ABA Provider Quality Monitoring Tool

GENERAL
The record is accurate and clearly legible to someone other than the writer.
Each page of the record identifies the member.
All entries in the record include the responsible service provider's name.
All entries in the record include the responsible service provider's professional degree and relevant identification number, if applicable.
All entries in the record include date where appropriate.
All entries in the record include signature (including electronic signature for EMR systems in accordance with Louisiana Administration Code, Title 48, Part 1, Chapter 7 at https://www.doa.la.gov/Pages/osr/lac/books.aspx, if applicable).
Each record includes member's address.
Each record includes employer and/or school address and telephone number, if applicable.
Each record includes preferred telephone number.
Each record includes emergency contact information.
Each record includes date of birth.
Each record includes gender.
Each record includes relationship and/or legal status, if applicable.
For members age 0 to 18, documentation of guardianship is included in the record, if applicable.
Each member has a separate record.
MEMBER RIGHTS
There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the member and/or legal guardian.
The Patient Bill of Rights is either signed or refusal is documented.
There is evidence of the member being given information regarding member's rights to confidentiality.
COMPREHENSIVE DIAGNOSTIC EVALUATION
Does the CDE in the member's record match the CDE used for the approval of services?
Comprehensive Diagnostic Evaluation performed by a Qualified Health Care Professional (QHCP) as determined according to the provisions of the Louisiana Administrative Code (LAC), Title 50, Part I, Chapter 11.
TREATMENT PLAN
Evidence the licensed professional supervising treatment performed a functional assessment of the recipient utilizing the outcomes from the CDE.
Evidence the licensed professional supervising the treatment developed a behavior treatment plan.
Evidence additional assessments **should** occur every six months, if applicable.
The behavior treatment plan identifies the treatment goals to increase or decrease the targeted behaviors.

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Treatment goals target a broad range of skill areas such as communication, sociability, self-care, play and leisure, motor development and/or academic.
Treatment goal *instructions* target a broad range of skill areas such as communication, sociability, self-care, play and leisure, motor development and/or academic.
Treatment goal instructions should break down the desired skills into manageable steps that can be taught from the simplest to more complex.
Treatment goal instructions must be developmentally appropriate.
Treatment goals must be developmentally appropriate.
The behavior treatment plan must be person-centered.
The behavior treatment plan must be based upon individualized goals.
The behavior treatment plan must delineate the frequency of baseline behaviors.
The behavior treatment plan must delineate the treatment development plan to address the behaviors.
The behavior treatment plan must identify long-term goals that are behaviorally defined.
The behavior treatment plan must identify intermediate goals that are behaviorally defined.
The behavior treatment plan must identify short-term goals that are behaviorally defined.
The behavior treatment plan must identify long-term objectives that are behaviorally defined.
The behavior treatment plan must identify intermediate objectives that are behaviorally defined.
The behavior treatment plan must identify short-term objectives that are behaviorally defined.
The behavior treatment plan must identify the criteria that will be used to measure achievement of behavior objectives.
The behavior treatment plan must clearly identify the schedule of services planned.
The behavior treatment plan must clearly identify the BCBA(s) responsible for delivering the services.
The behavior treatment plan must Include care coordination involving the parent(s) or caregiver(s).
The behavior treatment plan must Include care coordination involving the school, if applicable.
The behavior treatment plan must Include care coordination involving state disability programs, if applicable.
The behavior treatment plan must Include care coordination involving others as applicable.
The behavior treatment plan must include parent/caregiver training.
The behavior treatment plan must include parent/caregiver support.
The behavior treatment plan must include parent/caregiver participation.
The behavior treatment plan must identify objectives that are specific.
The behavior treatment plan must identify objectives that are measurable.
The behavior treatment plan must identify objectives that are based upon clinical observations of the outcome measurement assessment.
The behavior treatment plan must identify objectives that are tailored to the recipient.
The behavior treatment plan must ensure that interventions are consistent with ABA techniques.
The provider must address ALL of the relevant information specified in the LDH treatment plan template.
The behavior treatment plan must indicate that direct observation occurred.
The behavior treatment plan must describe what happened during the direct observation.

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If there are behaviors being reported by caregiver that did not occur during assessment/observation and these behaviors are being addressed in the behavior treatment plan, indicate all situations in which these behaviors have occurred and have been documented, if applicable.
If there are behaviors being reported that did not occur and these behaviors are being addressed in the behavior treatment plan, indicate all frequencies at which these behaviors have occurred and have been documented, if applicable.
If there is documentation from another source, that documentation must be attached, if applicable.
If applicable, there is any other evidence of the behaviors observed during the direct observation and that are proof of these behaviors, these must be reported on the behavior treatment plan as well.
The behavior treatment plan includes a behavior reduction plan completed by the licensed supervising professional if intervening with problem behavior.
If applicable, the behavior reduction plan includes a functional behavior assessment or analysis with a hypothesized function of all problem behaviors for which a goal is developed.
If applicable, behavior reduction plan describes the topography of all problem behaviors for which a goal is developed.
If applicable, behavior reduction plan states the frequency of all problem behaviors for which a goal is developed.
If applicable, behavior reduction plan states the duration of all problem behaviors for which a goal is developed.
If applicable, behavior reduction plan states the latency of all problem behaviors for which a goal is developed.
If applicable, behavior reduction plan states the intensity of all problem behaviors for which a goal is developed.
If applicable, behavior reduction plan includes behavior improvement goals with criteria for mastery.
If applicable, behavior reduction plan includes a plan for intervention that addresses the function of the behaviors for which goals were developed.
If applicable, behavior reduction plan identifies plan for strengthening functional replacement behaviors.
The behavior treatment plan shall include a weekly schedule detailing the number of expected hours per week for the requested ABA services.
The behavior treatment plan shall include a weekly schedule detailing the location for the requested ABA services.
The provider shall indicate the intensity of the therapy being requested.
The provider shall indicate the frequency of the therapy being requested.
The provider shall indicate the justification for this level of service.
If technician services are being provided, supervision by a licensed behavior analyst must be a part of the treatment plan.
The licensed supervising professional must frequently review the recipient's progress using ongoing objective measurement, at a minimum of 5 percent of the total direct intervention time spent providing applied behavior analytical services per month.

The licensed supervising professional must adjust the instructions in the behavior treatment plan as needed, if applicable.
The licensed supervising professional must adjust the goals in the behavior treatment plan as needed.
The behavior treatment plan should indicate if the recipient is in a waiver which can be determined by checking the MEVS/REVS system.

DOCUMENTATION
Documentation shall accurately state the nature of the services previously provided.
Documentation shall accurately state the nature of the services currently provided.
Providers shall have records that demonstrate, if technician services are being provided, that 2 hours of supervision by a licensed behavior analyst occurred for every 10 hours of services provided by a technician, unless otherwise clinically indicated and prescribed in the treatment plan.
Documentation shall accurately state the fees or charges.
Providers shall have records that demonstrate all codes were delivered to the proper client.
Providers shall have records that demonstrate all codes were billed and used properly.
Start and stop times shall be recorded for every code billed.
Start and stop times should be used following a break that is 12 minutes or longer.
Start and stop times should be used when there is a switch to a different billing code.
The daily documentation/log note shall include names of session attendees.
The daily documentation/log note shall include start time for each session.
The daily documentation/log note shall include stop time for each session.
The daily documentation/log note shall include a narrative of what happened in the session describing what programs/ interventions were run during the session.
The daily documentation/log note shall include a narrative of what happened in the session describing each attendees' responses to interventions through the session.
The daily documentation/log note shall include a narrative of what happened in the session describing each attendees' barriers to progress.
The daily documentation/log note shall include that all documentation must be individualized to each client.

CONTINUITY AND COORDINATION OF CARE
The record documents that the member was asked whether they have a PCP/APRN.
PCP/APRN's name is documented in the record, if applicable.
PCP/APRN's address is documented in the record, if applicable.
PCP/APRN's phone number is documented in the record, if applicable.
The record documents that the member was asked what other medical and/or ancillary services they are receiving.
Evidence of coordination of care between ABA services and other medical and/or ancillary services, if applicable.

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PATIENT SAFETY
If there is evidence in the record of suicidal/homicidal ideation/behaviors, there is documentation that appropriate precautionary measures were taken.
If there is evidence documented in the record for Abuse or Neglect, there is documentation that appropriate protective agencies are notified immediately upon discovery.

ADVERSE INCIDENTS
For members age 0 to 18, documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within 1 business day of discovery.
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency within 1 business day of discovery.
Documentation that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate.
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the health plan within 1 business day of discovery.

CULTURAL COMPETENCY
Primary language spoken by the member is documented.
Any translation needs of the member are documented, if applicable.
Language needs of the member were assessed (i.e., preferred method of communication), if applicable.
Identified language needs of the member were incorporated into treatment, if applicable.
Religious/Spiritual needs of the member were assessed.
Identified religious/spiritual needs of the member were incorporated into treatment, if applicable.
Racial needs of the member were assessed (e.g., oppression, privilege, prejudice…etc.), if applicable.
Identified racial needs of the member were incorporated into treatment, if applicable.
Ethnic needs of the member were assessed.
Identified ethnic needs of the member were incorporated into treatment, if applicable.
Sexual health related needs were assessed, if applicable.
Identified sexual health related needs of the member were incorporated into treatment, if applicable.

DISCHARGE PLANNING
Documentation of discussion of discharge planning/linkage to next level of care.
Course of treatment (the reason(s) for treatment and the extent to which treatment goals were met) reflected in the discharge summary, when member is discharged or transitioned to a different level of care.
A discharge summary details the recipient's progress prior to a transfer or closure when member is discharged or transitioned to a different level of care.