The BHCOE 2017 Annual Report provides stakeholders with an overview of the condition of applied behavior analysis service delivery across the United States, Australia and Canada, and suggestions for best practices. The annual report discusses milestones and initiatives related to the BHCOE strategic priorities and details the organization’s regulatory and policy initiatives. Additionally, the report discusses benchmark data related to quality of care for individuals receiving applied behavior analysis services.

BHCOE Accreditation ® is a designation given to an applied behavior analysis provider once it has demonstrated it has met and continues to meet an assortment of clinical and administrative standards as determined by an independent third-party evaluator.
The Behavioral Health Center of Excellence® (BHCOE®) is an international accrediting body created to meet accreditation needs specific to the delivery of behavior analysis services.
The BHCOE’s accreditation requirements undergo regular review according to international standards for organizations that grant accreditation. All BHCOE requirements and survey questions are reviewed annually by content experts.

CONSUMERS SURVEYED YEAR TO DATE

6,900

STAFF SURVEYED YEAR TO DATE

8,375
BHCOE Accreditation® is a designation given to an applied behavior analysis provider once it has demonstrated it has met and continues to meet an assortment of clinical and administrative standards, as determined by an independent third-party evaluator.

2017 First-Time Pass Rate Without Corrections: 57%

2017 Pass Rate With Minor Corrections Provided: 73%
Year in review 2017
2017 Program Accomplishments

The Behavioral Health Center of Excellence has experienced tremendous growth over the last year. BHCOE is currently the only ABA-specific accrediting body that uses Board Certified Behavior Analysts to review clinical quality, administrative transparency, staff satisfaction and consumer satisfaction. Since the Behavioral Health Center of Excellence Accreditation (BHCOE) was created in 2015, the number of accredited organizations has grown significantly, particularly in the USA. BHCOE has continued to focus on four key initiatives as outlined last year.

1. Enhance the BHCOE existing practice standards through collaboration with professional organizations

Collaborative efforts with the Centers for Medicare & Medicaid Services (CMS), State Departments of Education and Health, Private Insurers, and others help assure efficiency and consistency in ABA Services provided throughout the United States. The aim of this type of collaboration is to foster industry-wide agreement on current and new priorities, and on new and improved methods for optimizing the quality of services provided.

In addition, Behavioral Health Center of Excellence has entered into a consolidation agreement with Code of Ethics for Behavioral Organizations (COEBO). Organizations credentialed by COEBO will now be evaluated on BHCOE’s quality standards. Both organizations were created in response to a need for increasing the quality of behavior analysis throughout our community.

This consolidation will reduce fragmentation in the field and give COEBO organizations increased opportunities through an expanded set of resources and guidelines.

BHCOE continues to seek out opportunities to work collaboratively with other organizations, funding bodies, state legislators, provider and parent support groups to create alliances on issues of importance to the behavioral health community.

2. Promote quality applied behavior analysis (ABA) service standards

BHCOE continues to promote quality standards by advocating for federal policies, programs, and legislation that respond to the needs of the autism community.

BHCOE promotes evidence-based best practices and standards for organizations. BHCOE evaluates systems that enhance quality staff training and supervision, staff qualifications, clinical decision making, outcome measure analysis, and more. These standards are promoted at regional, national and international conferences to assist with dissemination.

BHCOE accreditation provides assurance to persons seeking services that a provider has demonstrated conformance to internationally accepted quality standards.

As BHCOE continues to strive to expand to each state, autism insurance laws have helped ensure the economic feasibility of applied behavior analysis providers. With the most recent autism mandate being passed in Idaho, and the passing of the revised Kentucky mandate, there continues to be increased access to services for individuals with autism. Only one state, Wyoming, remains without a specific insurance mandate for autism. The passing mandates are promising, yet the disconnect between the state government funders and the autism providers continues to increase.

Our organization continues to serve as a provider network so that organizations can collaborate across state lines in regard to best clinical and business practices. The peer network program allows for matching of organizations with similar characteristics to facilitate peer-to-peer collaboration and resource-sharing.

BHCOE has also established group pricing with organizations seen as allies in promoting quality care. Accredited providers can enjoy discounted rates on staff training software, data collection software, documentation templates, liability insurance, and more. For a complete list of partner organizations, please visit BHCOE’s website.

Preliminary Accreditation was created and piloted for newer organizations or organizations preparing to meet full accreditation review within one year. This consists of a high-level review of organizational systems to identify readiness to serve clients and areas for improvement prior to growth. Preliminary Accreditation consists of an interview, document review and systems analysis. Areas evaluated include organizational structure, hiring process, HIPAA compliance, intake, clinical systems, and consumer protection. For a the most up-to-date list of preliminary accreditation standards, please visit the BHCOE’s website.

3. Expand membership to all 50 states

As BHCOE continues to strive to expand to each state, autism insurance laws have helped ensure the economic feasibility of applied behavior analysis providers. With the most recent autism mandate being passed in Idaho, and the passing of the revised Kentucky mandate, there continues to be increased access to services for individuals with autism. Only one state, Wyoming, remains without a specific insurance mandate for autism. The passing mandates are promising, yet the disconnect between the state government funders and the autism providers continues to increase.

BHCOE has taken an active role in meeting with government funders to ensure there are benchmarks in place to ensure providers are appropriately incentivize for the quality services they provide.

4. Provide support and resources for the BHCOE Provider Network.

Our organization continues to serve as a provider network so that organizations can collaborate across state lines in regard to best clinical and business practices. The peer network program allows for matching of organizations with similar characteristics to facilitate peer-to-peer collaboration and resource-sharing.

BHCOE has also established group pricing with organizations seen as allies in promoting quality care. Accredited providers can enjoy discounted rates on staff training software, data collection software, documentation templates, liability insurance, and more. For a complete list of partner organizations, please visit BHCOE’s website.

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5. Pilot Preliminary Accreditation Standards for small or newly formed organizations.

The aim of this type of collaboration is to foster industry-wide agreement on current and new priorities, and on new and improved methods for optimizing the quality of services provided.

In addition, Behavioral Health Center of Excellence has entered into a consolidation agreement with Code of Ethics for Behavioral Organizations (COEBO). Organizations credentialed by COEBO will now be evaluated on BHCOE’s quality standards. Both organizations were created in response to a need for increasing the quality of behavior analysis throughout our community.

This consolidation will reduce fragmentation in the field and give COEBO organizations increased opportunities through an expanded set of resources and guidelines.

BHCOE continues to seek out opportunities to work collaboratively with other organizations, funding bodies, state legislators, provider and parent support groups to create alliances on issues of importance to the behavioral health community.
Accreditation Decisions

The accreditation and reaccreditation decision-making processes assess a BHCOE provider’s compliance with the accreditation requirements. Based on these compliance findings, BHCOE decides on the provider’s accreditation status, using one of these five options.

1. Three-Year Accreditation Score: 96%-100%
   - The organization satisfies most of the BHCOE Accreditation Conditions and demonstrates substantial conformance to the standards. The organization’s programming is designed and operated to benefit the persons served. The organization has demonstrated quality improvement from any previous periods of BHCOE Accreditation.

2. Two-Year Accreditation Score: 91%-95%
   - The organization satisfies a majority of the BHCOE Accreditation Conditions and demonstrates conformance to most of the standards. Although there are some areas of improvement in relation to the standards, there is clear evidence of the organization’s capability to correct the deficiencies and commitment to progress toward their correction.

3. One-Year Accreditation Score: 85%-90%
   - The organization satisfies 85-90% of the BHCOE Accreditation Conditions and demonstrates conformance to many of the standards. Although there are some areas of improvement in relation to the standards, there is evidence of the organization’s capability to correct the deficiencies and commitment to progress toward their correction.

4. Provisional Accreditation
   - If the participating provider receives a score less than 85%, the provider may earn a Provisional Accreditation and will receive a Quality Improvement Plan (QIP) to assist the provider in adjusting their organizational practices. It is requested that these adjustments be made within 3-6 months following the receipt of the plan. After 3-6 months, the provider is then re-assessed in the areas addressed in the QIP.

5. Non Accreditation
   - The organization has major deficiencies in several areas of the standards, and there are serious questions as to the benefits of the services the provider offers; there are serious questions as to the health, welfare, or safety of those served; the organization has failed over time to bring itself into substantial conformance to the standards; or the organization has failed to satisfy critical BHCOE Accreditation Conditions.
Figure 1. This graph represents the cumulative number of providers evaluated annually.
Accreditation 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.

In addition to peer-reviewed journal articles, here are some of the documents we use to guide our assessment:

1. National Standards Project Phase 2


3. Consumer Guidelines for Identifying, Selecting and Evaluating Behavior Analysts Working with Individuals with Autism Spectrum Disorders
   Autism Special Interest Group, Association for Behavior Analysis, International (2013).
The BHCOE’s Code of Effective Behavioral Organization (the “BHCOE Code”) includes 7 sections relevant to professional and ethical behavior of organizations providing Applied Behavior Analysis therapy, along with suggested evidence of compliance. This code is effective January 1, 2018, for all BHCOE Accredited organizations.

1.0 Staff Qualifications, Training & Oversight

1.01 Participating provider will retain clinical director-level staff who hold adequate education and qualifications.

1.02 Participating provider will retain supervisory staff who hold adequate education and qualifications.

1.03 Participating provider will retain direct staff who hold adequate education and qualifications.

1.04 Participating provider will conduct for clinical competence prior to staff providing treatment to clients.

1.05 Participating provider will provide training 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.).

1.06 Participating provider will provide staff with continuing education in line with their areas of need.

1.07 Participating provider will ensure consistency of treatment across staff members through staff overlap, data collection, and/or team meetings.

1.08 Participating provider will utilize employee performance evaluation processes such as goal-setting, performance measurement, regular performance feedback, and self-evaluation, as evidenced by documentation of employee progress.

1.09 Participating provider has defined organizational structure and hierarchy.

1.10 Participating provider has job descriptions and expectations for all current positions.

2.0 Treatment Program & Planning

2.01 Participating provider utilizes standardized assessments to evaluate client outcome annually, or more frequently if needed.

2.02 Participating provider collects and monitors individual outcome data.

2.03 Participating provider collects and monitors organizational outcome data.

2.04 Participating provider utilizes evidence-based curricula when developing client goals.

2.05 Participating provider utilizes research-based skill-acquisition procedures.

2.06 Participating provider utilizes research-based behavior-reduction procedures.

2.07 Participating provider trains for and measures generalization throughout treatment.

2.08 Participating provider ensures skills are age-appropriate based on the developmental order in which skills are acquired in individuals with typical development.

2.09 Participating provider has resources available to service non-verbal/non-vocal children.

2.10 Participating provider collaborates with a speech language pathologist to facilitate language acquisition.

3.0 Collaboration

3.01 Participating provider notifies caregivers of expectations for involvement in programming.

3.02 Participating provider educates caregivers on clinical outcomes of parent involvement in their child’s progress.

3.03 Participating provider has standard requirements for caregiver participation, and training independent of the patient’s funding source.

3.04 Participating provider makes reasonable efforts to involve caregivers in training, participation and treatment planning.

3.05 Participating provider appropriately documents caregiver participation or lack of participation in treatment sessions and planning.

3.06 Participating provider ensures eLearning opportunities are easily accessible to caregivers.

3.07 Participating provider makes reasonable efforts to collaborate with other professionals (e.g., speech-language pathologists, occupational therapists, school staff, physicians, etc.) to maximize clients’ progress.

3.08 Participating provider provides a clear policy to clients on collaboration with non-evidence-based practices.

4.0 Ethics & Consumer Protection

4.01 If participating provider holds a waitlist, they clearly communicate expectations of waitlist time to families.

4.02 Participating provider offers resources to potential clients if unable to initiate services within 45 days of contact.

4.03 Participating provider offers families with peer-referral options to potential clients if unable to provide services within 1 month of contact.

4.04 Participating provider maintains close supervision over wait list times and caregiver needs.

5.0 HIPAA Compliance

5.01 Participating provider has identified their documented status as either a hybrid entity, affiliated covered entity, or part of an organized health care arrangement.

5.02 Participating provider has determined where PHI will be located.

5.03 Participating provider has appointed a HIPAA privacy/security official.

5.04 Participating provider has determined how or why PHI will be disclosed.

5.05 Participating provider uses HIPAA-compliant electronic communication.

5.06 Participating provider uses HIPAA-compliant cloud or server-based storage.

5.07 Participating provider has HIPAA breach policy.

5.08 Participating provider has a data backup plan.

5.09 Participating provider provides HIPAA compliance training to staff.

6.0 Caregiver Satisfaction

6.01 Participating provider operates in a manner that indicates caregiver satisfaction at 80% or higher.

7.0 Employee Satisfaction

7.01 Participating provider operates in a manner that indicates staff satisfaction at 80% or higher.

Guidelines for Accredited Organizations.

4.10 Participating provider appoints an internal Ethics Officer and/or Ethics Committee to address internal ethical issues.

4.11 Participating provider obtains any relevant consent from consumers of their services.

4.12 Before the commencement of service delivery, provider informs consumer where they can file complaints about any service provided by their organization.

4.13 Prior to the implementation of services, participating provider provides in writing, the terms of consultation, requirements for providing services, financial agreements, and responsibilities of all parties. If terms change, behavioral organizations will notify consumers.
Suggested Evidence of Compliance

Staff Qualifications
- Staff qualification form including staff name, license or certification number
- Sample employee offer letter outlining expectations for certification
- Staff resume or vita

Staff Training & Oversight
- Employee Handbook
- Documentation of training protocol
- Competency checklist
- Training participation log
- Continuing Education Policy
- Performance evaluation system

Treatment Program & Planning
- Auditor interview
- Auditor observation
- Client progress report
- Client assessment report
- Outcome analysis
- Policy on assessment and curricula usage
- Supplemental staff roster (e.g. SLP, PT, etc.)
- Policy on treatment recommendations
- Record review

Collaboration
- Caregiver training curricula recommendations
- Auditor observation
- Record review

Ethics & Consumer Protection
- Internal Waitlist guidelines
- Ethics committee/officer guidelines
- Client Intake Documents
- Website and Social Media Review
- Employee Handbook
- Whistle-blower policy
- Ethics committee/officer guidelines
- Client Intake Documents
- Website and Social Media Review

Caregiver Satisfaction, Staff Satisfaction and Turnover
- Survey Results
- Staff Turnover Assessment
2017 Accredited Providers
Of the 101 organizations who have gone through the accreditation process, 63 hold BHCOE accreditation based on the standards outlined on pages 21 through 25.

The following directory highlights these organizations and the locations that have been evaluated.
### 2017 Accredited Providers

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Accredited Since</th>
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<tbody>
<tr>
<td>ABA Pathways</td>
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<tr>
<td>ABC Group Hawaii</td>
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<tr>
<td>Achievable Behavior Strategies</td>
<td>Nevada</td>
<td>2017</td>
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<td>Alternative Behavior Strategies</td>
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<tr>
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<td>Love 2 Learn</td>
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<tr>
<td>Mau Loa Learning</td>
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<td>My Favorite Therapists</td>
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<td>STE Consultants</td>
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<td>Total Spectrum</td>
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Of the organizations evaluated in 2017, organizations with at least 25 clients and 25 staff were eligible to receive a distinction of “Best in Class” across three categories: Staff Satisfaction, Caregiver Satisfaction, and Overall Accreditation score.
Trends in Applied Behavior Analysis Clinical Quality Indicators
The purpose of this trends report is to identify indicators of quality applied behavior analysis providers in the United States and benchmark quality behavioral practices.

These results aim to assist clinicians, business owners in understanding benchmark data within behavioral organizations and assist them with decision-making.

The data below represent data from all organizations who participated in 2017 and provided ABA services through state, school, or insurance funding.

The participants in this data set are limited to those organizations who had been in operation at least 1 year and provided services to at least 20 clients. All participants provided payment in exchange for the evaluation activities. Cost was determined on a sliding scale based on the size and incorporation status of the organization. The evaluation consisted of six components, including:

1. Clinical Interview
2. Document Review
3. Staff Satisfaction Survey
4. Consumer Satisfaction Survey
5. Turnover Rate Analysis
6. Client Outcome Analysis

A report was provided to each individual provider which identified their areas of strength and areas of improvement. Organizations were also provided with in-depth data analysis, which identified patterns across these six areas that could contribute to the efficiency, quality, and effectiveness of their clinical services.

A report was provided to each individual provider which identified their areas of strength and areas of improvement. Organizations were also provided with in-depth data analysis, which identified patterns across these six areas that could contribute to the efficiency, quality, and effectiveness of their clinical services.

Figure 1. The clinical interview and document review evaluated the six areas noted in the graph above. The largest difference between organizations who achieved accreditation on their first attempt was in the collaboration category. On average, organizations who achieved accreditation received a 90% on the collaboration section of the evaluation, whereas non-accredited providers averaged 78%. The second largest difference between organizations was related to consumer protection and ethical marketing. These areas relate to notifying their potential clients of waitlist times, accurately representing the services they provide, and use of client photographs for marketing purposes.
Figure 2. This section refers to the social validity component of service delivery and represents the parent perspective of quality services. Caregivers who are receiving services from an accredited provider on average are 91% satisfied. Caregiver satisfaction surveys indicate that on average, organizations who achieved accreditation have higher overall satisfaction with their services than organizations who did not achieve accreditation.

Figure 3. Staff satisfaction reflects how staff members perceive the quality of services provided at their organization and the relationship they hold with their staff and clients. On average, employees are most dissatisfied with compensation and benefits, and most satisfied with work environment and work engagement. Of organizations who did not meet accreditation, the most common qualitative feedback related to lack of career opportunities and opportunities for mentorship.
ANNUALIZED BCBA TURNOVER RATE

Figure 4. Staff turnover rate is a new measure in the accreditation process. Turnover was self-reported by each organization that initiated the accreditation process in 2017. Organizations were asked to report on the past three years of turnover data at their organization. A total of 1,122 BCBA-level staff were assessed. Overall annualized turnover rates for supervisors ranged from 13% to 17%, which indicates a stable trend in turnover for BCBA-level staff.

ANNUALIZED TECHNICIAN TURNOVER RATE

Figure 5. Staff turnover rate is a new measure in the accreditation process. Turnover was self-reported by each organization that initiated the accreditation process in 2017. Organizations were asked to report on the past three years of turnover data at their organization. A total of 4,722 technicians were assessed in this process. Overall annualized turnover rates for technician-level staff ranged from 35% to 64%, with a clear decreasing trend. Turnover was requested for individuals who had completed orientation and training at the organization and had received at least one paycheck from the organization. For example, if a new-hire did not show up for training, this was not calculated into the organization’s turnover rate. Turnover appears to be steadily decreasing at the technician level.
Figure 6. Staff hourly rates were assessed to identify the distribution across technician-level staff. Hourly rate was self-reported by employees during the staff survey component of the evaluation. 2,722 technicians responded to this question. Average hourly rate for technicians is $18/hour (range $7.25 to $80). These data show that the majority of technicians are paid between $16 and $20 per hour. There are many factors that contribute to technician pay rate such as cost of living in the region, types of funding accepted by the organization and level of education, certification and experience of the technician.

Figure 7. Staff hourly rates were assessed to identify the distribution across BCBA's. Hourly rate was self-reported by employees during the staff survey component of the evaluation. Average hourly rate for technicians is $35.91/hour (range $11 to $95). If hourly rate was reported as a salary, it was converted based on a 40 hour work week. These data indicate that 45% of BCBA's are paid $30 or less per hour, whereas 28% of BCBA's make more than $41 per hour. There are many factors that contribute to BCBA pay rate such as cost of living in the region, types of funding accepted by the organization years of experience of the BCBA, and whether they hold a clinical or administrative role within the organization.
Future directions: During the next year, the BHCOE will continue its focus on steady growth while enhancing operational efficiency.

In 2018, the Behavioral Health Center of Excellence (BHCOE) will be entering into the third year of providing accreditation. The following is some insight into some of the initiatives that the BHCOE has accomplished and our plans to move forward over the next 12 months. Our future strategy is in response to our organization’s vision, our evaluation process, and the changing landscape across the delivery of applied behavior analysis services.

Our 2018 initiatives are:

- **Promote** quality standards
- **Expand** membership to all 50 states and increase international reach
- **Continue** collaboration with Medicaid, State Legislators and private funders
- **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, standardized peer review, 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 Self-Study Tool
4. Introductory Paperwork, Forms and Timeline

Learn more at www.bhcoe.org

2017 Advisory Board

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Diana Davis-Wilson, DBH, BCBA, LBA
Jean Johnson, PhD, BCBA
Michael Mozzoni, PhD, BCBA-D
Jamie Pagliara, MBA
David Pyles, PhD, BCBA-D
Denise Rockwell, PhD, BCBA-D
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Special Thanks

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