 90-days, the provider can apply for re-evaluation within one year.

Reassessment Cycle

The BHCOE distinction is valid for two years, with the requirement to conduct an annual refresher to maintain BHCOE status. The evaluation refresher consists of the staff satisfaction and consumer satisfaction surveys and analysis of results. A report is provided that specifies the survey results as compared to the prior year. The purpose of these surveys is to ensure that the organization has not experienced any significant changes in staff or consumer satisfaction.
One of the most significant barriers to services is limited accessibility of quality service providers. The Behavioral Health Center Of Excellence (BHCOE) aims to address these barriers by creating a comprehensive assessment to identify quality behavioral providers. At the BHCOE, we believe quality is as important as the availability of the services. We use a number of qualitative and quantitative evaluation methods to understand the quality indicators of a behavioral health organization.

1. Semi-Structured Interviews

Attributes of Semi-Structured Interviews

- The evaluator and respondent engage in an interview.
- The evaluator uses an interviewing guide. The interview guide is a list of questions that must be covered during the conversation in a standardized order.
- The evaluator follows the interviewing guide, but also follows the respondent’s train of thought within the conversation that may stray from the guide but addresses other areas of the interview.
- The responses are recorded via textual data through speech to text transcription and note taking.

When to use Semi-Structured Interviews

- According to Bernard (1998), semi-structured interviewing is best used when the researcher won’t get more than one chance to interview someone.
- The semi-structured interview is also useful when there are multiple evaluators in the field collecting similar types of data.

- The semi-structured interview guide provides a clear set of instructions for interviewers and can provide reliable, comparable qualitative data.
- Using open-ended questions and training evaluators to follow the relevant topics that may stray from the interview guide allows for the opportunity to identify new ways of seeing and understanding the topic at hand.

How do we use Semi-Structured Interviews?

- We use semi-structured interviews to understand training, treatment programming, caregiver training, collaboration, social media, and marketing practices.
- We supplement this interview with a comprehensive document review as a fidelity check between the interview and the organization’s policies and practices.

2. Survey Methods  

Characteristics of Survey Design

Surveys are “a systematic method for gathering information from a sample of individuals in order to describe the attributes of the larger population of which the individuals are members” (Jansen, 2010). The attributes attempt to describe basic characteristics or experiences of large and small populations in our world. (Enanoria, 2005)

- Surveys allow our organization to collect large amounts of data in relatively short periods.
- Surveys allow our organization to identify concerns among our participants’ staff and consumers.
- Anonymous 3rd party surveys allow for customers and staff to provide honest and insightful feedback otherwise not mentioned in interviews or in-person meetings.

How do we use Surveys?

- We use survey methodology to understand staff satisfaction in the work place.
- We use a measure developed by the Society for Human Resource Management which evaluates satisfaction in healthcare workers.
- We use survey methodology to understand caregiver involvement and satisfaction with their behavioral health services.
- We are able to benchmark these data in order to provide our members with a comparison of performance across other organizations with similar characteristics.

3. Outcome Measure Analysis

Organizations can choose to participate in the BHCOE outcome measure analysis. The outcome measure analysis within an organization is used to provide additional information regarding the organization’s larger impact on client progress over time. Typically, outcome research seeks to provide evidence about which interventions work best for which types of patients, under which circumstances. In this case, current methodology on outcome analyses are limited within the field of applied behavior analysis. This assessment attempts to begin the process of standardizing these methods across multiple organizations.

Individual measures of quality include: the number of goals met, transition placement after treatment, or reduction of challenging behaviors. Macro-level measures of quality include client outcome via standardized measurement such as the Autism Diagnostic Observation Schedule, Verbal Behavior Milestone Assessment and Placement Program, Assessment of Basic Language and Learning Skills-Revised, and Peabody Picture Vocabulary Test.

In the BHCOE assessment, outcome is measured via average improvement between first and last administration of a standardized evaluation tool. A Pearson Correlation is also calculated to assess the relationship between the length of treatment and the improvement in the client’s standardized outcome score.

Measuring client outcomes is an important component of healthcare in order to:

- Improve the patient’s experience of care.
- Improve the outcome for the individual.
- Increase cost effectiveness of services.

Our organization assists in measuring client outcome in a standardized method so that all BHCOEs can work towards the standardization of quality outcomes in the field.
The current BHCOE network spans across 20 states, with states with the most BHCOEs being California, Texas, and Illinois. Our biggest challenge is identifying quality providers in states with minimal resources.

4,117
NUMBER OF STAFF SURVEYED

3,256
NUMBER OF CONSUMERS SURVEYED

53%
2016 PASS RATE FOR COMPLETED AUDITS
BEST IN CLASS

BEST IN STAFF SATISFACTION

Top Provider score: 86%

Top Provider score: 86%

BEST IN CAREGIVER SATISFACTION

Top Provider score: 97%

Top Provider score: 97%

HIGHEST IN CLINICAL QUALITY

Top Provider score: 98%
Of the 57 organizations who have participated in our quality assurance evaluation in 2016, 30 were selected as Centers of Excellence based on the standards outlined above.

- **Achievable Behavior Strategies**
  Justin Kyriannis, MA, BCBA
  Nevada

- **Alternative Behavior Strategies**
  Jeff Skibitsky, MA, BCBA
  Utah, California

- **Animate Behavior**
  Alex Lorenzo, MS, BCBA
  Yaz Aboul, MS, BCBA
  California

- **Attentive Behavior Care**
  Kaitlin Causin, MA, BCBA
  New York, New Jersey, Maryland

- **Autism Outreach Southern California**
  Abigail Bunt, MEd, BCBA
  California

- **BCBA Services**
  Katie Cook, MEd, BCBA
  California

- **Behavior And Education**
  Barbara Endlich, Psy.D, BCBA-D
  California

- **Behavior Frontiers**
  Helen Mader, MA, BCBA
  California, Texas, Colorado

- **Behavioral Perspective**
  Candice Gizewski, MA, BCBA
  Illinois

- **BEST Strategies**
  Brian Yankouski, EdS., BCBA
  New Jersey

- **Bierman ABA Autism Center**
  Courtney Bierman, MA, BCBA
  Massachusetts, Indiana

- **Center for Autism Spectrum Treatment**
  Efi Pyladaki, MA, BCBA, LMFT
  California

- **Eastside ABA**
  Paul Johnson, MA, BCBA
  Washington

- **Educational and Developmental Therapies**
  Richard Laitinen, PhD, BCBA-D
  California, New York, Utah

- **Epic Developmental Services**
  Kathleen Stengel, MS, BCBA
  Pennsylvania, Maryland, New Jersey, Texas

- **Fresh Starts**
  Claudia Jimenez, MA, BCBA
  Florida

- **Good Behavior Beginnings**
  Rachel White, PhD, BCBA-D
  Alaska

- **Including Kids**
  Jennifer Dantzler, MEd, BCBA
  Texas

- **In STEPPS**
  Erin McNerney, PhD, BCBA-D
  Yvonne Bruisina, PhD, BCBA-D
  California

- **Indiana Behavioral Academy**
  Lisa Steward, MA, BCBA
  Indiana

- **Integrated Behavioral Solutions**
  Coby Lund, PhD, BCBA-D
  Janet Lund, PhD, BCBA-D
  Georgia

- **JumpStart Autism Center**
  Brian Lopez, PhD, BCBA
  New Mexico, Colorado

- **KGH Consultation & Treatment**
  Jill Hollederer, MA, BCBA
  Nan Huai, PhD, BCBA-D
  Illinois, Wisconsin

- **Northwest Behavioral Associates**
  Stacey Shook, PhD, BCBA-D
  Washington

- **Pathways Behavioral Consulting**
  Becky Lamont, MEd, BCBA
  Georgia

- **Positive Behavioral Connections**
  Emily Deeney, MEd, BCBA
  Niki Thurkow, PhD, BCBA-D
  Illinois

- **Prism Autism Education & Consultation**
  Rebecca Giammatti, MS, BCBA
  Connecticut

- **Spark Center for Autism**
  Emily Morris, MS, BCBA
  Reena Naami, MS, BCBA
  Michigan

- **STE Consultants**
  Sarah Trautman-Eslinger, MA, BCBA
  California

- **Total Spectrum**
  Leah Adamvik, MA, BCBA
  Illinois, Indiana, Michigan, Wisconsin
CLINICAL QUALITY INDICATORS
EMPLOYEE ENGAGEMENT & CONSUMER SATISFACTION TRENDS
The purpose of this project was to identify quality applied behavior analysis (ABA) providers in the United States. These results aim to assist clinicians and business owners in understanding benchmark data within behavioral organizations and assist them with decision-making.

Invitations to participate in this evaluation were distributed to approximately 180 (ABA) providers across multiple states, in August 2015, who provided ABA services through state, school, or insurance funding.

The participants were limited to those organizations who had been in operation at least 2 years and provided services to at least 20 clients. All participants provided payment in exchange for the evaluation. Cost was determined on a sliding scale based on the size and incorporation status of the organization. The evaluation consisted of five components, including:

1. Clinical Director Interview
2. Document Review
3. Staff Survey
4. Consumer Survey
5. Social Media Review

A report was provided to each individual provider, which identified their areas of excellence and areas of improvement. Organizations were also provided with in-depth data analysis, which identified patterns across these five areas that could contribute to the efficiency and effectiveness of their clinical services.
Figure 1 shows that the most participants operate in California. The three state with the most participants besides California in descending order were Texas, New Jersey, and Indiana. These correspond with the states with the high saturation of providers and population of certified clinicians.
Figure 2 shows the average scores across clinical quality indicators and best practice standards for providers who participated in the BHCOE evaluation. Clinical indicators refer to indicators in clinical practice that have correlational relationships with client outcome. Providers averaged the highest in the treatment program and planning category. Providers scored the lowest in accessibility to services and collaboration efforts. Providers who were distinguished as BHCOEs scored above 80% across all categories.

TREND: Providers who score above 80% across all categories are most likely to have rigorous caregiver training requirements (e.g. participation requirements, workshop opportunities, incentives for participation, etc.).
Figure 3 shows the percentage of providers who employed qualified staff at each service tier. 82% of providers evaluated adhered to best practices in clinical director qualifications. 83% of providers adhered to BHCOE standards regarding appropriate qualification level for supervisory staff. 93% of providers evaluated adhered to BHCOE standards of appropriate direct interventionist qualifications.

TREND: Providers who adhere to appropriate staff qualifications at the supervisory level typically promote from within.
Figure 4 shows the most commonly used terminology to describe the individual who provides direct services to consumers, with the most common title being “Behavior Technician.”
Figure 5 shows the most common terminology used to describe individuals who act as supervisory staff to direct service staff. These individuals are either BCBA-certified or eligible for certification. 31% of providers utilize the term “BCBA” within their organization to identify these individuals. 17% use the term “Clinical Supervisor” to identify these individuals.

TREND: Most providers reserve the title of “Supervisor” to those individuals who hold BCBA certification.
Figure 6 shows the average scores for the treatment program & planning section of the evaluation tool. Providers scored highest in areas related to using evidence-based teaching procedures when guiding their treatment programs. This is measured via interview and document review. Providers struggled most with integrating electronic medical records into their practices. In addition, some providers struggled with appropriate recommendations of frequency and intensity of treatment.

TREND: All providers reported that their biggest challenge regarding appropriate intensity and frequency of treatment recommendations related to funder requests.
Figure 7 shows the average scores for the collaboration section of our evaluation tool.

66% of providers followed best practices in caregiver participation and involvement by either having minimum requirements for participation or having set parent training curricula in place. 75% of providers had a formal policy on collaboration with alternative treatments that were provided to caregivers at the onset of treatment. These providers also provided training on identifying and distinguishing between evidence-based and non-evidence-based practices. Over 80% of providers established relationships with other professionals, such as the client’s primary care physician, at the onset of services to assist with continuity of care.
Figure 8 shows the average scores for accessibility to services. 45% of providers had a waitlist for services. Of the total number of providers with a waitlist, 48% had a waitlist longer than a month. 59% of providers had a formal waitlist policy that informed caregivers of duration of waitlist, expectations of treatment timeline, and provided them with additional support resources until treatment began. 82% of providers had appropriate supports in place to transition clients to age-appropriate programming as they grow older.
Figure 9 shows the average scores for consumer satisfaction. High satisfaction with scheduling revealed correlative relationships with overall satisfaction in caregivers. Satisfaction with child progress was not related to overall satisfaction with services.
Figure 10 shows the average scores for staff satisfaction. The industry standard for satisfaction with compensation was 77%. Most staff were dissatisfied with benefits. This could be due to lack of knowledge about what is available and accessible to them. Although compensation satisfaction was low, there was a correlative relationship between satisfaction and utilization. Thus, an employee was more satisfied with a lower compensation and higher hour utilization, whereas those with higher compensation and lower hour utilization were less satisfied.
OUR FUTURE VISION
In 2017, the Behavioral Health Center of Excellence (BHCOE) will be entering in its second year of our evaluation cycle. During the next year, the BHCOE will focus on growing its membership to span across all 50 states. The following is some insight into some of the initiatives that the BHCOE will develop over the next 12 months in response to our organization’s vision, our evaluation process, and the changing landscape across the delivery of applied behavior analysis services.

Our 2017 initiatives are:

- **Promote** quality standards
- **Expand** membership to all 50 states
- **Enhance** the BHCOE existing practice standards through collaboration with professional organizations
- **Provide** support and resources for the BHCOE Provider Network
BECOME A
BHCOE TODAY

Our community is stronger together. Our doors are always open for like-minded organizations who value ethical services, efficient business practices, and a community-based approach to behavioral services. If your organization may be a good fit, don’t hesitate to let us know.

To begin the evaluation process, submit an application and our clinical team will be in touch to schedule an informational session. Upon confirmation of your organization, you will be provided with:

1. ENGAGEMENT LETTER
2. BUSINESS ASSOCIATES AGREEMENT
3. BHCOE EVALUATION TOOL
4. INTRODUCTORY PAPERWORK, FORMS AND TIMELINE

Learn more at www.bhcoe.org
THANK YOU
FOR YOUR CONTINUED SUPPORT

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