Attachment 10: Individual Service Definitions

The following services within the CBC Provider Agreement are defined as follows:

Maladaptive Behavioral Analysis/Assessment

Maladaptive behavioral analysis will be based upon the following:

a. Direct observation of the identified client;
b. Interviews with the identified client, family, Service Providers, and stakeholders;
c. Evaluation of the identified client's home and/or other settings where the identified maladaptive behaviors are exhibited and conditions in which they occur and do not occur;
d. Functioning level of the identified client;
e. Assessment of the family and Service Provider's skill set and community readiness;
f. Review of previous interventions used; and
g. Review of existing records and services (when available).

The Functional Behavioral Analysis/Assessment will include, at minimum:

- Reason for referral;
- Summary of observations (strengths, abilities, what works/ doesn't work, likes, dislikes);
- Identified behaviors/triggers (description of behaviors, intensity, frequency, durations, function);
- Additional identified problems (if any);
- Planned interventions/implementation; and
- Any other relevant observations regarding the client.

The Consultant will provide a copy of the written Maladaptive Behavioral Analysis/Assessment along with specific recommendations to the Service Provider and DBH.

Behavioral Intervention/Implementation Plan

The Consultant will develop a written behavioral intervention or implementation plan, based on observations, recommendations, and review of assessments. Plans will use techniques that are designed to decrease maladaptive behaviors while increasing positive alternative behaviors, or enhance system infrastructure. The plan will be developed collaboratively with all stakeholders and the Consultant. This service is intended to guide providers, families, and communities in identifying, developing, and maintaining the skills necessary to support individuals safely and effectively at the community level, and avoid institutional placement.

An individual's Plan of Care is the responsibility of the Service Provider. Recommendations from the Consultant (including recommendations for further testing/assessments) are evaluated for inclusion in the plan of care, but the final decision rests with the treating provider and client. Any additional testing/assessments, resulting from the Consultant's recommendations will be completed utilizing Alaska Medicaid providers as appropriate to the individual served.

The behavioral intervention plan will clearly delineate:

a. Salient factors that likely contributed to the dysfunctional behavior;
b. Interventions and activities designed to develop and stabilize replacement behaviors that serve the same function;
c. Frequency of the interventions and activities;
d. Individuals other than the person of focus who may also require programmatic intervention to ensure desired treatment effects for the person of focus and their behavioral support plans;
e. Resources (funding, people, time, programmatic access, training, etc.) required for the plan to be successful, including additional testing/assessments to be completed utilizing Alaska Medicaid Providers as appropriate;
f. Person(s) and entities responsible for implementing the interventions and activities;
g. Data elements required and a method for tracking implementation of the interventions and activities; and
h. Data elements required, a method for tracking identified client progress, and frequency for review of the behavior intervention plan for effectiveness and modification as necessary.

At minimum the plan will include:

- Identified behaviors/problem;
- For each behavior/problem-
  - Predictors/function related to demands;
  - Predictors/function related to activities/objects;
  - Predictors/function related to social attention/interaction; and
  - Predicators/function related to internal state.
- Summary statements of predicators;
- General Triggers;
- Behavior Precursors;
- Setting Events;
- Environmental Maintaining Consequences;
- Hypothesis;
- Interventions;
- Desired outcomes; and
- Recommendations.

The Consultant will provide a copy of the written Behavioral Intervention/Implementation Plan to the Service Provider and DBH.

Training and Technical Assistance

Training and technical assistance should be mutually agreed upon by the Consultant and the Service Provider, or project stakeholders (with approval from the Program Manager) driving the type and duration of technical assistance needed. While on site, the Consultant will:

a. Train the identified client's family, Service Provider staff or other stakeholders about implementing the behavioral intervention/implementation plan through modeling, mentoring and shadowing;
b. Share observations and offer suggestions about how to better interact with the client/stakeholders, implement the behavior plan/recommendations, and make modifications;
c. Based upon identified need, and upon prior approval by the Program Manager, offer a generalized behavior modification training for all agency staff as needed. Note: Training may include staff from multiple agencies since more than one agency may be working with individuals exhibiting similar behaviors or providing services to one individual; and
d. Based on identified project objectives, and upon prior approval by the Program Manager, offer technical assistance to key project stakeholders as needed.

In addition to the on-site training and technical assistance, the Consultant will provide on-going technical assistance to answer questions and problem solve through teleconferencing, video conferencing, or other means as directed by the Program Manager.

Transition Plan

Development of a transition plan for clients in institutional care will begin as soon as the Consultant has met the client and the Consultant and the Service Provider have reviewed the case and supporting clinical. To the extent possible, the transition plan will be developed five business days prior to the client's return to their home community.

Monthly Report

The Consultant will meet with the Program Manager monthly and provide written monthly updates for each client. The update should summarize the activities of the previous month and include at minimum:

- Reason for referral;
- Summary of what was accomplished that month;
- Impact of interventions/recommendations implemented;
- Client/Staff/Agency/Stakeholder response to interventions;
- Client response to recommendations and project activities;
- Trainings – family, direct care staff, agency wide, others;
- Client/Stakeholder response to trainings and technical assistance;
- Identified issues;
- Change in Status;
- Change in Providers;
- Summary of Progress;
- Next Steps; and
- Exit Strategy.

Service Completion (Discharge Report)

Five business days prior to ceasing services, the Consultant will provide a written report with summary of findings to include recommendations for the client's continued success. The Consultant will provide a copy of the written Discharge Summary to the Service Provider and DBH. The report will include, at a minimum:

- Date of Discharge from services;
- Reason for referral;
- Identified behaviors/issues;
- Summary of interventions/Strategies;
- Summary of Training;
- Client's/Stakeholder's response to Behavioral/Implementation plan;
- Agency/Stakeholder response to behavioral plan and trainings;
- Recommendations;
- Identified problems/issues (system, agency, CBC, etc.); and
- Conclusions/Summary Statement.