CASP

The Council of Autism
Service Providers

Organizational Guidelines & Standards

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An essential checklist will be provided for each chapter to be used as an organizational self-assessment.

I. Executive Summary

The CASP Organizational Guidelines and Standards Project articulates best practices for organizations providing evidence-based services to individuals with autism spectrum disorder (ASD). Until now, there has not been a published set of standards, guidelines, or resources specifically designed to address needs at the organizational level. The overarching goal of the document is to fill this void, and to help organizations committed to providing high-quality treatment ensure their sustainability and position themselves to grow the services and supports they are able to provide to individuals with ASD and their families.

This project is inspired by the new urgency for higher standards of care and our commitment to sustainable, effective care. With the increasing prevalence of ASD, mandates recognizing ABA as a treatment to be covered by health plans, the growing interest of governmental entities in service regulation, and the variety of economic pressures associated with treatment, autism provider organizations have no time to waste in establishing comprehensive organizational practice guidelines and standards.

While the guidelines and standards are written for service providers, they are intended to help all stakeholders: those who directly receive ABA services, their families, payers, regulators, and advocates — in short, all of those working to help providers deliver a high standard of care that is also cost effective.

The content covered in these guidelines and standards is divided into three general areas:

1. **OPERATIONS AND COMPLIANCE** covers corporate compliance, information management, leadership development, and organizational health.

2. **RISK MANAGEMENT** addresses concerns related to quality assurance, health and safety, grievances, and specific considerations that should be taken into account when providing services to individuals with autism.

3. **ENGAGEMENT** focuses on communication with stakeholders and marketing, as well as each organization's responsibility to contribute to and promote evidence-based research.

The following pages will describe the organizational structure, activities, and processes needed to deliver and sustain high-quality clinical services. These guidelines and standards are based on the best available evidence and clinical consensus of more than 75 professionals, consumers, and stakeholders specializing in evidence-based services.

ABOUT THE COUNCIL OF AUTISM SERVICE PROVIDERS

The Council of Autism Service Providers (CASP) is a nonprofit 501(c)(6) organization. Its membership is composed of not-for-profit and for-profit organizations serving individuals with autism spectrum disorder (ASD) and related disabilities. CASP serves as a force for change by leading in the development and dissemination of practices that enhance the quality of services. We are focused on helping to define sustainable, high-quality services.

We have 100+ member organizations which collectively account for more than $1 billion in service revenue to more than 50,000 individuals with autism across the life span each year. Our organizations come from every geographic region of the United States, as well Canada and South America. CASP member organizations vary in size from small regional agencies to large national providers. Organizations involved in CASP provide a range of services representing the spectrum of needs of individuals with ASD (e.g., intensive early intervention, intensive intervention for dangerous behaviors, school consultation, employment support, residential services, focused social skills training). Sources of funding for services is equally varied. Most members have multiple funding streams and contract with commercial and public health plans, state and local departments of special education, as well as federal and state disability services. Diversity across all of these variables means that CASP is vested in elevating the quality of services for all individuals with autism, regardless of demographics or funding stream.

CASP's Current Goals:
› Ensure quality, safe, and effective care
› Promote continuous quality improvement
› Help to ensure that the money spent for care and treatment is directed to the most effective, evidence-based practices
› Represent providers of care to government, payers, and the public
› Support members and educate them on organizational best practices as they balance effective treatment and economic principles
› Provide a platform for senior leaders to collaborate, share ideas, and solve problems related to operating autism service agencies

PROJECT PURPOSE

There are many resources available to guide practitioners focused on achieving certain behavioral and treatment outcomes. But until now, there have been no guidelines and standards for organizations that provide evidence-based treatment to patients with autism.

CASP's purpose is to develop a set of best practices for organizations providing services to individuals with ASD. Whereas existing resources mainly focus on clinical aspects of service delivery, these guidelines and standards also include the structural supports that need to be in place at the organizational level to help ensure that clinical services are implemented efficiently and effectively.

As the ABA field grows and more organizations are able to share knowledge and experience, providers benefit from sharing and defining best-practice policies and high-level criteria to best protect and support their clients and create a unified field. CASP seeks to promote this growth and exchange of information.

Another focus is ensuring that effective treatment is delivered in ways that are sustainable and cost effective. Effective treatment can be costly, and CASP is committed to helping identify ways in which organizations can provide cost-effective, high-quality services. We also note that the cost of no treatment, as well as ineffective treatment, is even higher.

These guidelines are based on expert opinion and best practices regarding the operation of ASD service organizations. CASP's goal is to provide an infrastructure to help organizations meet their mission of providing the highest quality of evidence-based care.

K. Telehealth

Telehealth service delivery models have the potential to extend the reach of existing health care resources and change how some behavioral health care is delivered. In rural and under-served communities with provider shortages and limited access to specialty care, telehealth service delivery models are critical for ensuring that patients can access appropriate care. They can also serve as a means to enhance care in urban communities. Additionally, telehealth models can help to reduce health care costs and improve the quality of care for patients in metropolitan and urban communities alike.

Telehealth has been increasingly leveraged across the health care industry to enhance the delivery and coordination of care. The rapid adoption and expansion of telehealth among the nation's leading health care systems have correspondingly led to its increased application within ABA treatment models. ABA providers should consider taking advantage of telehealth technology as a method to deliver parent training, client consultations, and comprehensive ABA treatment within tiered service delivery models.

K. Telehealth

I. Unique Challenges in Telehealth

As with any technological advancement, some unique challenges to the telehealth model have arisen that require careful consideration by ABA providers:

1. Training practitioners.

Much of ABA treatment takes place in close quarters in both one-on-one sessions and in group activities. Telehealth delivery of care changes this established structure somewhat. ABA providers beginning to implement a telehealth service model will need specialized training to ensure they can safely and effectively deliver care from a distance.

2. Establishing robust telehealth policies and safeguards.

Organizations incorporating telehealth service models must develop comprehensive policies and safeguards to ensure that patient privacy and confidentiality are maintained.

3. Mitigating cultural and socioeconomic barriers.

Given the geographic reach of telehealth service delivery, cultural and socioeconomic gaps commonly exist between patients and their providers. Providers should think about potential conflicts that may arise from these gaps and assess their ability to handle them prior to accepting patients into their care.

4. Dual relationships.

It is common for patients in rural communities to have existing relationships with local clinicians while also pursuing telehealth services. Unfortunately, conflict may arise from these dual relationships as the supervising provider may not be able to detect that professional boundaries are being challenged. Supplemental training may help clinicians and direct-care staff mitigate the ethical and logistical challenges that emerge from dual relationships.

5. Navigating telehealth rules and regulations.

Administrative oversight within an organization requires compliance with various laws, rules, and regulations. These regulations are often state specific and may include stipulations related to operations and practice such as licensure, the rules surrounding employment of telehealth practitioners residing outside the service area, supervision ratios and on-site visitation requirements, and the protocols for ensuring patient privacy.

K. Telehealth

II. The Telehealth Model

Telehealth is a *means of delivering health care*, not a separate or distinct health care service. It is a tool that allows providers to deliver the health care service directly to the patient using electronic telecommunication technologies without requiring the patient to travel to receive care (Health Resources and Services Administration). Telehealth services can be delivered using multiple modalities and can take place synchronously or asynchronously.

Synchronous Transmissions.
Synchronous transmissions refer to live, two-way video and audio interactions between the provider and patient. This is the most commonly employed modality within ABA treatment models and is often the only modality accepted by health care funders.

Asynchronous Transmissions.
Also described as "store and forward" transmissions, asynchronous transmissions include the transmission of electronic health records such as video, data, or other health information to a provider at another site for later review. Mobile health applications are gaining in popularity and are often used to record a patient's compliance with their treatment plan. Although asynchronous transmissions have multiple benefits, they may not be covered by health care funders authorizing ABA treatment and therefore are not as widely implemented.

These guidelines focus primarily on interactive, synchronous live-video streaming interactions between two sites with the purpose of delivering the same level of supervision and consultation that is delivered when the provider is on-site. They should be used to inform the delivery of ABA treatment for:

› Focused and comprehensive treatment carried out under a tiered supervision model. Under this model, a direct-care staff member is on-site with the client while a clinician supervises via telehealth technology.

› Parent training models under which a clinician provides a caregiver with instruction and coaching on ABA strategies to be implemented with the client.

It is recommended that providers refer to the *Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers* published by the Behavior Analyst Certification Board, Inc.® for clinical information related to ABA treatment models. See Recommended Resources.

K. Telehealth

III. Clinical Practice: Risk Assessment

Prior to initiating telehealth services, organizations should establish a formal patient admissions process to determine whether it is clinically appropriate to deliver ABA treatment using a telehealth service delivery model. Additionally, since the direct-care staff will need a secure internet connection to receive clinical supervision and access electronic health records, the provider needs to know whether the site can offer access to a secure connection or if the organization must supply a secure mobile internet device to staff.

Once it has been determined that both patient and site are eligible to receive telehealth services, a thorough risk assessment should be performed and any necessary changes implemented to prepare for treatment. Organizations will need to develop policies and safeguards to address the following:

A. Patient and Provider Safety. Organizations should have operational procedures clearly outlined for providers to ensure the patient can be safely served. Providers should assess the severity and frequency of aggressive and self-injurious behavior to determine whether they can maintain the safety of the patient, family, and direct-care staff.

B. Local Provider Expertise and Contact Information. Organizations providing telehealth services need to assess the local direct-care staff's training in managing aggressive and self-injurious behavior. In rural communities, organizations may be limited in their ability to treat a wide variety of cases if they do not have enough staff who possess the required expertise. Providers should identify local crisis intervention and emergency response resources and collect the family's emergency contact information prior to initiating services. All of this information should be kept with the patient's records for easy access.

C. Therapeutic Environment. Organizations should complete an environmental assessment, including a standardized and comprehensive review of the treatment site, to ensure that the environment is therapeutically beneficial and safe for the client and the direct-care staff. For example, features of a home such as a swimming pool may present a hazard to the client or the staff. As the supervising clinician may not be physically present at the time the home is assessed, these safety risks will need to be flagged by the provider making the assessment. Organizations should have protocols for addressing environmental modifications that may be needed in home, school, or community settings.

Providers also need to ensure that the family can access recommended therapeutic materials. A list of these materials and how to obtain them should be prepared so that all programs can be implemented as discussed and in a timely manner.

D. Technology Requirements. It is crucial that the patient and direct-care staff member be within view of the camera at all times for clinical supervision. Additional equipment (e.g., camera mount) may be required to optimize the clinician's view. The environmental arrangement should allow for the client and direct-care staff member to move freely within and across rooms within the treatment setting.

E. Informed Consent. Informed consent is a process that describes the benefits and risks involved in treatment and allows patients and caregivers to make informed decisions about services. Prior to delivering treatment under a telehealth model, providers should take care to educate clients about the benefits and risks involved in utilizing telehealth technology and detail what to expect from a telehealth encounter. Families should be educated in the different telehealth mechanisms employed by the organization (e.g., live-video streaming, store and forward), and providers should obtain consent for each modality and service provided.

K. Telehealth

IV. Technical Design

A. Privacy and Security:

Organizations practicing telehealth need to consider the unique methods in which protected health information (PHI) is transmitted through the telehealth model and should offer training so that providers thoroughly understand their legal and ethical responsibilities. ABA service providers are required to comply with the rules and regulations imposed by the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. To reduce liability, organizations need to provide ongoing oversight to ensure that providers are taking all necessary precautions to protect PHI within their everyday practice. Privacy recommendations relevant to telehealth service delivery and systems include:

1. Adopting an electronic health records system to ensure that PHI can be accessed, maintained, and transmitted securely.
2. Utilizing HIPAA-compliant, single-session video streaming software with the ability to lock meeting rooms.
3. Ensuring that all data from asynchronous methods are encrypted and transmitted securely.
4. Developing acceptable-use policies and physical-security policies for company-issued devices and telehealth equipment.
5. Updating all security software.
6. Developing security protocols for providers rendering telehealth from a home office location.
7. Outlining protocols for mobile device configuration, including a forced timeout after a brief period of inactivity.
8. Utilizing a software program that allows the provider organization to remotely remove data from company-owned devices.
9. Reporting the loss or theft of technology in addition to any breach or violation of privacy guidelines as soon as discovered.
10. Providing procedures for secure backup and restoration of electronic information.

B. Telehealth Hardware & Ancillary Equipment:

Provider organizations should strive to ensure that patients and providers have access to high-quality video and audio telehealth technology. Organizations should budget for both essential technology and supplemental equipment including:

Telehealth Clinician Equipment	Direct-Care Staff Equipment
Computer with a built-in or external webcam	Tablet technology
Second monitor and vertical monitor mount	Protective casing and mobile chargers for technology
White-noise machine for a telehealth home office for patient privacy	Mobile tablet mount for the direct-care setting
Headset for noise reduction and patient privacy	Wireless earbuds
	Visual diagrams demonstrating technology placement in a direct-care setting
	Wi-Fi extenders
	Mobile Wi-Fi device

Preliminary draft subject to change before final publication.

K. Telehealth

IV. Technical Design, continued

C. Connectivity and Bandwidth:

All telehealth services should be provided through a secure internet connection (e.g., Ethernet, wireless). Whenever possible, backup networks should be established to avoid disruptions due to connectivity issues. Video conferencing software should also adapt to changes in bandwidth without losing the connection between the patient and provider. Providers are encouraged to test bandwidth prior to initiating services to ensure an adequate connection. Protocols outlining contingency plans for loss of internet connection should be incorporated and planned for at the onset of treatment.

D. Telehealth Office Design:

The patient experience is a crucial component of any health care service as it aids in building trust and a strong therapeutic alliance. The physical arrangement of the provider site requires careful planning and foresight to create a professional environment that promotes efficient practices. The following design elements should be considered by the provider when creating an optimal video conferencing environment for telehealth services:

Background:
Make sure the background has minimal distractions and that any decor is professional.

Clothing:
Be mindful of the effect clothing may have on the patient's experience. Providers may want to avoid wearing clothing with patterns or bright colors when conducting video sessions.

Lighting:
Natural light is best; however, any type of light that mimics warm sunlight is ideal. Do not place lighting behind the provider's head, as this may hamper the provider's ability to adequately view the screen or create a shadow that limits visibility.

Monitor arrangement:
The optimal monitor arrangement is a vertical design, where one monitor is placed directly above the second monitor and the video camera is placed in between.
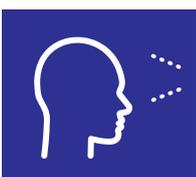
Camera angles:
The position of the camera is an essential component of creating a professional environment because it will either enhance or inhibit the provider's ability to simulate eye contact with the family. The ideal position of the camera is directly in front of the provider's face, just above eye level.

Preliminary draft subject to change before final publication.

K. Telehealth

Telehealth Case Example:
Involving Remote Family Members

A nine-year-old boy and his mother move to another state to access ABA treatment while the father remains in their home state to work. The closest provider the family can find in their new location is forty-five minutes away and unable to provide in-home services. Instead, the family contacts an agency that is equipped to provide telehealth.

The father visits the family every other month and remains active in his son's treatment. The telehealth clinician, recognizing the importance of ongoing parental involvement from both caregivers, schedules parent training and treatment review meetings with both parents via a secure video conferencing system. During these meetings, both parents are able to simultaneously participate in the meeting to discuss their son's progress and next steps for his treatment.

In addition, the telehealth clinician invites the father to her clinical supervision sessions. During the sessions, the clinician and the father observe the direct-care provider working with the client and discuss the procedures being implemented, the rationale, and the progress being made. When the father visits his family, he is up to date on his child's treatment goals and able to actively participate in intervention and goal advancement. Both parents report high levels of satisfaction with treatment and express a renewed hope for their son's future.

K. Telehealth

V. Business Infrastructure

Whether organizations are seeking to employ clinicians outside the state or provide telehealth services outside an established service location within the same state, a thorough understanding of relevant federal, state, county, and local laws and regulations is essential. In addition, organizations utilizing telehealth technology across geographic boundaries should extensively research insurance coverage plans, funding sources, and technology management resources. The following section breaks down some of the most important considerations organizations need to be aware of.

A. Federal, State, and Local Regulations:

Business Registration and Licensing.
Achieving compliance requires registration and licensing with a number of state and local agencies, including the Secretary of State, the state Department of Taxation, and the state Department of Labor. Prior to registering, some states may also require organizations to seek registration approval from relevant state practice boards. Provider organizations operating in multiple states must comply with provider licensure requirements in all jurisdictions where work is performed. Some states may also require a separate license to practice telehealth.

Taxation and Accounting.
Organizations are encouraged to engage an experienced corporate tax attorney to ensure compliance with state and local tax laws. Each state has specific requirements on how the organization's income must be reported and taxed based on the organization's legal structure, income sources, and where income is being generated. Employees who live in one state and work in another should consult with a tax professional to better understand tax implications.

Labor Law.
When hiring employees or engaging contractors, it is crucial to adhere to federal and state-specific labor laws. Organizations must thoroughly understand how laws ranging from worker classification to minimum wage to rest breaks apply to various workers. Organizations should engage professional legal counsel with experience in the state where workers are employed. The federal and state Departments of Labor are also excellent resources for both employers and employees.

State-Specific Telehealth Regulations.
ABA organizations and providers should familiarize themselves with and remain up to date on state-specific reimbursement laws and regulations surrounding telehealth within ABA services. Some states offer specific telehealth protections that require state-regulated commercial health insurance funders to reimburse telehealth services in the same way they would reimburse in-person care.

Mandated Reporting.
All autism service providers are required to comply with federal and state laws related to the reporting of suspected abuse or neglect of children and vulnerable adults. Organizations are encouraged to invest in state-specific, mandated reporter training for clinical and administrative staff members and should provide access to relevant reporting resources.

K. Telehealth

V. Business Infrastructure, continued

B. Liability Insurance Coverage:

Workers' Compensation Insurance.
All employers in the United States must obtain workers' compensation insurance policies covering staff in all states where work is performed.

Professional Liability Insurance.
Professional liability coverage is generally required when working under contract with health insurers, school districts, state Medicaid programs, and other funders. Organizations should verify that their professional liability policy covers telehealth service delivery as well as the providers in all locations where work is performed.

Cybercrime Insurance.
Organizations that rely on online transmission and storage of PHI should purchase a cybercrime insurance policy to protect the company against potential financial losses that result from cyberattacks.

C. Funding Requirements:

Jurisdiction considerations.
Organizations should conduct telehealth treatment consistent within the jurisdictional, regulatory, licensing, credentialing, malpractice, and insurance laws for their profession in both the jurisdiction in which their providers are practicing as well as the jurisdiction in which the patient is receiving treatment (American Telemedicine Association, 2014).

Patient benefits.
A benefits eligibility review should be conducted for each patient to verify that the patient's plan includes telehealth coverage. Telehealth guidelines and what the payer recognizes as a billable telehealth procedure can differ from one funding source to another.

Procedural codes.
Given that the same health care service is being delivered, the same procedural codes should be used when delivering services in-person and via telehealth. Reporting telehealth service delivery may require the use of specified service locations and modifiers to report which services took place at the originating (patient) site and which services took place at the distance (provider) site.

K. Telehealth

V. Business Infrastructure, continued

D. Information Technology (IT) Management:

Organizations should consider developing an infrastructure to oversee the governance of company-owned technology and technological operations and take the following steps to establish parameters for IT management:

› Understand cost and establish a budget for the required technology and the administrative management of that technology.

› Establish a system for managing inventory.

› Establish procedures for distribution, loan, and return of company-issued technology.

› Provide technological training and support to staff, ensuring that staff understand how to operate and optimize technology in addition to understanding their legal and ethical obligation to protect PHI.

› Establish procedures for maintaining, repairing, deactivating, disposing of, and replacing problematic devices.

› Obtain and maintain Business Associate Agreement (BAA) with entities such as telemedicine platforms regarding responsibilities related to PHI per HIPAA requirements.

K. Telehealth

VI. Coordination of Care

A. Therapeutic Alliance Within the Home:

A successful telehealth service delivery model requires that providers, patients, and families work together as a team to provide optimal care and ensure a healthy treatment environment. Telehealth providers are encouraged to identify potential barriers to developing this therapeutic alliance. For example, some families may not be comfortable meeting with a provider via video conference or may have difficulty navigating the required technology. Provider organizations are encouraged to collaborate with families and to develop support resources to ease the introduction of technology, enhance the patient experience, and establish appropriate treatment plans. The therapeutic alliance should remain a top priority and be continuously evaluated throughout the course of treatment.

Establishing protocols to guide clinicians through telehealth service initiation and the establishment of new relationships via technology will be beneficial. Introductory protocols may include completing test calls with families to ensure their comfort with the technology or sending an on-site provider to the home to initiate introductory video conference calls.

B. Community-Based Services:

Community-based treatment offers a variety of benefits including increased access to social environments and longer-term maintenance of positive outcomes. When providing services in a community setting, the provider needs to be familiar with what resources are available. Initial meetings followed by clearly defined communication protocols are critical to the success of community collaboration via telehealth. ABA service providers are encouraged to develop an interview process to learn about the culture at the community site as well as to define the roles and responsibilities of relevant stakeholders. Moreover, they need to ensure that stakeholders understand telehealth services, feel comfortable with the technology, and are confident their privacy will be protected.

Community partners often require education in the telehealth service delivery model and assurances that all video-streaming observations are private and secure. Consider a school-based setting. School-based telehealth services allow service providers to functionally address the symptoms of autism that interfere with a student's ability to access education. Generally, this poses minimal disruption to staff and students. However, the school as a community partner may require informed consent from all parents for the clinician to observe the classroom through real-time video streaming. If the school does not approve of real-time observations of the patient while other children are present, the provider may need to find an alternative therapeutic environment or modify the treatment plan. Providing one-on-one services in a private space may not be conducive if the client's goals are primarily targeted toward the acquisition of social skills.

Providers rendering services via telehealth have the responsibility to identify local resources and referral sources for families. Provider organizations are encouraged to maintain a referral database for each state or community where services are rendered to assist them with coordinating care.

C. Clinical Continuing Education:

Providers are encouraged to seek continuing education and mentorship in telehealth service delivery to stay apprised of technological advances and continue delivering high-quality care. Continuing education in the following areas is critical to achieving meaningful outcomes for families: telehealth service delivery models and practice recommendations, supervision requirements for direct-care staff, effective parent coaching, therapeutic alliance development, facilitation of family engagement, privacy and security in a telehealth office space, and technical competence.

K. Telehealth

Telehealth Case Example:
Sleep Protocol

A telehealth clinician is supervising ABA treatment for a five-year-old boy diagnosed with ASD. The client's mother serves as his primary caregiver and reports that the client is unable to self-soothe during nap and bedtime, which has resulted in extensive bedtime rituals and co-sleeping. Further, he engages in severe tantrum behavior when awakened. The client's mother reports high levels of stress and exhaustion and requests support to improve her child's sleep habits.

Although the client's family lives in a metropolitan city, the clinician's long commute impedes her ability to provide on-site daily support. Additionally, the current treatment authorization does not cover implementing intensive sleep protocols. The clinician prepares a parent-implemented sleeping protocol and schedules a meeting to review the procedures and obtain consent. The clinician also schedules clinical overlaps at the beginning of the sleep routine and conducts a daily check-in with the family to review the client's progress and determine the need for protocol modification.

Per clinical guidelines, the parent consults with the clinician after three hours of unsuccessful attempts to get the client to sleep. Through the use of headphones and a secure video conferencing feed, the clinician discreetly coaches the mother through environmental modification and implementation of the sleep protocol. By providing the parent with clinical support at the time it is needed most, the clinician strengthens the therapeutic alliance and improves the mother's confidence in implementing the protocols independently. Through consistent parent implementation, the client successfully sleeps in his own room two weeks after this encounter.
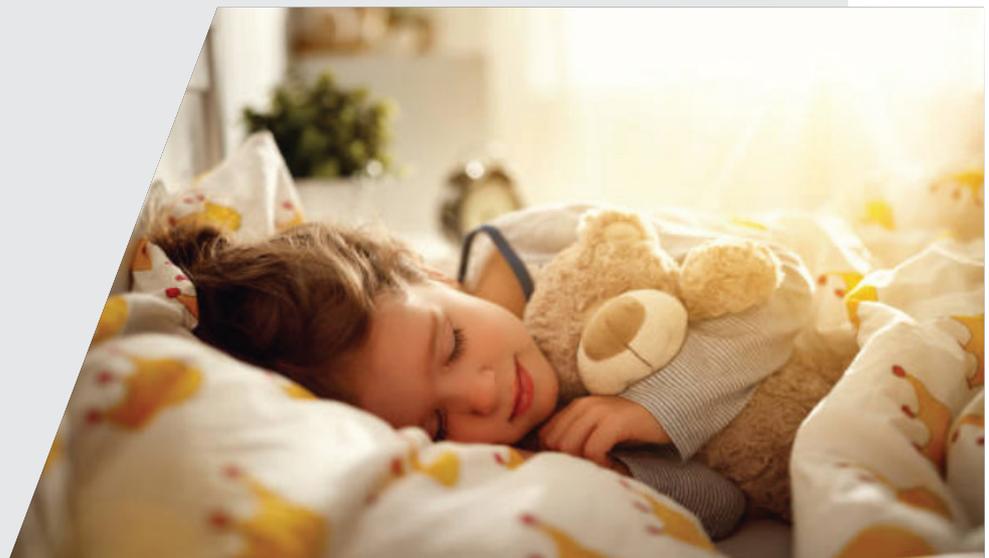
K. Telehealth

Recommended Resources:

American Telemedicine Association. (2014). Core operational guidelines for telehealth services involving provider-patient interactions. Retrieved from: http://www.americantelemed.org

Behavior Analyst Certification Board (BACB). (2014). Applied behavior analysis treatment of Autism Spectrum Disorder: Practice guidelines for healthcare funders and managers. Retrieved from: https://www. bacb.com/wp-content/uploads/2017/09/ABA_Guidelines_for_ASD.pdf

Health Resources and Services Administration (HRSA). (2018). Telehealth programs. Retrieved from: https://www.hrsa.gov/rural-health/telehealth/index.html

D. Crisis Prevention and Management

Crises such as physical or sexual abuse, financial malfeasance, or a client fatality are the nightmare of every autism service provider. A crisis not only presents a significant liability, but also typically results in regulatory and licensing implications, negative media coverage, and tensions between staff and clients. Unfortunately, the occurrence of adverse events is not a matter of if, but when. Poor handling of a crisis can taint an organization's reputation—at best—or shut down an organization—at worst.

Organizations are wise to arm themselves with insightful strategies to not only prevent crises from occurring, but to prevent the organization from being toppled when a crisis does occur. The following sections discuss the importance of pre-crisis planning, management of the crisis during and directly after its occurrence, reporting requirements, internal and external communications and media relations, and action to be taken post-crisis.

D. Crisis Prevention and Management

I. Unique Challenges in Crisis Management

While crisis management in any type of organization takes considerable planning, preparing for and responding to emergencies in an ABA setting poses some unique challenges.

Client Population:	Multiple Settings:	Communications and Confidentiality:
Individuals with autism may be prone to self-injurious behavior or violent reactions that can trigger crises other types of organizations do not need to prepare for as diligently.	ABA provider organizations need to not only prepare for crises that can strike any organization with staff and property, but also for events that could impact the care centers, hospitals, mental health facilities, and schools in which they provide treatment.	When a crisis event occurs, provider organizations must quickly and competently communicate with stakeholders and the public about the event and maintain client confidentiality throughout the process. Poorly phrased messaging can result in potential liability to the organization.

II. Crisis Management System

The autism services industry is prone to crisis situations by its very nature. While the possible scenarios are many and varied, they tend to fall into three broad categories:

› **Physical harm** includes injury, death, or abuse to students or staff. It may be accidental, intentional, or the result of negligence.

› **Malfeasance** includes an array of ethical, behavioral, and criminal actions such as racist or sexist conduct, verbal abuse, theft, or financial improprieties.

› **Site destruction** includes property-related events such as fire, flooding, vandalism, or other damage to an organization's buildings or grounds.

Pre-Crisis Planning

Careful preparation is key to successfully navigating a crisis, and every crisis management system needs a crisis manual that sets forth a basic plan for response and investigation, and a crisis management team who will execute it.

D. Crisis Prevention and Management

II. Crisis Management System, continued

A. Crisis Manual:

A crisis manual is created by the organization's management and department heads. It should be updated as needed and include:

> › Step-by-step procedures for different crisis scenarios
> › Emergency response and evacuation procedures
> › Checklists for processes and reporting requirements
> › Sample forms for fulfilling state agency reporting requirements
> › Emergency contact information for staff, emergency responders, legal counsel, state agencies, and insurance companies
> › Guidelines for internal and external communications
> › Placeholder or template messaging for likely crisis scenarios
> › Social media policy and recommendations

While most of these elements will be tailored to each organization's unique setup and risk scenarios, samples of general responses, reporting requirements, and guidelines for communications and social media are provided in Section III.

B. Crisis Management Team:

Every organization needs a crisis management team of carefully chosen, well-trained, and reliable staff members and others who will competently execute the response plan set forth in the crisis manual. Involved staff members should review the crisis manual regularly and be tested on their comprehension so they thoroughly understand their specific role in a crisis. A crisis management team may include:

Legal counsel. Keeping a legal expert familiar with the organization's business and potential conflicts (civil and criminal) close at hand allows an organization to more confidently execute internal and external communications following a crisis. Additionally, retaining a lawyer before civil litigation ensues keeps privileged information confidential.

Communications experts. Open communication, both internal and external, is vital after an incident, and communications experts who are careful to avoid negative tones and recrimination should be readily available to respond publicly to a crisis event.

CEO and executive leadership. Leaders at the executive level represent an organization to the outside world and are responsible for guiding it through a crisis and implementing solutions to immediate problems.

Staff trained in emergency response and first aid. Staff members who act as part of the crisis response team should regularly update their skills and be prepared to assist in a variety of crisis events.

D. Crisis Prevention and Management

II. Crisis Management System, continued

An organization's crisis management team should also develop close relationships with local emergency response teams (e.g., police, fire department, emergency medical services). Having a ready response team that is familiar with the organization's setup and practice can be of enormous benefit during a crisis. Additionally, the organization's board of directors should strive for open communication with third-party inquirers (e.g., insurance companies, state agencies, parents, funders) about the organization's emergency preparedness plans.

C. Training and Practice:

Once the crisis manual and crisis management team are established, run regular drills to keep your organization on its toes. Test response times, expose gaps, and make improvements. Develop muscle memory for crises so that when one strikes, the organization is prepared to handle it. In addition to the crisis management team, all staff should be trained in emergency response, evacuation protocol, and the response plan outlined in the crisis manual.

D. Insurance:

ABA provider organizations need to carry appropriate levels of insurance to prepare for potential liability following a crisis. An organization should determine whether its insurer will support up-front defense against criminal or liability issues following an adverse event. Negotiating this type of arrangement with an insurance company when purchasing a policy can save organizations from significant financial hardship in the case of a future settlement.

E. Day-to-Day Management:

Beyond a crisis manual, a well-trained crisis management team, and insurance coverage, day-to-day administration of the organization should consistently work to reduce the likelihood of a crisis occurring. Good crisis management includes attention to hiring practices; appropriate supervision of employees; quarterly or annual evaluations of staff; consistent training on health, safety, and compliance issues; and open access to reference materials that define the organization's policies and procedures.

D. Crisis Prevention and Management

III. In the Event of a Crisis: Response and Investigation

When a crisis occurs, an organization must respond on several levels to manage the immediate consequences and potential fallout. The responses can be divided into three phases: operational response, management response, and public response.

A. Operational Response:

The operational response includes activating the crisis management plan outlined in the manual, notifying the crisis management team, and notifying emergency personnel and stakeholders of the incident as needed. Organizations should also contact their attorney and other third-party experts for advice on future actions (e.g., whether they need to seek independent counsel). Communications at this stage should be carefully controlled until the crisis has been assessed.

B. Management Response:

The management response involves a thorough investigation of the incident. The organization needs to immediately determine what happened, whether any staff is culpable for the incident, and the implications of the event. Be aware that anything you say to licensing agencies, the press, state officials, parents, or staff can ultimately be used later in a criminal, civil, or licensing proceeding.

A criminal investigation may also occur, involving state or local police or a medical examiner. The organization's management needs to ensure that the organization cooperates fully and provides all necessary documentation of the incident. You can assume that any time a client dies or is severely injured in your care, whether or not it was accidental, a criminal neglect or criminal intent charge will be pursued in addition to civil litigation. State agencies may also prepare an inquest into the incident or the organization more generally. Section IV delves into reporting requirements in more detail.

C. Public Response:

In the aftermath of the incident and its investigation, the organization may need to release a public statement about the event. A public statement should include the corrective action the organization plans to take. It should also detail its efforts to rebuild the program's reputation as necessary. All communication from the organization should be controlled, carefully crafted, and delivered by the CEO or president. See Section V for more recommendations on communications protocol.

D. Crisis Prevention and Management

IV. External Reporting Requirements

It is imperative to inform appropriate local authorities, state agencies, insurance agents, and other stakeholders (e.g., parents and guardians of clients) of any crisis that occurs. Insurance carriers must immediately be notified in writing of all claims or potential claims that arise from harm or injury to a client. Be aware that other reporting regulations vary by state. Keep relevant contact information and any state-specific emergency response forms in the crisis management manual for easy reference. When reporting harm that has occurred, be judicious about how information is crafted and how the event is described. Additionally, be aware of statements that may sound like admissions of liability or culpability.

| STATE Agencies | LOCAL Authorities | INSURANCE Agents | FAMILIES and Other Stakeholders |

In some cases, a reportable event necessitates a review of the incident and the associated program by state agencies. The state review, which may play out in civil or criminal litigation, can result in a substantial corrective action plan and a list of specific areas of noncompliance needing stricter management. If the list is significant and the organization is found to have operated improperly, sanctions may be levied against it, including a freeze on new referrals to the program. Most attorneys will counsel cooperation with the state agency, families, and staff members to stabilize the situation and maintain positive relationships with the state. Organizations should then take appropriate actions to improve their management practices.

V. Communications

There is the process of communication, and then there is the substance of communication. Preparing sample messaging for a variety of scenarios will improve efficiency in case of an event. Have legal counsel approve the final text of any statement before it is issued.

Message Template:

Consider the crisis scenarios your organization may face and prepare placeholder messaging for internal/external communications. This will accelerate your response time if a similar-type crisis were to occur. The text will be adapted to the facts of the actual event at the time the statement is issued.

Tone:

The tone of messaging should be open, honest, action-oriented, and apologetic. If a mistake was made, discuss the steps that are being taken to rectify it and to prevent a reoccurrence.

Medium:

Crisis messaging should be delivered via the communication mediums preferred by your stakeholders; e.g., press statements, letters, emails, media responses, social media posts, or a verbal script.

D. Crisis Prevention and Management

V. Communications, continued

A. Public Communication Sequence:

The communications sequence depicted below should begin as soon as possible so that parents and stakeholders can be notified immediately that an event has occurred. These four statement types form the basis of internal and external communications, whether they are provided in writing or delivered by an executive spokesperson. Variations on the content can be used for responding to questions, social media posts, or publication in other mediums. It is worth mentioning again that all statements should be approved by legal counsel before being issued.

| STAGE **1** Holding Statement | STAGE **2** Statement to Key Stakeholders | STAGE **3** Summary Public Statement | STAGE **4** Follow-Up Statements |
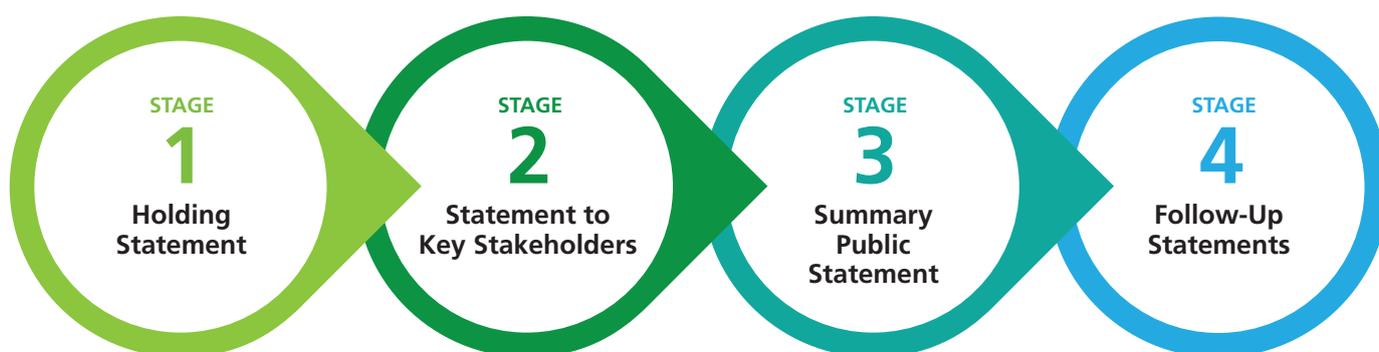
Stage One: Holding Statement
Prepare a brief holding statement for need-to-know parties as soon as possible. The holding statement provides the most basic facts of the incident, advises relevant parties that a crisis event is occurring or has occurred, and begins to actively control the narrative of the situation. The holding statement buys time for a more detailed follow-up statement. It is not an invitation for the media to ask questions. Be aware that confidentiality issues may preclude the release of certain information.

Stage Two: Statement to Key Stakeholders
Depending on the severity of the crisis, issue a short communiqué to key stakeholders (e.g., board members, key funders) apprising them of the event's status and to assure them that proper procedures are being followed to resolve it. The communiqué should be sent on the same day the event occurred or the following morning.

Stage Three: Summary Public Statement
A detailed public statement includes the who, what, when, where, and why of an event. The text from placeholder messaging can serve as an outline for documenting the facts of the current incident. The more transparent the message the better. Media statements are typically the most highly detailed as they are written to address questions from reporters and investigators. However, confidentiality requirements may prevent the disclosure of certain information.

Stage Four: Follow-Up Statements
Follow-up statements may be necessary to close the communication cycle with the media and the organization's stakeholders.

D. Crisis Prevention and Management

V. Communications, continued

B. Statement Format and Sample Placeholder Messaging:

The outline below is a paragraph-by-paragraph breakdown of the content that should be included in a summary public statement. The hypothetical narrative following the outline is an example of a placeholder message that should be part of the crisis manual.

1st Paragraph: The Overview
The overview details the date, time, and location of the incident; it provides a statement of what happened and to whom, and outlines the organization's response.

2nd Paragraph: Further Details
If confidentiality requirements permit, an additional layer of detail can be provided to describe the specific sequence of events, the responses that occurred during and after the event, a description of the client(s) and the characteristics of their diagnosis, the staff members present, and the procedures followed (if applicable).

3rd Paragraph: Client and Family Focus
If relevant, this section would discuss the client's current status, family notification status, and any client/family/staff support or counseling offered.

4th Paragraph: Internal Investigation
This paragraph would be a discussion of any relevant organization staff training, supervision, and procedural issues; internal investigation details thus far, including staff/students/witnesses interviewed; cooperation with external agencies; and a road map for ongoing investigation. The level of detail may be contingent on confidentiality requirements.

5th Paragraph: Notifications and External Investigations
This paragraph provides details of notification to law enforcement and state agencies; the organization's full and open cooperation with outside investigations; status of police/fire/state/local agency investigations; and anticipated next steps.

6th Paragraph: Wrap Up
Finally, acknowledge the gravity/tragedy of the crisis; reiterate the focus on safety; highlight the successful track record of the organization and the professional training provided to staff (if applicable); pledge to fully investigate and, if necessary, make changes to policy, training, etc.

D. Crisis Prevention and Management
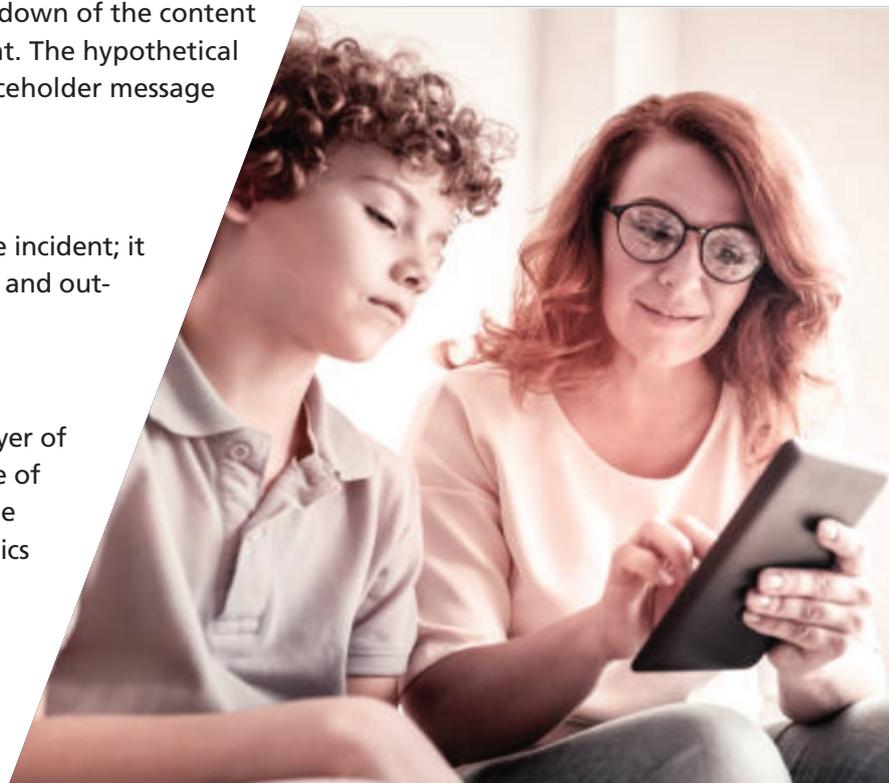
V. Communications, continued

Sample Messaging

Yesterday morning at 10:30 a.m., a client initiated a violent altercation with another client resulting in serious injury to the client and mild injury to an Organization provider. The clients were in a room in the main building, where a disagreement with another client arose over an iPad. It very quickly flared into an argument and fight. A staff member immediately interceded and restrained the violent client, whose continued struggling required a second staff member to aid in subdual of the client.

The injured client was immediately treated by Organization Health Services. He was transported by ambulance to City Hospital where he received five stitches on his head from the injury. He was hospitalized for one day under observation and released the following day. The staff member was treated by Organization Health Services and did not require a hospital visit.

Parents of both clients were immediately notified. The parents of the injured client joined their son at City Hospital. Organization notified the necessary state and local agencies including X, Y, and Z.

The aggressor client is diagnosed with autism and a seizure disorder. He functions at the severe level. He has had behavioral issues including self-injury and aggression, both of which were, until this recent incident, under control with positive reinforcement-based behavioral programming.

Given that our client population includes children with severe cases of autism who may pose a threat to others or themselves, we take the issue of safety very seriously. Clinicians and staff members receive special training to detect emotional turbulence and prevent adverse behavior. Staff members often wear protective clothing and are present in higher staff-to-client ratios than would be necessary for less severe cases. Teaching aids such as tablet computers are padded. Despite such precautions, unpredictable behavior does occasionally surface. We have started an immediate investigation and review of safety procedures and protocols.

D. Crisis Prevention and Management

VI. Media Relations

While adept crisis management can sometimes contain a crisis and prevent exposure in the media, often this is impossible. Skillful media relations—media to include traditional print, television and radio broadcasts, on-line websites, and social media sources—can make the difference between a modulated crisis and a disaster. Keep in mind the following pointers:

Be Prepared.

Following the best practices defined in your crisis manual, your organization should have placeholder messaging and written statements on hand for the media. Again, be cognizant that confidentiality issues may prevent the release of names or other information.

Individualize Communications.

The appropriate frequency of communications may vary depending on the character of the individual crisis. An initial statement and closing post-investigation statement may be enough in some cases. A more severe or ongoing crisis may require multiple rounds of statements or interviews.

Control the Conversation.

Written statements are controlled and limited. Media interviews are open ended and unpredictable, even to those who may be media trained. Ongoing investigations may legally prevent you from discussing the case in detail, so be wary of giving interviews. In these circumstances, the conclusion of the investigation may permit a final statement or resolution to be shared, which may be satisfactory.

Get It Right.

Speed, transparency, and accountability gain the trust of both the public and the media. Stonewalling and defensiveness will be conveyed through the media and can result in potentially negative impressions of the organization.

Follow Up.

If the media misrepresent the story, contact the reporter for a correction. The Letters-to-the-Editor section of the newspaper is another avenue for feedback. If the outcome of an investigation is favorable to the organization but has not been reported, contact the news outlet to follow up on it.

D. Crisis Prevention and Management

VI. Media Relations, continued

Social Media

Depending on an organization's particular client base and their previous media interactions, social media may be a primary channel of communication. Twitter, Facebook, Instagram, and other social media platforms can quickly disseminate the news of a crisis. More and more often, social media actually breaks news ahead of the traditional media. Control social media as you do all corporate communications, and be careful not to discuss facts beyond your prepared holding and summary public statements.

Monitoring social media during and after a crisis helps an organization catch mentions of the crisis and respond accordingly. Social media communication may range from several to dozens of posts, including from individuals who retweet, repost, or comment on the issue through their own accounts. If possible, request that the conversation be taken offline by initiating one-on-one communication with the person(s) directly impacted by the crisis. Once reports have made it to social media, even if they are taken down, be sure to provide updates on the investigation and report the resolution on the same platforms in which the reports started. This helps to "close the loop" in the social sphere and reinforce the organization's transparency. If the social media sphere is silent regarding the crisis, it is not necessary to spread the bad news proactively. During a period of public crisis, an organization's "business as usual" social media activity should be constrained. Maintaining upbeat or off-topic posts during a public crisis may be viewed as insensitive.

Set a social media policy as part of your employee handbook and emphasize that employees should not respond via social media to negative posts. Examples of negative social media posts include parent complaints about the organization; inappropriate or offensive posts, photographs or videos; and posts compromising client confidentiality. Avoid extended back-and-forth social media conversations with posters who are emotional or argumentative.

D. Crisis Prevention and Management

VII. Post-Crisis Analysis and Steps for Improvement

Once a crisis has run its course, stakeholders and the media have been addressed, and damages paid to the extent possible, the organization should conduct a self-review of the incident, taking the following steps to prevent a reoccurrence.

Post Event Analysis

After the crisis resolves, rigorously examine your policies and procedures to discover flaws or areas for improvement.

Take Action Regardless

Even if your organization is not at fault, it is likely there are steps that can still be taken to help your constituents feel better about the situation going forward and possibly prevent a reoccurrence.

Institutional Reinforcement

Having best-practice policies outlined in human resources handbooks, organizational procedures, and the crisis manual is vital to preventing future crises. Review these documents regularly to ensure proper discussion of crisis prevention and response.

Rebuilding Your Brand

A crisis can taint or destroy your organization's reputation. It may be necessary to proactively rebuild your brand through marketing and public relations. Highlight new solutions and policies. Demonstrate positive achievements through human interest stories and other media posts. Eventually, success will once again define your organization.

V. CASP History and the Development of Organizational Guidelines and Standards

CASP HISTORY

In 2009, leaders from ten provider agencies met in Las Vegas for a unique conference. From this modest beginning, The Council on Autism Services (CAS) was formed. The goal of this group was to provide a forum for senior executives from like-minded organizations to meet, share ideas, and solve problems. In 2010, the invitation to participate was extended to other agencies that demonstrated a commitment to serving individuals with ASD using evidence-based treatment approaches. Responding to participant feedback, CAS pledged to remain small and offer a different kind of opportunity to interact with colleagues through short workshops, discussion groups, roundtables, and informal networking.

In 2015, leaders of CAS recognized the need to formalize the association to meet growing needs of the providers and individuals they served. A small group of agency leaders met to identify the mission and values and set the strategic direction of the new association. The name changed from The Council of Autism Services to The Council of Autism Service Providers (CASP), and it was established as a 501(c)(6) organization in December 2015.

Founders of CASP recognized the need for a strong national voice for autism providers and the need to both lead and train leadership of organizations whose mission is to offer evidence-based services in ways that are sustainable and cost effective.

While there are successful associations representing parents and self-advocates, the priorities of these groups may not always align with the needs of provider agencies, including the need to establish organizational guidelines and standards regarding operations and clinical care. Consumers and payers are demanding results, and CASP is working to establish guidelines and standards and define expected outcomes from high-quality, evidence-based treatment.

CASP supports its members by cultivating, sharing, and advocating for provider best practices in autism services. It envisions a world where high-performing, responsible provider organizations will provide only quality care and ensure the best possible outcomes for all individuals with autism.

CASP Values:
- › Transparency
- › Collaboration
- › Accountability & Responsiveness
- › Engagement
- › Continuous Improvement
- › Evidence Based
- › Connecting/Networking

GUIDELINES AND STANDARDS DEVELOPMENT PROCESS

Domains, procedures, structures, and processes critical to the successful operation of organization that provides effective treatment to individuals with ASD were identified by CASP board members and 12 stakeholders representing consumer groups and those with organizational leadership and operational expertise.

More than 75 leaders and subject-matter experts have been recruited to provide content and identify resources for specific domains. Members of the steering committee collaborated on reviewing and revising content which was then edited in collaboration with a writer, a copy editor, and a graphic artist.

The project is being carried out in phases with Part I scheduled for release in 2020.

VII. Appendix

ESSENTIAL CHECKLIST:

Telehealth

WRITTEN POLICIES AND PROCEDURES	YES	NO	N/A
Written policies are in place that guide telehealth service delivery and address patient and provider safety and privacy (e.g., environment assessment, secure internet connection).			
Acceptable-use policies and physical-security policies for company-issued devices and telehealth equipment are defined in writing.			
Written procedures outline how to securely back up records; restore data; and deactivate, dispose of, and remotely remove data from company-owned devices.			

DOCUMENTATION	YES	NO	N/A
Electronic medical records and telehealth data (e.g., video) encryption, storage, and transmission are HIPAA compliant.			
Informed consent documents are discussed and signed by families and by all stakeholders affected in other places of service (e.g., school setting).			

OVERSIGHT	YES	NO	N/A
The organization uses a formal client intake process to ensure that it is clinically appropriate to deliver ABA services via telehealth modalities.			
The organization identifies local emergency response resources and collects the family's emergency contact information prior to initiating service. All of this information is kept with the patient's records.			
The organization maintains appropriate insurance coverage, including policies for workers' compensation, professional liability, and cybercrime.			
The organization thoroughly understands relevant federal, state, and local regulations and maintains appropriate registration and licensure.			
A benefits eligibility review is conducted for each patient to verify that the patient's plan includes telehealth coverage.			

DISSEMINATION, ACCESSIBILITY, AND TRAINING	YES	NO	N/A
The organization has established procedures to report the suspected abuse or neglect of children and vulnerable adults, trains staff in reporting methods, and provides access to reporting resources.			
The organization regularly trains providers in telehealth service delivery and technology, their legal and ethical responsibilities, and relevant rules and regulations (e.g., HIPAA, HITECH).			
Scheduled trainings are held to ensure that all employees understand both how to operate technologies and what their legal and ethical responsibilities are in protecting PHI.			
The organization promotes the therapeutic alliance and collaborates with families to develop appropriate treatment plans.			

ESSENTIAL CHECKLIST:

Crisis Prevention and Management

WRITTEN POLICIES AND PROCEDURES	YES	NO	N/A
A crisis management system is in place and includes a crisis management manual and a designated crisis management team.			
Written best-practice policies that include staff supervision plans and scheduled evaluations and trainings provide guidance on day-to-day management of the organization to reduce the likelihood of a crisis occurring.			
External reporting requirements and relevant contact information and reporting forms are provided in the crisis management manual.			

DOCUMENTATION	YES	NO	N/A
Crisis events are immediately documented and reported to the appropriate stakeholders (e.g., parents) and agencies (e.g., insurance companies, state agencies, local authorities).			
The organization develops placeholder or template messaging that can be adapted and utilized in the case of an event.			
Guidelines for preparing statements in the public communication sequence, including the holding statement, board statement, summary public statement, and follow-up statements, are available in the crisis management manual.			

OVERSIGHT	YES	NO	N/A
A designated crisis management team is responsible for managing emergency situations when they arise.			
Legal counsel is consulted before any follow-up actions are taken or internal or external communications are issued post-crisis.			
The organization arranges appropriate insurance coverage to protect against liability in a variety of possible events.			
The responsibility for the external reporting of events is assigned to a designated person on the crisis management team (e.g., CEO or president of the organization) who has communications expertise.			
Both before and after a crisis event, the crisis management team and executive leadership regularly examine policies and procedures to identify areas for improvement.			

DISSEMINATION, ACCESSIBILITY, AND TRAINING	YES	NO	N/A
Information about crisis management is readily accessible to all stakeholders.			
Scheduled trainings are held to ensure that all employees understand the crisis management system and their role in its implementation.			
All staff receive training on social media and public communications protocol.			

CONSIDERATIONS FOR USE

These guidelines and standards are provided for informational purposes only and do not represent professional or legal advice. There are many variables that influence and direct policies and practices of organizations that provide Applied Behavior Analysis (ABA) services. CASP and the authors of these guidelines and standards assume no liability or responsibility for application of these guidelines and standards in the delivery of ABA services.

The guidelines and standards presented in this document reflect the consensus of a number of subject matter experts, but at present do not represent the only acceptable practice. These guidelines and standards also do not reflect or create any affiliation among those who participated in their development.

CASP does not warrant or guarantee that these guidelines and standards will apply or should be applied in all settings. Instead, they are offered as an informational resource that should be considered in consultation with organizational leadership, professionals employed by these organizations, regulators, and healthcare funders and managers.

CASP
The Council of Autism
Service Providers

The Council of Autism Service Providers
401 Edgewater Place, Suite 600
Wakefield, MA 01880

Email: info@casproviders.org
www.casproviders.org