Autism Training 1.a

SECTION 18 - APPLIED BEHAVIOR ANALYSIS

The purpose of this policy is to clarify developmental screening policy for children who may be affected by Autism Spectrum Disorder (ASD), and to describe coverage and processes for the treatment of ASD for beneficiaries 18 months through 5 years of age.

According to the U.S. Department of Health & Human Services, autism is characterized by impaired social interactions, problems with verbal and nonverbal communication, repetitive behaviors, and/or severely limited activities and interests. Early detection and treatment can have a significant impact on the child's development. Autism can be viewed as a continuum or spectrum, known as Autism Spectrum Disorder (ASD), and includes Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS). The disorders on the spectrum vary in severity and presentation, but have certain common core symptoms. The goals of treatment for ASD focus on improving core deficits in communication, social interactions, and restricted behaviors. Changing these fundamental deficits may benefit children by developing greater functional skills and independence.

18.1 SCREENING

The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder and its underlying etiology may affect the medical treatment of the child and family intervention planning for his/her parents. Screening for ASD typically occurs during a well-child visit with the pediatrician or family physician as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service.

18.2 REFERRAL

The primary care physician (PCP) who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the Autism Benefit additional screenings, evaluation, assessment, diagnosis and services for Applied Behavior Analysis (ABA) for eligible Medicaid beneficiaries and for the related medically necessary services under the Mental Health Specialty Services. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s) to arrange a follow-up appointment for a diagnostic evaluation. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation of ASD.

18.3 DIAGNOSIS/DETERMINATION OF ELIGIBILITY FOR TARGET GROUP

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The following is the process for determining eligibility for ABA for a child referred to the PIHP with a suspected diagnosis of autism or one of the related ASDs, including Autistic Disorder, Asperger's Disorder, and PDD-NOS. The MDCH Behavioral Health and Developmental Disabilities Administration (BHDDA) will make the final eligibility determination for ABA services.

Determination of diagnosis of ASD shall be performed by a child mental health professional (CMHP), which includes physicians, fully licensed psychologists, limited licensed psychologists, licensed or limited

licensed master's social workers, licensed or limited licensed professional counselors, and registered nurses with a minimum education of a master's degree in a mental health-related field from an accredited school. The CMHP, as defined above, must have at least one year of experience in the examination and treatment of children with ASD, and is able to diagnose within their scope of practice and professional license. The determination of diagnosis will be performed using the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2). A developmental family history interview, such as the Autism Diagnostic Interview-Revised (ADI-R), shall be administered with validation of diagnosis by a physician (preferably a child psychiatrist) and/or a fully licensed psychologist unless the diagnosis is made by either of those professionals.

The CMHP, as defined above, will use the appropriate ADOS-2 module that includes the Toddler Module or Module 1, 2, or 3. The ADOS-2 modules are appropriate to use from 12 months of age through adulthood. The ADOS-2 is to be administered at intake and discharge.

An ASD developmental family history interview, such as the ADI-R, shall be administered by the clinicians who are required to obtain advance training in conducting the ADI-R. Interviews should thoroughly address all domains relevant to ASD (social affective/communication skills, restricted repertoire).

The target group for the ABA benefit includes children 18 months through 5 years of age with a diagnosis of ASD based upon a medical diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of ASD and who have the developmental capacity to clinically participate in the available interventions covered by the benefit. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS should be given the diagnosis of ASD.

A diagnosis of ASD must not be:

- attributable to a disorder of sensory impairment (e.g., deafness), to a primary language disorder, to schizophrenia, or to social phobia.
- associated with a progressive neurodegenerative condition that would preclude anticipated benefits of treatment, as determined by a physician.
- associated with motor or sensory deficits so severe as to preclude benefit from treatment.

The target group criteria for ASD are operationalized using the criteria below.

18.3.A. Criteria for Autistic Disorder

To be diagnosed with AUTISTIC DISORDER, the child must exhibit:

A. A total of six (or more) items from (1.), (2.), and (3.), with at least two from (1.) and one each from (2.) and (3.):

1. Qualitative impairment in social interaction, as manifested by at least two of the following:

a. marked impairment in the use of multiple nonverbal behaviors (such as eye-to-eye gaze, facial expression, body postures, and gestures) to regulate social interaction.

b. failure to develop peer relationships appropriate to developmental level.

c. lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest).

d. lack of social or emotional reciprocity.

2. Qualitative impairment in communication, as manifested by at least one of the following:

a. delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime).

b. in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others.

c. stereotyped and repetitive use of language or idiosyncratic language.

d. lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

3. Restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

a. encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.

b. apparently inflexible adherence to specific, nonfunctional routines or rituals.

c. stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements).

d. persistent preoccupation with parts of objects.

18.3.B. CRITERIA FOR ASPERGER'S DISORDER

To be diagnosed with ASPERGER'S DISORDER, the child must exhibit:

A. A total of three (or more) items from (1.) and (2.), with at least two from (1.) and one from (2.):

1. Qualitative impairment in social interaction, as manifested by at least two of the following:

a. marked impairment in the use of multiple nonverbal behaviors (such as eye-to-eye gaze, facial expression, body postures, and gestures) to regulate social interaction.

b. failure to develop peer relationships appropriate to developmental level.

c. lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest).

d. lack of social or emotional reciprocity.

2. Restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

a. encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.

b. apparently inflexible adherence to specific, nonfunctional routines or rituals.

c. stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements).

d. persistent preoccupation with parts of objects.

B. A clinically significant impairment caused by the disturbance.

C. No clinically significant general delay in language.

D. No clinically significant delay in cognitive development [Developmental Quotient (DQ) or Intelligence Quotient (IQ) > 75] or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment.

18.3.C. CRITERIA FOR PERVASIVE DEVELOPMENTAL DISORDER - NOT OTHERWISE SPECIFIED

To be diagnosed with PERVASIVE DEVELOPMENTAL DISORDER-NOT OTHERWISE SPECIFIED (PDD-NOS), the child must exhibit:

A. A total of four (or more) items from (1.), (2.), and (3.), with at least two from (1.) and one each from (2.) and (3.):

1. Qualitative impairment in social interaction, as manifested by at least two of the following:

a. marked impairment in the use of multiple nonverbal behaviors (such as eye-to-eye gaze, facial expression, body postures, and gestures) to regulate social interaction.

b. failure to develop peer relationships appropriate to developmental level.

c. lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest).

d. lack of social or emotional reciprocity.

2. Qualitative impairment in communication, as manifested by at least one of the following:

a. delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime).

b. in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others.

c. stereotyped and repetitive use of language or idiosyncratic language.

d. lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

3. Restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
   a. encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
   b. apparently inflexible adherence to specific, nonfunctional routines or rituals.
   c. stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements).
   d. persistent preoccupation with parts of objects.

18.4 Independent Evaluation

The MDCH/BHDDA will apply the needs-based criteria (described in the Needs-Based Criteria Subsection) to determine whether the child in the target group is eligible for ABA services.

The PIHP will provide evidence from diagnosis and assessments to MDCH/BHDDA related to the child's functional abilities in the areas of Social Interaction and Patterns of Behavior. Evidence regarding diagnosis will be based on the ADOS-2, an instrument for diagnosing and assessing autism.

The independent evaluation requires that a re-evaluation be performed annually. A formal review of the individual plan of service (IPOS) will occur no less than annually with the child and family. Neither the ADOS-2 nor the ADI-R (or similar tool) are required for re-evaluation. The Vineland Adaptive Behavior Scales-Second Edition (VABS-2) is administered at intake, annually as part of the IPOS review, and whenever there is a level of change. In addition, a behavioral outcome measurement tool (Verbal Behavior-Milestones Assessment and Placement Program [VB-MAPP] or Assessment of Basic Language and Learning Skills-Revised [ABLLS-R]) is to be administered at intake and every six months. On an annual basis, MDCH/BHDDA will make the determination of continuing eligibility based on evidence provided by the PIHP that the child meets the needs-based criteria for the child to continue to receive the ABA benefit.

18.4.A. Needs Based Criteria

The child demonstrates substantial functional impairment in social interaction (as evidenced by needing ABA to address two or more items from A below) and significant functional impairment in age-appropriate activities due to the interference by restricted, repetitive and stereotyped patterns of behavior, interests and activities (as evidenced by needing ABA to address one or more items from B below).

A. Qualitative impairment in social interaction, as manifested by at least two of the following:
   1. marked impairment in the use of multiple nonverbal behaviors (such as eye-to-eye gaze, facial expression, body postures, and gestures) to regulate social interaction.
   2. failure to develop peer relationships appropriate to developmental level.
   3. lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest).

4. lack of social or emotional reciprocity.

B. Restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

1. encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
2. apparently inflexible adherence to specific, nonfunctional routines or rituals.
3. stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements).
4. persistent preoccupation with parts of objects.

The child may possess age-appropriate expressive and receptive language skills, learning [defined as cognitive development (DQ or IQ > 75)], self-care skills, mobility, adaptive behavior (other than in social interaction), and curiosity about the environment.

18.5 Independent Assessment

The independent assessment is performed by a psychologist who is fully-licensed, limited-licensed or temporary limited licensed by the State of Michigan (MCL 333.182 et seq.) and who has one year of experience working with children with ASD.

The independent assessment by the psychologist will determine recommendations for the intensity of the ABA service and should include cognitive testing. If cognitive testing is not completed at the initial assessment, it is required to be completed within the first quarter of intervention using one of the following cognitive assessment tools:

Cognitive Assessment Tools

Cognitive Assessment Tool	Age Range	Purpose of Tool
Mullen Scales of Early Learning	Children from birth to 5 years 8 months of age	Assesses motor, language, spatial processing skills, and global cognitive ability
Wechsler Preschool and Primary Scale of Intelligence-III (WPPSI-III) or Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV)	Children 2 years 6 months of age through 7 years 6 months of age	Assess processing skills and the child's global IQ
Differential Ability Scales-II (DAS-II)	Children 2 years 6 months of age through 17 years 11 months of age	Assesses a child's global cognitive ability

An adaptive behavior assessment (the VABS-2 Interview) must be administered at the time of cognitive testing. The VABS-2 is an adaptive behavior assessment that is used from birth to 90 years of age and is administered at intake, annually and whenever there is a level of change.

It is required that one of the behavioral outcome measurement tools (VB-MAPP or ABLLS in the table below) be used and administered by a Board Certified Behavior Analyst (BCBA), licensed or limited

licensed psychologist (LP, LLP), or CMHP who must possess a minimum of a master's degree from an accredited institution in one of the degree categories approved by the Behavioral Analyst Certification Board (BACB) every six months for every child that is receiving Early Intensive Behavioral Intervention (EIBI) and Applied Behavioral Intervention (ABI).

Behavior Outcome Measurement Tools

Behavior Outcome Measurement Tool	Age Range	Purpose of Tool
Verbal Behavior-Milestones Assessment and Placement Program (VB-MAPP)	Children from birth to 4 years of age	Assesses verbal behavior, play-based behaviors
Assessment of Basic Language and Learning Skills-Revised (ABLLS-R)	Children from birth to 8 years of age	Assesses expressive and verbal language

Other medically necessary assessments of other functional domains will be performed by appropriately qualified professionals to determine service needs leading up to development of the IPOS. Results from the independent assessment and any other medically-necessary assessments by qualified providers including, but not limited to, behavioral, psychosocial, communication/speech, occupational and/or physical therapy assessments, as well as health/medical concerns and psychosocial/family support needs, are information used in the person-centered planning process. Assessment and planning functions are completed by a planning team, with a case manager, supports coordinator, or other qualified staff overseeing the development of the IPOS. The strengths, needs, preferences, abilities, interests, goals and health status of the child are determined through pre-planning and the person-centered planning process using the results of the independent assessment, other medically necessary assessments by qualified providers, and the family. For children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach that encompasses the belief that the family is at the center of the service planning process and the service providers are collaborators.

The IPOS includes:

- the identification of outcomes based on the child's and family's stated goals;
- the establishment of meaningful and measurable goals to achieve identified outcomes;
- determination of the amount, scope, and duration of all medically-necessary services (including ABA) for those supports and services provided through the public mental health system; and
- identification of other services and supports the child and family or authorized representative(s) may require, to which the public mental health system will assist with linking the family or authorized representative(s).

The IPOS must address the health and welfare of the child. This may include coordination and oversight of any identified health care needs to ensure health and safety, such as medication complications, changes in psychotropic medications, medical observation of unmanageable side effects of psychotropic medications, or comorbid medical conditions requiring care. The IPOS must address risk factors identified for the child and family, specify how the risk factor may be minimized, and describe the backup plan for each identified risk. For example, a risk factor might describe how to ensure consistent staffing in the event of staff absence. The backup plan is that the agency has staff who are trained in the child's IPOS and can provide required services in the absence of staff. Each child and family must be offered the choice of working with a case manager, supports coordinator, other qualified staff, or an independent

facilitator to assist them in being actively engaged in the process of the development of the IPOS. The case manager, supports coordinator, or other qualified staff will perform the core requirements of case management. This will include linking the child and family back to the medical home, and assure linkage of planning and information to the child's PCP. The IPOS is a dynamic document that is revised based on changing needs, newly-identified or -developed strengths, and/or the result of periodic reviews and/or assessment. A formal review of the IPOS is to occur no less than annually with the child and family.

18.6 ABA Intervention

ABA services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) for an appropriate period of time, depending on the needs of the child and their family within their community. Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the child's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the child would typically be in school but for the parent's choice to home-school the child. Each child's IPOS must document that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) that are available to the individual beneficiary through a local education agency. The recommended service intensity, setting(s), and duration will be included in the child's IPOS, with the planning team and the family reviewing the IPOS at regular intervals (minimally every three months) and, if indicated, adjusting service intensity and setting(s) to meet the child's changing needs. Intensity includes the number of hours of intervention provided to the child. Service intensity determination will be based on research-based interventions integrated into an IPOS with input from the planning team.

Treatment methodology will use an ethical, positive approach to any serious behaviors (e.g., self-injury, aggression) based on a comprehensive bio-psychosocial assessment including, but not limited to, functional analysis/assessment performed by a BCBA. The use of punitive, restrictive, or intrusive interventions is prohibited during ABA. The use of restraints, seclusion, and aversive techniques are prohibited by the Michigan Department of Community Health (MDCH) in all community settings.

There are two levels of intensity within ABA Services: Early Intensive Behavioral Intervention (EIBI) and Applied Behavioral Intervention (ABI). The PIHP's Utilization Management will authorize the intensity of services prior to delivery of services. EIBI is available to any eligible child who has an ADOS-2 score that falls within the Autism range and is provided an average of 10-20 hours a week (actual hours as determined by an ABA plan and interventions required). EIBI is available for children 18 months through 5 years of age as defined by the child's ability to actively engage in the therapeutic treatment process. ABI is a level of intervention available for children 18 months through 5 years of age who have an ADOS-2 score that falls within the Autism or ASD range who are not receiving EIBI and is provided an average of 5-15 hours a week.

18.6.A. Early Intensive Behavioral Intervention (EIBI)

EIBI is a structured ABA program that relies upon discrete trial training (DTT) methods and incidental teaching opportunities that can be administered in a child's home or clinic setting. This intensive intervention is available for children who have Autism Spectrum Disorder and an Autism Diagnostic Observation Schedule (ADOS-2) score that falls in the classification range of autism. It is typically provided in the home or in a center, several hours per day, five to seven days per week, for two to three years. EIBI is used for

reducing intrusive, disruptive behaviors, and/or stereotypic autistic behaviors and for improving socially acceptable behaviors and communication skills. The EIBI consists of various evidence-based interventions. (Refer to the National Autism Center's [NAC] National Standards Report, 2009, Chapter 4 located on the NAC website. Refer to the Directory Appendix for website information.) A comprehensive assessment is utilized to identify goals for intervention. Evidence-based interventions include DTT which includes the following Established Treatments: Behavioral Package, Antecedent Package, Comprehensive Behavioral Treatment for Young Children, Modeling, Joint Attention Intervention, Naturalistic Teaching Strategies, Peer Training Package, Pivotal Response Treatment, Schedules, Self-Management, and Story-based Intervention Package. DTT and other interventions from the NAC National Standards Report, 2009 are utilized over the course of treatment to teach imitation skills; establish play behaviors; integrate the family into treatment; develop early expressive and abstract language; increase peer interactions, social skills, and academic skills; and move toward integrating the family into the community and school system.

The comprehensive, individualized ABA behavior plan is part of the child's IPOS and identifies specific targeted behaviors for improvement and includes measurable, achievable, and realistic goals for improvement. Ongoing determination of this level of service (every six months) requires evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with the use of reliable and valid assessment instruments, such as ABLLS-R or VB-MAPP. The IPOS is updated as the child gains new skills and addresses maintenance of acquired skills in a clear progression over the course of the intervention. The IPOS will be reviewed at regular intervals (minimally every three months) and, if indicated, adjusted for service intensity and settings to meet the child's changing needs. This intensive treatment involves training the parents/caregivers to continue the behavioral interventions in the home environment. Coordination with the school and/or early intervention program is also critical.

18.6.B. Applied Behavioral Intervention

The ABA Intervention requires that ABI includes behavioral interventions provided with a focal approach toward targeted goals. This intervention is available for children who have Autism Spectrum Disorder, who are not receiving EIBI services, and who have an ADOS-2 score that falls in the classification range of autism or autism spectrum disorder. Like EIBI, interventions include those from the Established Treatment list from the NAC National Standards Report, 2009 and are directed toward developing functional communication, independent self-care tasks, receptive language, expressive language, play behaviors, social skills, imitation, and/or any additional behaviors that will enable the child to more readily integrate with typically developing peers. ABI may include a Behavioral Package, Antecedent Package, Comprehensive Behavioral Treatment for Young Children, Modeling, Joint Attention Interventions, Naturalistic Teaching Strategies, Peer Training Package, Pivotal Response Treatment, Schedules, Self-Management, and Story-based Intervention Package that focus on teaching specific adaptive skills.

As part of the IPOS, there is a comprehensive, individualized ABA plan that includes specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals for improvement. Ongoing determination of this level of service (every six months) requires evidence of measurable and ongoing improvement in targeted

behaviors as demonstrated with the use of reliable and valid assessment instruments (i.e., ABLLS-R, VB-MAPP). If indicated, the ABA plan may adjust service intensity and setting(s) to meet the child's changing needs. The IPOS will be reviewed at regular intervals (minimally every three months). ABI includes training for parents/caregivers that continues the intervention outside of the ABI professional intervention to extend the treatment into the home.

18.7 Provider Qualifications

ABA services are provided to increase developmentally-appropriate skills to facilitate a child's independence. These services must be provided directly to, or on behalf of, the child by training their parents/caregivers, ABA Aides, and/or a Board Certified Assistant Behavior Analyst (BCaBA) to deliver the ABA services. The ABA services must be provided under the supervision of a BCBA, other appropriately qualified LP or LLP, or a Master's-prepared CMHP.

- LPs and LLPs must have extensive knowledge and training in ABA. Extensive knowledge is defined as having taken documented coursework at the graduate level at an accredited university in at least three of the following six content areas:
  - Ethical considerations
  - Definitions, characteristics, principles, processes, and concepts of behavior
  - Behavioral assessment, selecting interventions, outcomes, and strategies
  - Experimental evaluation of interventions
  - Measurement of behavior, and developing and interpreting behavioral data
  - Behavioral change procedures and systems supports
- The CMHP providing ABA services or supervising others must possess a minimum of a master's degree from an accredited institution in one of the degree categories approved by the BACB.
- The LP, LLP, or CMHP supervising the ABA plan must:
  - have one year of experience in diagnosing and/or treating children with ASD based on the principles of ABA;
  - enroll in a BCBA-eligible course sequence within one year of the time they begin providing ABA services;
  - complete all coursework and experience requirements; and
  - be certified as a BCBA no later than September 30, 2016.
- The LP and LLP must work in consultation with a BCBA, and the CMHP must be supervised by a BCBA. If the LP or LLP does not have the documented coursework as defined above, they are considered to be a CMHP requiring supervision by the BCBA.
- The BCaBA must have certification as a BCaBA through the BACB and work under the supervision of a BCBA. The BCBA must provide one hour of supervision for every 10 hours of direct treatment.
- Other Bachelor-degreed professionals (supervised by a BCBA) may provide direct provision of ABA services.

- The ABA Aide must be:
  - at least 18 years of age;
  - able to prevent transmission of communicable disease;
  - able to communicate expressively and receptively;
  - able to report on activities performed;
  - in good standing with the law;
  - able to perform basic first aid procedures; and
  - trained in the child's IPOS.

  The ABA Aide must also:

  - receive training in the principles of behavior, behavioral measurement and data collection, function of behaviors, basic concepts of ABA, generalization and its importance in sustainability of learned/acquired skills, and medical conditions/illness that impact behaviors.
  - work under the supervision of a BCBA, LP, LLP or CMHP overseeing the ABA plan, with one hour of supervision for every 10 hours of direct treatment.