2011 Annual Report

Submitted to the Governor and Alabama Legislature

IACC

Alabama Interagency Autism Coordinating Council

IN ACCORDANCE WITH THE RILEY WARD
ALABAMA AUTISM SUPPORT ACT (#2009-295)

The Alabama Interagency Autism Coordinating Council (AIACC), created by the Alabama Autism Support Act of 2009 (Act #2009-295) and is charged with meeting the urgent and substantial need to develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system of care (SOC) for individuals with Autism Spectrum Disorder (ASD) and their families.

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Foreword: Autism in Alabama

The *1985 Alabama State Department of Mental Health and Mental Retardation Statewide Service Plan for Autism* demonstrates that the needs of individuals with autism spectrum disorder that have continued into the 21st century in Alabama. This report includes recommendations for the "development of a statewide continuum of services for the autistic population of Alabama." The report identifies five areas that need to be developed in order to meet the growing need: "1) intensive treatment group homes for residential placement; 2) Evaluation, Family Outreach/Technical Assistance and Respite Care Services; 3) Autism Services Network, to include linkage with existing human service organization and education services; 4) Research and Information Center on Autism; and 5) Advisory Board for Autism." The prevalence rate in 1985 was one in 2,000 births. **As of April 2012, the prevalence rate of autism spectrum disorders is one in 88.** Boys are affected almost 5 times more than girls. Between the years 2002-2008, the prevalence rate increased 78% in the United States. While we don't know why the numbers are climbing so rapidly, we do know that many more families are in need. The work of the Alabama Interagency Autism Coordinating Council (AIACC) seeks to address this urgent need. The kinds of needs have not changed since 1985, but they have increased in prevalence, as autism is the fastest growing developmental disability.

The median age of the earliest diagnosis in Alabama is 5 years, 1 month according to the latest CDC statistics. A diagnosis can reliably be made at 18 months. This lag in time until a diagnosis causes families to miss opportunities for progress and services for their loved ones.

A recent study found that the families spend $1.4 million on the lifetime care of an individual with an autism spectrum disorder. If an intellectual disability is present, the cost increases to $2.3 million. These figures do not include the standard costs of raising a child. In addition, families with children with an autism spectrum disorder earn 28% less income than other families with children with no healthcare limitations. Mothers of children with ASD earn 56% less than mothers of children with no healthcare limitations. These mothers are 6% less likely to work and work 7 hours per week less than mothers of children with no healthcare limitations. Although the costs are greater for raising a child with ASD, families must sacrifice an income in order to provide care for their child.

The need for support for individuals and their families in Alabama and across the country is great. Together, we must come together to ensure quality services and resources for families affected by Autism Spectrum Disorders.

AIACC Membership

Key: Autism Spectrum Expert Advisor (A.S.E.A.), Autism Spectrum Family Advisor (A.S.F.A.), Autism Community Advocate (A.C.A.)

Governor appointed members include:

Linda Bachus, A.S.F.A.
Julie Brown, A.S.F.A.
Robert Tristan Dunn, A.S.E.A.
Jerimie W. Goike, A.S.E.A.
Bama Folsom Hager, Ph.D., A.S.F.A., Co-chair
Evan Lang Krchak, A.S.E.A.
Jim Mercer, A.C.A.
Sandra King Parker, M.D.
Hanes Swingle, M.D., M.P.H.
Kathy Welch, M.A., C.C.C./S.L.P.

Senate Appointee: Cam Ward, A.S.F.A., Co-chair

House Appointee: Becky Nordgren, A.C.A.

The chief executive officer or a representative from each of the following state agencies serves as an ex officio member:

Alabama Department of Children's Affairs
Alabama Institute for Deaf and Blind
Alabama Department of Education
Alabama Department of Human Resources
Alabama Department of Insurance
Alabama Department of Mental Health
Alabama Department of Public Health
Alabama Department of Rehabilitation Services
Alabama Medicaid Agency
University Center of Excellence in Developmental Disabilities Education, Research, and Service
Autism Society of Alabama
Alabama Council on Developmental Disabilities
Alabama Academy of Pediatrics

PROGRESS SUMMARY & PROGRAM DEVELOPMENT

Standards of Practice

The Standards of Practice Committee is divided into six workgroups: Services Birth-5, Services 6-21, Transition Services, Adult Services, Diagnostic Clinics, and Professional Preparation and Training. See a summary of their progress below.

Diagnostic Clinics

- The Diagnostic Clinics Workgroup has drafted recommendations for 1) a multidisciplinary autism spectrum disorders diagnostic evaluation, 2) autism-specific screening, and 3) implementation of care coordination. The recommendations for the diagnostic evaluation provide minimum standards, in addition to best practices, for the following: audiological testing; vision screening; psychological evaluations that include measures of the child's cognitive and adaptive abilities, direct observation of the child's behaviors using a standardized, validated instrument such as the Autism Diagnostic Observation Schedule (ADOS), and a Diagnostic and Statistical Manual (DSM) based interview with the caregivers; an assessment of speech and language skills including pragmatic language abilities; evaluations for sensory processing and motor delays; and a comprehensive medical evaluation that includes a medical and 3-generation family history, as well as a physical examination which focuses on the identification of recognizable syndromes that are associated with autism.
- This workgroup has drafted recommendations for autism specific screening and has offered suggestions for screening instruments to be used by pediatricians and other primary care providers.
- The workgroup recognizes the need for Care Coordination for children and families affected by autism. Models of Care Coordination have been identified. To review the full report, see Appendix C, Part 1.

Birth-5 Years Services

This workgroup will need to be reconvened and new leadership identified. Findings for the full report were unavailable at time of printing.

- The Birth – 5 Workgroup is developing a draft of program standards for private providers of services (other than AEIS and ASDE Pre-School special education) to children with ASD from birth through five years of age, based on best available scientific research and informed by the National Autism Center (NAC) Standards Report. Key areas of focus include:
    - Program Standards: policies and procedures, environmental supports (program-level), collaboration between community and agencies, curriculum, and transition
    - Child/Family Standards: service plan (assessment to intervention), environmental supports (individual-level), collaboration for families, and curriculum.

6-21 Years Services

- Work is progressing as the group investigates quality indicators in the following areas: instructional plan, instructional activities, instructional methods, instructional environment, review and monitoring of progress, family involvement and supports, social behaviors, transition, personnel development, and program evaluation. Each area will have identification of minimum, progressive, and best practice standards. To see the full report, see Appendix C, Part 2.

Transition Services

- The Transition Work Group Committee has extensively researched the transitional process by reviewing literature, research and examining what other states are doing in terms of transition. There are five common elements found in the research, literature, and in programs that assists individuals with disabilities in having successful outcomes in terms of transitioning into life after high school (Kohler, 1996). The five common elements are: student focused planning, student development, family involvement, interagency collaboration, and program structure.
- Recommendations regarding educational services, vocational services, post-secondary education, economic support for transition, collaboration between school systems and ADRS, and service provider trainings are being developed.
- Key agencies that are involved in the Transition process (i.e., Alabama Department of Education, ADRS, and DMHMI) have specific guidelines and/or standards. Therefore, the committee is recommending that the creation of a time-line be introduced to all agencies; thereby not changing their individual standards but streamlining the process in order to create greater collaboration between all agencies. The timelines are for individuals seeking a standard diploma and pursuing post-secondary education or AOD or certificate of attendance seeking employment. To see the full report, see Appendix C, Part 3.

Adult Services

- A review of existing standards was conducted by the Adult Services Workgroup. Values and principles were adapted from the Alabama Council for Developmental Disabilities. Standards were identified for: socialization, housing, rights and responsibilities, service planning, community access and support, residential options, employment, and case management. To see the full report, see Appendix C, Part 4.
- Relatively little information exists regarding adults and transition into adulthood. Three surveys were conducted that polled adults with ASD and family members of adults on the spectrum. When asked what was needed in the areas of life skills, social skills, and vocational skills, it was found that the desires were no different than that of the typical population. Adults want to work, have friends, live on their own, and don't want people telling them what to do.
- Recommendations will be developed rather than standards since there is so little literature on the subject of adults on the spectrum. The standards that do exist are difficult to generalize among agencies, but some workable standard recommendations were identified.

Professional Preparation and Training

- This group examined current professional preparation programs for teachers (general and special education) and rehabilitation counselors serving individuals with ASD. The group developed directories of existing teacher education programs offering behavior management or ASD specific classes and points of contact, as well as psychology programs that are autism specific within the state of Alabama. The workgroup also developed a similar directory for two-year colleges offering courses in childcare, early childhood, elementary, or special education. See Appendix C.
- Charge: to determine the current level of training that teachers receive.
- Findings: Students with ASD are in general prep classrooms; teacher preparation programs do not provide teachers with the knowledge necessary; teachers trained in special education are trained in methodologies but may not have the administrative and financial support needed.

- Action Items: Teachers should receive pre-service and in-service training regarding ASD and specific intervention strategies; there should be a way to monitor and track training; teachers should have access to model sites.
- Draft Recommendations: provision of more professional development opportunities for paraprofessionals, promotion of collaboration between education and psychology programs, inclusion of professional development opportunities on the Autism Alabama link on the ALSDE website, development of an autism professional development lattice for educators to classify qualifications of those providing services for individuals with ASD/DD, and provision of an autism endorsement for qualifying teachers. To view the full report, see Appendix C, Part 5.

Strategic Planning

The Strategic Planning Committee completed their work in May 2011. Their work is incorporated into the Proposed Long Term Plan (see Appendix B). To view the Strategic Plan, visit http://autism.alabama.gov/Documents/AIACC_Strategic_Plan.pdf.

Special Projects

The Special Projects Committee is divided into four workgroups: Awareness, Community Services, Early Screening and Surveillance, and Family Supports. See a summary of their progress below.

Awareness

- There have been continued submissions to add to the development of the *Alabama Autism Lifespan Resource Tree and Directory*, which will provide online access to state resources from birth through adulthood services.

Community Services

- The *A Child is Missing* program is in 93 agency districts as of April 2012. Eleven new agencies have joined this program in the past year. According to *A Child is Missing*, a child goes missing every 40 seconds in the United States. This free program assists law enforcement in the search and safe recovery of children, the elderly, and disabled persons using a rapid-response neighborhood alert program utilizing high-tech telephony systems (http://www.achildismissing.org/about.asp).

Early Screening and Surveillance

- A $15, 000 grant was awarded by the Centers for Disease Control and Prevention (CDC) and Association of Maternal and Child Health Programs, one of only ten such grants in the nation. The grant, LTSAE: Act Early Alabama Awareness and Training Initiative is a collaborative effort among members of the Council with five main goals: reconvene stakeholders from across the state, many of whom participated in the 2009 Act Early Summit; make *Learn the Signs. Act Early.* information state specific; creation of *Act Early Alabama* website; develop webinar to provide training with CMEs and/or CEUs; development of a network of trainers across the state to disseminate the *Learn the Signs. Act Early.* message in every county. The initiation of these projects will be completed by May 2012.

Family Supports

- In partnership with the Alabama Lifespan Respite Resource Network, the Family Supports workgroup is seeking grant monies to support respite care for families affected by ASD. Individuals with ASD currently do not qualify for many respite opportunities.

Bylaws

The Bylaws were updated to include an Executive Committee. To see the Bylaws and updates, visit http://autism.alabama.gov/Documents/AIACC_Bylaws.pdf.

YEAR IN REVIEW

Legislative Review

Relevant Legislation: Senate Bill 216 allowed for the use of service dogs by individuals with an autism spectrum disorder. The bill was enacted and is now part of the Alabama Code, Section 21-7-4.

Budget: State budget monies in the State General Fund to support the mission and recommendations of the AIACC have been dropping since the Council's creation. In 2009, $75,000 was allocated to this endeavor in the State General Fund. In 2010, the amount contributed was reduced to $67,500. In 2011, the amount budgeted was $63,750. The 2012 budget shows even deeper cuts with an allocation of $40,631 (*http://www.lfo.alabama.gov/pdfs/SGF%20FY%202012%20Enacted.pdf*). The Education Trust Fund budget for the AIACC for 2012 was $55,000 (*http://www.lfo.alabama.gov/pdfs/ETF%20FY%202012%20ENACTED.pdf*).

Barriers

In consideration of the creation of a System of Care (see Appendix A) for individuals on the Autism Spectrum, the AIACC and its various committees contributed to the creation of the Proposed Long Term Plan (see Appendix B), spearheaded by State Autism Coordinator, Caroline Gomez, Ph.D. In August 2011, the Autism Coordinator resigned, and the position was filled in March 2012 by Anna McConnell, L.C.S.W., M.P.H. The completion of the Annual Report was delayed due to the recent hiring of an Autism Coordinator. While there was a lapse in the presence of an Autism Coordinator, the committees and workgroups carried on the duties of the Council. One workgroup will need to be reconvened, as the leader was on personal leave.

The workgroups are also postponing some of their recommendations, or recommendations may need to be altered, when the Diagnostic and Statistical Manual – V is released. The DSM-VI (TR) is under revision; drafts of DSM-V have proposed changes to the diagnosis and terminology used for the Pervasive Developmental Disorders. The upcoming DSM-V changes will likely result in revision of currently used diagnostic instruments, e.g., the ADOS, ADI, GARS, GADS, etc., which will need us to revise our recommendations to prevent them from appearing dated.

Other Important Updates

- The State Implementation Grant for Improving Services for Children with Autism and Other Developmental Disabilities was submitted to the Health Resources and Services Administration on May 9, 2011. If funded, this grant would have provided $300,000 a year for three years and allow for further efforts including implementing a pilot system of care.
- Alabama is now one of 18 states included in the *VR Counselor Directory for the VR Service Models and Autism Spectrum Disorders Project*. This directory is intended to help consumers and families initiate contact with the VR System. Carl Nowell, Rehab Specialist with the Department of Rehabilitation Services will be the contact listed.
- The Department of Mental Health's Division of Intellectual Disabilities was changed to the Division of Developmental Disabilities. The implementation of this change in regard to services and eligibility remains in progress.
- Changes to self-funded insurance plans to include expanded occupational, physical, and speech therapies, as well as behavior therapy, was called for by the Council and its participants. In the *2007 Alabama Autism Needs Assessment*, the need for insurance coverage of these therapies was one of the strongest needs conveyed, as these therapies are considered most evidence based and best practice, yet not adequately covered by insurance.

CONCLUSION

The Alabama Interagency Autism Coordinating Council has made significant steps toward crafting a system of care that will benefit individuals affected by Autism Spectrum Disorders and their families, as well as those providing services. While there is much left to be done, the cooperation among agencies and individuals has made the process more efficient. Drafts of recommendations that have been made for standards of practice will need to be completed, reviewed, approved, and implemented when the opportunity is available. Cooperation among state agencies is vital in providing a smoother system of care for individuals with ASD. Establishment of a Regional Autism Network/Center hinges on funding availability. However, the Council's committees are working hard to be prepared for when that funding does become available.

Appendix A: System of Care

The AIACC is charged with developing a long-term plan, to be reviewed annually, for a comprehensive statewide SOC for individuals with ASD and their families. The SOC model is an organizational philosophy and framework that involves collaboration across agencies and families for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports.

Values

The core values of the SOC philosophy specify that the SOC should be:

1. Individual centered and family focused, with the needs of the individual and family dictating the types and mix of services provided;
2. Community based, with the locus of services as well as management and decision-making responsibility resting at the community level; and
3. Culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the individuals they serve.

Principles

There are ten foundational principles of the SOC philosophy, all addressed in development of the AIACC SOC plan.

1. Individuals should have access to a comprehensive array of services that address their physical, emotional, social, and educational needs.
2. Individuals should receive individualized services in accordance with the unique needs and potential of each Individual and guided by an individualized service plan.
3. Individuals should receive services within the least restrictive, most typical environment that is clinically appropriate.
4. The families should be full participants in all aspects of the planning and delivery of services.
5. Individuals should receive services that are integrated, with linkages between agencies and programs with mechanisms for planning, developing, and coordinating services.
6. Individuals should be provided with care coordination to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children should be promoted by the SOC in order to enhance the likelihood of positive outcomes.
8. Individuals should be ensured smooth transitions to the adult services system as they reach maturity.
9. The rights of individuals should be protected and effective advocacy efforts should be promoted.
10. Individuals should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics with services being sensitive and responsive to cultural differences and special needs.

Implementation

Building a SOC involves processes and structures. Process addresses (a) who is involved in a system-building effort; (b) the roles, rights, and responsibilities each is accorded or assumes; and (c) how the various stakeholders communicate, negotiate, and collaborate with one another. Process also requires strategic planning. Structure refers to those functions that become organized in certain defined arrangements. For example, how individuals enter the

system (i.e., Regional Autism System of Care), how care is managed (i.e., Care Coordination), and how services and supports are individualized.

System of Care Logic Model

Turning SOC ideas into solid strategies for change requires approaching system development at multiple levels (a) policy and administrative, (b) program implementation, and (c) practice. To accomplish this, stakeholders need to anchor their SOC ideas in clear and specific expectations for the individuals and families they expect to serve, what they hope to accomplish, and how they believe they can effectively achieve their goals. A tool used to describe a theory of change is a logic model. The following logic model outlines activities in the AIACC proposed long-term plan toward a comprehensive SOC with inputs and outputs leading to short-term, intermediate, and long-term outcomes.

System of Care Logic Model

Inputs

- Time
- Money
- Staff
- Volunteers
- Partners
- Facilities
- Equipment
- Technology
- Supplies
- Research Base

Outputs

Systems Infrastructure:

State
Region

Pilot Site:

Guide, Family Survey, Provider Survey, Resource Map, Public Forum, Advisory Board, Cost Analysis, Sustainability Plan

Care Coordination:

Guidelines/Training

Individualized Interagency Intervention Plan & Guide

Learn the Signs. Act Early. Campaign

Family Resources:

Resource Directory, Navigation Guide, Web-site

Outcomes

Short-term

- Understanding of State and regional systems infrastructure/procedures for system/network
- Support for system of care values & principles
- Commitment to care coordination values & principles
- Awareness of importance of early screening

Intermediate

- Infrastructure/procedures/policies implemented for system/network
- Needs of individual/family dictate services with full family participation
- Services coordinated with change within system components as needed
- Services attuned to cultural, racial, and ethnicity of individual/family
- Agencies/providers collaborate to develop and deliver services/supports
- Services provided in community, in least restrictive setting

Long-term

- Family-centered, community-based and coordinated system of care for individuals with ASD and their families
- Coordinated system of care meets the multiple and changing needs of individuals and their families
- Policies and practices reflect system/network of care

Evaluation

Measurement of Process Indicators

Measurement of Outcome Indicators

Appendix B: Proposed Long Term Plan

Each step in the proposed long-term plan for building the statewide SOC involves activities devoted to both process and structure, while adhering to the system of care philosophy (i.e., values and principles). The AIACC is now engaged in activities in step one of a four-step long-term plan toward a comprehensive statewide SOC. The proposed plan is an AIACC work in progress and in no way constitutes policy. In addition, this Annual Report is for information purposes only and is not a request for funds to support AIACC efforts.

Proposed Long Term Plan Step 1: Building the Foundation

Step one includes two dedicated committee efforts to support implementation of a comprehensive statewide SOC, (a) Strategic Planning and (b) Standards of Practice. In addition, a Special Projects committee is addressing currently identified needs of the ASD community. Detailed information on committee progress, beyond information presented in this Annual Report, can be accessed at http://www.autism.alabama.gov.

Strategic Planning Committee

System level change is required to meet the urgent need for a statewide comprehensive SOC for individuals with ASD and their families. The Strategic Plan process has built consensus needed among committee members to guide the system level change. In addition, the process has inspired synergy among stakeholders, for a unified strategy that leverages resources and expertise. The Strategic Plan progress to date effectively communicates the AIACC mission, values, goals, and priorities as outlined below.

Mission Statement

The Alabama Interagency Autism Coordinating Council guides a collaborative effort to facilitate a lifelong system of care and support for persons and their families living with Autism Spectrum Disorder or associated conditions, so that they enjoy a meaningful and successful life.

Values Statement

We believe that a successful system of care will provide innovative best practices services for individuals with ASD and their families. These services should be ACCESSIBLE to families across the state of Alabama, provide PERSON AND FAMILY CENTERED services, and promote meaningful PUBLIC AWARENESS and COMMUNITY INTEGRATION AND INCLUSION. We value a system of care that is responsive to the current SENSE of URGENCY, is ACCOUNTABLE for providing best practice services, that includes COLLABORATIVE PARTNERSHIPS, and offers HOPE to families and service providers across the state.

Definition of Values

- **Person and Family Centered –** We respect and value the uniqueness of all individuals. The system of care and support that will serve those with an Autism Spectrum Disorder (ASD) is based upon the individual's distinctive strengths, abilities, interests and choices. We recognize when given the opportunity, each person can make a unique contribution to family, community and to society. The individual's needs drive their unique program.
- **Sense of Urgency -** Due to the overwhelming necessity for quality services and knowledgeable, reputable providers, our focus will be on the steps we can take to respond rapidly, efficiently and effectively to the immediate and life-long needs and challenges of people living with an ASD and their families.

- **Partnerships in Action -** We promote improved public awareness and understanding of those living with an ASD and advocate for public policy and funding that expands medical, therapeutic, educational, vocational, recreational, social and residential options.
- **Spirit of Collaboration -** Cooperative partnerships will be created between those living with an ASD and their families and those agencies, organizations and professionals that serve them. These partnerships will encourage collaboration and lead to an enhanced and more efficient service delivery to their clients. We value partnerships founded on honesty, integrity and mutual respect. We will treat all interested parties with respect, listen to diverse views with open minds, discuss submitted public comments and foster discussions where participants can comfortably offer opposing opinions.
- **Accountability -** We will pursue innovative best practices of the highest quality for each individual to protect the safety and advance the interests of people affected by an ASD. We will promote a SMART (Specific, Measurable, Achievable, Realistic and Time-specific) structure for service delivery. This structure will be aligned with the needs of each individual with an ASD and their family. Methods will be used to evaluate and determine the success of service delivery. Services will be adjusted as necessary to promote meaningful and successful lives for those living with an ASD.
- **Hope** - Although autism can be an isolating and involved experience, we will encourage hope for the autism community by endorsing our values on each and every service provider, agency and organization that touches them. We will also promote education for family members and those living with an ASD, so that they will be knowledgeable in what the possibilities are for their lives.

Priorities and Goals

Standards of Practice Committee

Standards of practice (SOP) are statements that outline what level of service one can expect to be provided and how the service will be provided. The SOP Committee consists of six workgroups addressing SOP from screening and diagnosis through the adult services. The committee's work has been towards developing SOP based on evidence-based practice, which provides a framework for integrating what is known from research into real-world practice. In effect, evidence-based practice bridges the science-to-practice gap with three core components (a) best research evidence, (b) clinical expertise and judgment, and (c) individual values and preferences.

Standards of Practice Workgroups

Diagnostic Clinics
Services: Birth-5 Years
Services: 6-21 Years

Transition Services
Adult Services
Professional Preparation and Training

Functions

- Advise the AIACC on appropriate standards for programs and services provided or to be provided for individuals with ASD.
- Provide information to be used in monitoring the implementation of Standards of Practice in programs and services.
- Be used to recognize the achievement of good standards and quality in the provision of programs and services

For the individual with ASD and his or her family, the SOP will (a) tell them what they can expect from a service, (b) give them greater awareness of their rights and responsibilities, (c) give them confidence in the quality of services, and (d) provide them with the opportunity to have a say in the development and review of services.

The SOP will assist the service providers as they work to (a) improve outcomes for individuals and families who use their services, (b) provide opportunities for their staff to improve their skills, (c) improve use of resources, (d) plan and improve their processes and systems, and (e) satisfy accountability requirements.

The resulting SOP will also (a) inform development of a quality rating system (QRS) for programs and providers that participate in the SOC and, and (b) provide parents, policymakers, funders, and the public with information about the level of quality of programs and providers participating in the SOC.

Quality is meeting (and where possible exceeding) the assessed needs and defined expectations of the service user through efficient and effective management and processes. The QRS will be composed of four common elements including:

- Standards
- Accountability measures
- Program and provider technical assistance
- Parent/consumer education efforts

Special Projects Committee

The special projects committee is addressing currently identified needs of the ASD community through four workgroups.

Autism Awareness Workgroup

The Autism Awareness Workgroup is focused on developing resources to help families navigate the current system of services available in Alabama. The first focus has been on developing an Alabama Autism Spectrum Lifespan Resource Tree and Directory with direct links to and contact information for services/providers throughout the State.

- Autism Lifespan Resource Tree: This information graphic is organized by need from birth through adulthood. Under each category, statewide providers/resources are listed with links to the Directory.
- Autism Lifespan Resource Directory: This section provides detailed contact information and direct links (where available) for each of the resources on the Tree.

Community Services Workgroup

The Community Services Workgroup is focused on a Safety Campaign for individuals with ASD. The first AIACC initiative in the Safety Campaign was a *First Responder Training for Autism* provided in collaboration with the Alabama Departments of Public Health and Mental Health, Alabama Council for Developmental Disabilities, and the Autism Society of Alabama. The training was provided by an internationally recognized expert in June 2010 with 118 attendees including police officers, fire department officials, social workers, nurses, counselors, paramedics, rehabilitation counselors, sheriff dispatchers, mental health specialists, behavior analysts, clinical and educational providers, parents, and agency officials.

The second initiative in the Safety Campaign is to register all Alabama law enforcement districts in *A Child is Missing*, a nation-wide program that is provided at no cost to law enforcement agencies. *A Child is Missing* is one of the fastest and most effective programs law enforcement can activate in the first critical minutes after a child is reported to be missing. When a law enforcement agency calls *A Child is Missing*, 1000 phone calls can be generated in 60 seconds in the calling area where the child was last seen. Adding to its effectiveness, *A Child is Missing* is not restrained by jurisdictional boundaries, which permits alert calls to be made across city, county, and state lines.

Developmental Surveillance & Early Screening Workgroup

The Developmental Surveillance and Early Screening Workgroup is focused on implementing a statewide ASD awareness campaign utilizing the *Learn the Signs. Act Early.* materials available from the Centers for Disease Control and Prevention (CDC). The efforts of this group were initially driven by discussions and goals set by a team of lead agencies, service providers, and other consumers attending a CDC sponsored Act Early Summit in October 2009. The workgroup has developed a long-term plan of disseminating information regarding early identification of developmental delays and appropriate referrals for children with known or suspected delays, with a target audience including parents/caregivers, service providers (e.g., physicians), and early childcare providers (e.g., daycare centers, early education training programs).

The workgroup was awarded a grant in the amount of $15,000 from the Centers for Disease Control and Prevention (CDC) and Association of Maternal and Child Health Programs, one of only ten in the Nation. The grant funds will be used to develop a webinar and network of trainers across the state to disseminate the *Learn the Signs. Act Early.* message. The workgroup will be recruiting professionals, family members, and others interested in becoming part of a network to provide presentations in specific geographical areas. The workgroup's goal is to have at least one trainer in each county.

Family Supports Workgroup

The Family Supports Workgroup is focused on respite care in collaboration with the Alabama Lifespan Respite Resource Network. Respite care is temporary short-term relief for caregivers of individuals with special needs. The primary purpose of respite is to give relief to families and caregivers from the extraordinary and intensive demands of providing ongoing care in the home. The workgroup identified and contacted current respite providers in the state and is creating a Respite Resource Tree for families to streamline the process in obtaining respite services thorough vouchers.

Proposed Long Term Plan Step 2: Infrastructure

Step two of the proposed long-term plan address infrastructure necessary for the System of Care (SOC) to be integrated across service sectors, which are collectively responsible for achieving individual, family, and community outcomes. The resulting SOC will foster greater efficiency, bolster effectiveness, and alleviate service gaps for individuals with ASD and their families. The SOC is outlined below, although funds to support this initiative have not yet been identified.

Proposed Objectives

Objective 1: Initiate State efforts to improve infrastructure that results in community and State systems that are integrated across service sectors and are collectively responsible for achieving individual, family, and community outcomes.

Objective 2: Determine elements for an Individualized Interagency Intervention (III) Plan to facilitate meeting needed services and funding arrangements for the individual and family across a variety of programs, agencies, and services.

Proposed Activities

All activities will be informed by youth/family participation and specialist consultants.

1.1 Identify goals and guiding principles.
1.2 Maintain website to communication System of Care development.
1.3 Develop and follow protocols and mechanisms for ensuring the full participation of families, youth, and advocacy organizations in decision making, governance, and evaluations.
1.4 Hire research assistant.
1.5 Hire care coordinator.
1.6 Hire formal evaluator and draft evaluation plan.
1.7 Hire consultants and develop and implement plans for Continuous Quality Improvement, Systems of Care Development, Family Centered Care/Cultural and Linguistic Competence, and Family/Youth Involvement
1.8 Identify and organize formal and informal supports to facilitate development of an Individualized Interagency Intervention (III) Plan.
1.9 Complete and disseminate Service Provider Standards of Practice.
1.10 Review and analyze policies and procedures (legislative, organizational, multi-agency) and identify those that hinder and /or support the System of Care development and implementation.
1.11 Generate inventory of: required data elements from statutes, rules, and laws for service plans; common elements among existing service plans; additional required elements for some; additional information required to meet federal and state laws and/or rules.
1.12 Review collaborating agency organizational structure to inform building of collaborative governance structure.

1.13 Draft principles and values for inclusion in Individualized Interagency Intervention Plan Draft Guide.

1.14 Develop certification application package for System of Care service providers (e.g., guide with measurement criteria, process, and application).

1.15 Define State Infrastructure for interagency organization: structure of governing body; decision-making process and oversight; identification and roles of participants; define services to be provided; establish formal links between lead agency and other agencies; define referral and intake mechanisms.

1.16 Determine plans to be coordinated through the Individualized Interagency Intervention Plan.

1.17 Define communications protocol that outlines protocols between participants, state and local governments, the public, elected officials, current and potential funders, families, and other audiences identified by stakeholders.

1.18 Identify pilot location for first System of Care.

1.19 Generate *Pilot Guide: Steps to a Regional Autism Network of Care*.

1.20 Identify and make available documents, materials, and resources other than in English that have been useful in systems of care.

1.21 Identify and utilize pool of cultural brokers who will assist families in increasing access and decreasing disparities.

1.22 Put into place Memoranda of Understanding to detail roles, responsibilities, and relationships among stakeholders.

Proposed Long Term Plan Step 3: Functions

Policies and Procedures

Step three of the proposed long-term plan addresses functions essential to a System of Care (SOC) including policies and procedures, care coordination components, and benefit design. An AIACC Policy and Procedures Committee will include a number of workgroups to address areas listed below.

The considerations for policies and procedures listed below are not considered all-encompassing as SOC development is a dynamic process.

System Entry/Access
Screening, Assessment, and Evaluation
System Management
Decision-making/Oversight
Outreach and Referral
Crisis Management
Utilization Management
Staffing Structure, Support, and Development
Orientation and Training
External and Internal Communication
Protecting Privacy
Ensuring Rights
Financing
Purchasing/Contracting
Revenue Generation
Information Management
Quality Improvement
Evaluation
System Exit
Technical Assistance

Care Coordination Components

Care coordination is a central, ongoing component of an effective SOC. Care coordination engages families in development of a care plan and links them to services that address the full range of their needs and concerns. Principles of care coordination may vary from family to family, but start with identification of individual and family

needs, strengths and concerns, and aim simultaneously at meeting family needs, while building family capacity and improving systems of care.

Proposed Objectives

Objective 3: Create foundation for System of Care as informed by the State infrastructure planning.

Objective 4: Generate *Care Coordination Guidelines/Training Modules* and *Individualized Interagency Intervention Plan and Guide.*

Proposed Activities

All activities will be informed by youth/family participation and specialist consultants.

2.1 Provide ongoing consultant training in identified areas including Continuous Quality Improvement, Systems of Care Development, Family-centered Care/Cultural and Linguistic Competence, and Family/Youth Involvement.
2.2 Continue identifying and utilizing (a) a pool of cultural brokers and (b) non-English Systems of Care information.
2.3 Detail care coordinator responsibilities and requirements.
2.4 Identify III Plan data tracking system, data elements, and arrangement of data elements.
2.5 Survey families to assess access to services and supports.
2.6 Survey service providers to identify available services.
2.7 Analyze SOC environmental strengths, weaknesses, opportunities, and threats.
2.8 Map resources, partnerships, and assets.
2.9 Schedule and hold public forum to gather information on what different stakeholders want in a SOC.
2.10 Create SOC advisory board of stakeholders and agency representatives.
2.11 Increase provider and consumer awareness of importance of early screening of children for ASD and related disorders building on a state-wide *Learn the Signs. Act Early*. campaign.
2.12 Evaluate current fiscal utilization.
2.13 Develop process for case coordination, case review, and continuous quality assurance.
2.14 Identify strengths of stakeholders and agencies for collaboration.
2.15 Select and complete a cost analysis for the SOC.
2.16 Generate Draft (a) Care Coordination Guidelines and (b) III Plan and Guide.
2.17 Create crisis plan format and procedures.
2.18 Disseminate draft (a) Care Coordination Guidelines and (b) III Plan and Guide, request feedback, and make needed revisions.
2.19 Detail services to be provided in SOC.
2.20 Secure approvals for III Plan to replace pre-determined existing service plans.
2.21 Develop and implement social marketing plan, regional evaluation plan, and sustainability plan.
2.22 Design Care Coordination training plan and modules.
2.23 Finalize System of Care Evaluation Plan.

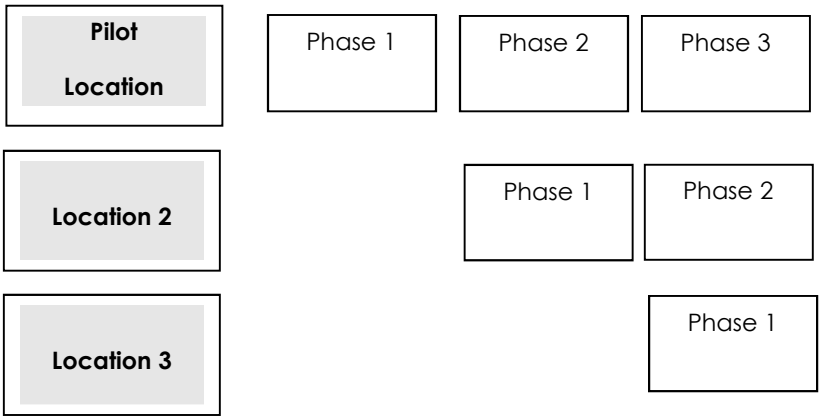
Benefit Design

A key principle of a SOC is that the benefit design incorporates a broad array of services and supports, including both traditional and nontraditional services and supports and both clinical services and natural supports. A second key principle is that benefit structure allow for individualized, flexible service provision with attention to the cultural

expectations of each family. An AIACC Benefit Design Committee will determine core system of care services and develop a system for fading in secondary services.

The committee will utilize the Standards of Practice (SOP) and Quality Rating System (QRS) developed in step one of the long-term plan. In order to benefit from lessons learned for the pilot location, new locations will open following a succession as shown below.

Location Phase Plan



Proposed Long Term Plan Step 4: Implementation

During step four, a Request for Proposals is initiated to inform recommendations for locations and service areas of System of Care (SOC) centers. Act 2009-592 provides for the establishment of regional autism centers to meet the identified urgent need for a system of care. Act 2009-592 charges the AIACC with recommending the locations and service areas of centers to the Governor, Lieutenant Governor, and the Speaker of the House of Representatives. To ensure fairness and equal opportunity, the AIACC will initiate a Request for Proposals to inform recommendations. The Governor, Lieutenant Governor, and the Speaker of the House of Representatives will then select the locations and service areas of centers.

The first location or pilot location is critical to future success and will undergo evaluation to identify and address the inevitable problems that pilot locations are created to uncover and resolve. The pilot location provides the care coordinators with a tool to evaluate the initial services of the SOC in a manageable environment and, if necessary, make changes before opening subsequent locations.

Proposed Objectives

Objective 5. Initiate a Request for Proposals to inform recommendations of locations and service areas of centers.

Objective 6. Initiate Systems of Care pilot location.

Proposed Activities

All activities will be informed by youth/family participation and specialist consultants.

3.1 Complete Request for Proposal process.
3.2 Begin pilot location care coordination services.
3.3 Provide ongoing training and technical assistance to pilot location

3.4 Provide on-going consultant training in identified areas including Continuous Quality Improvement, Systems of Care Development, Family-centered Care/Cultural and Linguistic Competence, and Family/Youth Involvement.
3.5 Continue identifying and utilizing (a) pool of cultural brokers and (b) non-English SOC information.
3.6 Organize and distribute an updated Alabama ASD Lifespan Resource Tree and Directory.
3.7 Create and distribute an *Alabama Family Navigation Guide to ASD* services.
3.8 Elicit feedback from all stakeholders to inform revision of process as needed.
3.9 Evaluate pilot location effectiveness of services, training, technical assistance, and revise as needed.
3.10 Evaluate effectiveness of *Pilot Guide: Steps to a Regional Autism Network of Care*.
3.11 Identify pilot replication sites throughout the State.
3.12 Disseminate SOC initiatives and results to audiences at events, conferences, state and national events.

Evaluation Plan

Both process and performance assessment activities will be conducted for the System of Care (SOC) utilizing the services of an outside evaluator. Performance assessment activities will be finalized after hiring the evaluator.

Process Evaluation

Process evaluation will be undertaken to (a) monitor the SOC implementation, (b) document whether or not the SOC is implemented as intended, (c) describe how the implementation is accomplished, and (d) allow for corrective action when objectives are not attained. The process evaluation focuses on factors that succeed or fail in producing the identified results and include but are not limited to factors such as program components, administration, implementation processes, program efficiency, family perceptions, staff perceptions, and the overall effect of the SOC.

Utilizing information gained through process evaluation, efforts will be made to explain how and why desired changes did or did not occur in relation to the SOC implementation protocols. Documentation of the implementation process allows for identification of the factors that contribute to program outcomes, and thereby, support replication of components found to be effective. Questions that will be asked through the SOC process evaluation activities include:

1. How closely did implementation match the SOC Plan?
2. What types of changes were made to the originally proposed Plan?
3. What factors led to the changes in the original Plan?
4. What barriers or opportunities have been encountered relative to implementation of the Plan?
5. What effect did the changes have on the planned intervention and performance assessment?
6. Who provided (program staff, contracted) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?
7. What strategies were used to maintain fidelity to the evidence-based SOC practices or interventions across providers over time?
8. How many individuals were reached through the program?

Answers to these questions and others will be provided through qualitative assessment techniques. Sources of process evaluation will include direct observation of services (e.g., Wraparound Fidelity Assessment System), one-on-one interviews with program participants (e.g., Family-centered Assessment Tool), focus group meetings, stakeholder

group meeting minutes, surveys, routine data collected from individuals during the course of service provision, and other methods.

Outcome Evaluation

Outcome evaluation for the SOC will (a) assess the impact of the SOC and the effectiveness of the SOC in meeting its stated goals, determine what program factors and individual factors were associated with what outcomes, and determine the durability of the effects. The SOC goals and related objectives, thus, serve as the basis of the data collection and analysis process for outcome evaluation, and will answer the following questions.

1. Did the SOC facilitate the development of family-centered, community-based and coordinated SOC for individuals with ASD and their families?
2. Did the SOC provide and promote family-centered, community-based and coordinated care for individuals with ASD and their families?

Outcome evaluation questions will also answer those related to the Healthy People 2010 Objectives and the Maternal and Child Health Bureau Performance Measures.

1. Did partnerships between professionals and families of individuals with ASD improve?
2. Did access to a culturally competent family-centered SOC, which coordinates care with community-based services increase?
3. Did access to adequate health insurance and financing of services improve?
4. Did early and continuous screening for ASD increase?
5. Were community services organized for easy use by families?
6. Did transition services to adults improve?

Answers to outcome evaluation data questions will be provided through analysis of parametric and non-parametric procedures and will include, but not be limited to, individual interviews conducted at intake and follow-up, interviews with staff, record reviews, administration of standardized assessment instruments, and observation of SOC activities.

Data Management

Quality of data collection and data processing procedures is essential to the success of the SOC. Principles upon which quality control are based relative to evaluation activities of the SOC include:

1. Use of clearly defined and specific protocols for all SOC evaluation activities, including training for data collection, management, and processing.
2. Ongoing training and re-training of program staff participating in any data collection activities.
3. Administration of evaluation tools and evaluation data collection instruments consistently across all program participants.
4. Validation and verification of all data collection and management procedures through data editing, including use of software capable of checking for out-of range values and other outliers.
5. Consistent meetings and progress reports to provide specific, well documented feedback on SOC staff concerning potential difficulties as well as sufficient follow-up to assure that problem resolution occurs in a timely manner.

The State Autism Coordinator will manage all data collection, entry, editing, generation of reports, and data analysis as informed by the contracted formal evaluator.

Instruments

The following instruments will be considered for use to support evaluation of the SOC goals and objectives:

1. The Wraparound Fidelity Assessment System,
2. Child and Adolescent Needs and Strengths: Autism Spectrum Profile,
3. Supports Intensity Scale,
4. System of Care Practice Review,
5. Family-centered Care Self-Assessment Tool- Family, and
6. Family-centered Care Self-Assessment Tool- Provider.

Data Analysis

Analysis of data will include the development of descriptive statistics, including tables, which summarize quantitative data (e.g., socioeconomic variables), using Contingency Tables and Chi Square. Analysis will proceed to the calculation of means, ranges, and other descriptive statistics to help describe the target groups and give clues to outcomes, which can be tested with more complex inferential statistical methods and illustrated in figures and tables. Individual outcome data will be analyzed at intake and ongoing follow-up. System and program outcomes will be analyzed on a quarterly basis.

Qualitative data will be analyzed according to procedures established by the evaluator, as appropriate to the variable collected. Quantitative data analysis results will be summarized in tables as well as be presented in narrative form.

Reporting and Integration of Data

Written updates will be provided quarterly to the AIACC and SOC staff regarding evaluation findings. A full report of findings will be disseminated twice a year. Each report will invite feedback relative to suggested improvements. Particular attention will be paid to evidence of disparate outcomes for different racial and ethnic populations, to provide for timely program adjustments as needed.

Information obtained from system, program, and individual evaluation of the SOC will guide development of programming by eliminating what is not working and enhancing what is working. Working in conjunction with the evaluator, the AIACC will establish formal policies and procedures to guide the incorporation of evaluation data and findings into program management and continuous quality improvement processes on an ongoing basis.

Participant Protection

The AIACC will develop and implement appropriate procedures to address confidentiality and other ethical concerns pertinent to the protection of clients. Data management procedures will include stringent security procedures relative to transportation and storing of data. Training in regards to confidentiality and ethics will be provided for all SOC staff participating in the evaluation process.

APPENDIX C: FINDINGS AND RECOMMENDATIONS*

The recommendations included in this document are in draft form. This report in no way constitutes policy or decision making. Changes and additions will continue to be made in partnership with appropriate parties.

Part 1: Diagnostic Clinics Workgroup

The Diagnostic Clinics Workgroup has drafted recommendations for 1) a multidisciplinary autism spectrum disorders diagnostic evaluation, 2) autism-specific screening, and 3) implementation of care coordination. The recommendations for the diagnostic evaluation provide minimum standards, in addition to best practices, for the following: audiological testing; vision screening; psychological evaluations that include measures of the child's cognitive and adaptive abilities, direct observation of the child's behaviors using a standardized, validated instrument such as the Autism Diagnostic Observation Schedule (ADOS), and a Diagnostic and Statistical Manual (DSM) based interview with the caregivers; an assessment of speech and language skills including pragmatic language abilities; evaluations for sensory processing and motor delays; and a comprehensive medical evaluation that includes a medical and 3-generation family history, as well as a physical examination which focuses on the identification of recognizable syndromes that are associated with autism. Our workgroup has drafted recommendations for autism specific screening and we offer suggestions for screening instruments to be used by pediatricians and other primary care providers. Lastly, our workgroup recognizes the need for Care Coordination for children and families affected by autism. Models of Care Coordination are discussed in our report.

Upcoming Challenges: The Diagnostic and Statistical Manual-IV TR (DSM-IV TR) is under revision; drafts of DSM-V have proposed changes to the diagnosis and terminology used for the Pervasive Developmental Disorders. The upcoming DSM-V changes will likely result in revision of currently used diagnostic instruments, e.g., the ADOS, ADI, GARS, GADS, etc., which will need us to revise our recommendations to prevent them from appearing dated.

The **GREATEST CHALLENGE** facing the AIACC in regards to the Diagnostic Clinic's Workgroups recommendations will be the acceptance of Regional Diagnostic Clinics' evaluations by the Public School Systems. Acceptance of the Diagnostic Clinics assessments would substantially reduce or eliminate unnecessary duplication of diagnostic testing and prevent unnecessary delays in the receipt of services for children affected by autism.

Introduction

Standards of Practice for Autism Diagnostic Clinics will guide providers of diagnostic services in the use of evidence-based best practices and will provide individuals and families who have concerns about autism spectrum disorders with reliable information about what to expect from a diagnostic evaluation, leading to greater confidence in the diagnoses and services rendered by the diagnostic clinics. Adoption of Standards will result in uniformity in the diagnostic evaluations provided across the state, lead to greater efficiency in the utilization of limited resources, increase accountability, improve the overall quality of services provided, and ultimately improve outcomes for those receiving diagnostic services.

The Diagnostic Clinics Workgroup of the Standards of Practice Committee is comprised of a multidisciplinary team of physicians, psychologists, audiologists, speech and language pathologists, social workers, occupational therapists, and others, all of whom have clinical experience and expertise in autism spectrum disorders. The workgroup members are comprised of volunteers from Alabama's public and private universities and other service providers from around the state. The process of developing standards has been an open and transparent one. Workgroup

members meetings have been open to anyone interested in helping with or observing the process. Members began their task of defining minimum and best-practice standards by reviewing current practices across Alabama. This was followed by a review of the recommendations and standards established by national organizations, e.g., the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, American Speech and Language Association, etc., reviewing standards implemented by states with regional autism centers, e.g., California and Washington, and by reviewing the scientific literature. In situations in which there were no national or state standards to guide our recommendation, which was the case in the audiology evaluation of children suspected of autism, the experts on the panel drew from the clinical experiences and knowledge to make their recommendations.

Diagnostic Clinics Standards

Standard	**Check all that Apply**		
	Service:	***Recipient:***	***Location:***
As part of a comprehensive interdisciplinary diagnostic evaluation, all children referred to a Regional Autism Diagnostic Clinic will receive a thorough medical evaluation.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	___Home ___School X Community

Check One: **X** Minimum Standard ___Best Practice Standard ___Gold Standard

X Best Practice Standard: The Best Practice Standard consists of a developmental-behavioral pediatrician, child psychiatrist, pediatric neurologist, or other physician with expertise and interest in autism spectrum disorders conducting and/or supervising the medical evaluation. Best practice also incorporates referrals, when appropriate, to other subspecialists, including (but not limited to) medical geneticists, nutritionists, gastroenterologists, allergists, pediatric ophthalmologists, etc.

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Introduction

Autism spectrum disorders (ASD), which in this report comprises the terms *autism, autistic disorder, Asperger's disorder, and pervasive developmental disorder - not otherwise specified*, are a heterogeneous group of behaviorally defined conditions that are neurologically based. Numerous medical, genetic, and metabolic conditions have been associated with the autism spectrum disorders.[1-4] The American Academy of Pediatrics, the American Academy of Neurology, the American Academy of Child and Adolescent Psychiatry, and state

Standards of Practice Guidelines have outlined the role of physicians in the diagnosis and subsequent management of ASD.[5-8] Though not always possible, determination of the specific etiology of an ASD and its associated medical conditions provide multiple benefits to the individuals and families affected by autism, which include the provision of anticipatory guidance, treatment options, prognosis, and genetic counseling.

Components of the Medical Examination

A comprehensive health, developmental, and behavioral history, along with a family history of medical and psychiatric illnesses, should be obtained on all children evaluated for suspicion of an ASD and/or developmental delay. Completion of a health questionnaire prior to the physician visit is recommended because it allows the physician to address and clarify relevant issues during the interview. Prenatal and perinatal factors known to affect development should be recorded. Information regarding the achievement of age-appropriate developmental milestones and a history of regression in language, social-emotional, or other developmental domains will be sought during the evaluation. Past and current illnesses, *e.g.*, encephalitis or seizure disorders, medications known to affect central nervous system functioning, and prior hearing and vision screenings, should be noted. Behaviors such as irritability, self-injury, sleep and eating disturbances, inattention, hyperactivity, impulsivity, distractibility, *etc.,* should be recorded. A 3-generation family pedigree should be obtained with regard to both medical and psychiatric illnesses, with emphasis on cognitive disabilities, ADHD and other learning disorders, epilepsy, autism, bipolar disorder, schizophrenia, and deafness.

A comprehensive physical and neurological exam that includes a thorough search for dysmorphic features, aberrations of growth (*e.g.*, microcephaly or macrocephaly), manifestations of neurocutaneous disorders, and abnormalities in tone, muscle stretch reflexes, cerebellar function, gait, and the presence of involuntary movements, is recommended as part of the comprehensive medical work-up of children suspected of autism.

All children evaluated for suspicion of autism should receive an audiology evaluation, vision screening, and dental care. Children diagnosed with an autism spectrum disorder and their families may benefit from genetic testing that may include a high resolution karyotype, DNA for fragile X, microarray comparative genomic hybridization (CGH), DNA testing for MECP2 mutations in girls with autism and/or developmental regression, and lead levels. The microarray CGH has recently been recommended as the first-tier genetic test for patients with unexplained autism spectrum disorders.[9] If there is a history of early seizures, cyclical vomiting, dysmorphic or coarse facial features, or if the adequacy of the newborn metabolic screening is in doubt, plasma amino acid chromatography, urine for organic acids, and tests for thyroid functioning may be warranted. Allergy testing and evaluation for primary gastrointestinal disorders should be individualized based on the patient's history and physical findings.[10]

Routine neuroimaging is not recommended for the diagnostic evaluation of autism, even in the presence of macrocephaly.[5] Cranial MRI or CT scanning, however, should be considered if focal findings are present on the neurological exam, or if there is microcephaly or a rapid increase in head circumference. Electroencephalography (EEG) should be considered when there is a suspicion of seizures or a history of language regression.

Medical Differential Diagnosis and Coexisting Conditions Associated with Autism Spectrum Disorders

Autism spectrum disorders (ASD) are biologically based neurodevelopmental disorders that are highly heritable. Chromosomal anomalies and single gene defects can be identified in 15% or more of individuals with autism, with the highest yields being obtained when microarray comparative genomic hybridization is used. ASD can be subtyped as either idiopathic or secondary.

Idiopathic ASD refer to the condition of individuals that do not have an identifiable co-morbid medical or genetic condition known to be associated with autism. Children with idiopathic ASD demonstrate variable behavioral phenotypes, although they are somewhat less likely to have co-morbid global developmental delay/intellectual disability (i.e., IQ$\leq$70).

The term syndromic or secondary autism is used to refer to individuals who have a single defined cause, such as fragile X syndrome or tuberous sclerosis, associated with the autism. Coexisting severe intellectual deficiency, especially in the presence of craniofacial dysmorphism, increases the likelihood of identifying a genetic disorder. The following are examples of well-described neurogenetic

syndromes associated with autism.

Fragile X syndrome is the most common known genetic cause of intellectual disabilities and is identified in 1-3% of children with autism. As many as 30% to 50% of individuals with fragile X syndrome demonstrate characteristics of ASD.

Tuberous sclerosis, an autosomonal dominant neurocutaneous disorder, is characterized by hypopigmented macules, seizures, intellectual disabilities, and benign tumors of the brain, skin, kidneys, and heart. Almost 50% of individuals with tuberous sclerosis manifest ASD.

Down syndrome (trisomy 21), the most common and well-known genetic syndrome associated with intellectual disability, is usually characterized by relatively good social skills compared with other areas of functioning. However, recent studies have reported that 6% to 7% of children meet criteria for an ASD.

Rett syndrome is a postnatal neurodevelopmental disorder, identified almost exclusively in females, due to a mutation in the MECP2 gene. Girls with Rett syndrome typically develop normally for the first 6-18 months, then demonstrate autistic-like regression and manifest acquired microcephaly, seizures, and hand-wringing stereotypies. Rett syndrome should be considered in all girls who present with autistic-like regression.

Microdeletions and duplications are increasingly being identified in children with ASD and are often associated with mild craniofacial dysmorphism. One percent of children with autism have a maternally-derived chromosomal duplication at the 15q 11-13 region. Autism spectrum disorders are also found with increased frequencies among children with Prader-Willi and Angelman's syndrome, which are due to paternal and maternal deletions in the 15q11-13 region, respectively. A 16p11.2 deletion, a deletion that is associated with a variety of other behavioral and psychiatric conditions, has been identified with 1% of children with autism.

Smith-Lemli-Opitz syndrome (SLOS) is a rare autosomal recessive multiple malformation syndrome caused by a deficit of 7-dehydrocholestrol reductase. More than 75% of individuals with SLOS have autistic symptoms, which may improve with dietary cholesterol supplementation.

Landau Kleffner syndrome (LKS), or acquired epileptic aphasia, is a rare childhood epilepsy syndrome characterized by the sudden or gradual development of aphasia, which is the inability to understand or express language. LKS occurs most often in children between the ages of 3-10 years who were developing normally, but then lose language skills. While many of these children have clinical seizures, some only have a distinctive electroencephalographic (EEG) pattern of status epilepticus appearing during slow-wave sleep. Anticonvulsants and corticosteroids may improve symptoms.

Several metabolic disorders, including phenylketonuria, creatine deficiency syndromes, adenylosussccinate lyase deficiency, and metabolic purine disorders, are associated with developmental delay and autism. In the past, phenylketonuria was frequently associated with autistic symptoms, but this association has almost vanished since the introduction of newborn screening and treatment of phenylketonuria.

Mitochondrial diseases are a group of heterogeneous disorders resulting from inborn, or sometimes acquired, defects that impair the function of mitochondria, tiny organelles inside cells that are essential for energy function. A number of recent reports have provided evidence of mitochondrial diseases in a subset of children with autism, and some have even suggested that mitochondrial disease might be one of the most common medical conditions associated with autism. The diagnosis of mitochondrial diseases is a complicated and often lengthy process, usually requiring the expertise of a metabolic specialist.

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Psychiatric Differential Diagnosis and Co-morbidities Associated with Autistic Disorder and Asperger's Disorder

The variability of expression of symptoms of Autistic Disorder and Asperger's makes the diagnosis difficult. Multiple co-morbidities confound the issue as well. According to the American Academy of Child and Adolescent Psychiatry the differential diagnosis of Autism includes the consideration of the various pervasive development disorders: Autistic Disorder, Childhood Disintegrative disorder, Rett's disorder, Asperger's disorder, and Pervasive Developmental Disorder, not otherwise specified. It also includes assessing for mental retardation not associated with PDD, specific developmental disorders (*e.g.,* of language or sensory impairment) and early onset psychosis as well as various other developmental and psychiatric conditions.

In Autistic Disorder the apparent onset of the condition is almost always within the first years of life. Parents may initially be concerned that the child is deaf although they also report unusual sensitivities to the nonsocial environment. Language is typically significantly delayed or absent. Unusual behaviors, (*e.g.,* stereotyped movements) are common, particularly after about three years of age.

In Childhood Disintegrative Disorder, there is a prolonged period of normal development followed by a marked regression in multiple areas and the development of many autistic-like features.

In Rett's disorder, very early growth and development is normal but is followed by a deceleration in head growth, development of marked mental retardation, and unusual hand washing stereotypies and other features.

In Asperger's Disorder, early development (including both cognition and language development) is apparently normal. The child shows impairments in social interaction, difficulty in verbal and nonverbal communication and intense interest in circumscribed topics.

In PDD-NOS, criteria for one of the other PDD are not met but the child has problems in social interaction and other areas consistent with a diagnosis of PDD.

Usually in mental retardation, social and communication skills are at levels expected given the child's overall development. Individuals with severe and profound mental retardation may exhibit various autistic-like features, particularly stereotyped movement. It is difficult to differentiate autism from mental retardation in children with mental ages below two years of age.

Language-related disorders may sometimes mimic autism and related conditions. Usually in the language disorders, the primary deficits are in the area of language/communication, social skills are relatively preserved, and the usual restricted interests and behaviors associated with autism are not present.

Unlike Autism Spectrum Disorders (ASD), the onset of schizophrenia in children less than 7 is extremely rare. Usually there is a previous history of normal or near normal development although some children later diagnosed with schizophrenia have been described as having findings of language impairment in infancy and early childhood as well as impairments in fine and gross motor functioning. Some authors say these children can be characterized as socially unresponsive as infants who also demonstrated excessive clinginess, mood lability and unexplained rage reactions in early childhood. As the child with schizophrenia approaches adolescence he/she may have increased difficulties with peer relationships, academics, school adaptation and restricted interests. Finally, premorbid social withdrawal aloofness, detachment and developmental disorders of speech, language and motor functioning were found in adolescents with schizophrenia. Usually the appearance of characteristic hallucinations and delusions occurs. In ambiguous cases a high familial loading of psychiatric illness (schizophrenia, bipolar, etc.) indicates a strong possibility of schizophrenia rather than a PDD. Children and adolescents with schizophrenia typically function within the borderline to low normal ranges of cognitive

functioning on standard intelligence tests with nonverbal strengths relative to their language skills. Children with schizophrenia usually have social withdrawal as their social impairment. Their ability to understand nonverbal social cues and the pragmatics of communication (conversational turn-taking, eye gaze to regulate interaction, etc.) may be lower than in typically developing children, but they are generally less impaired than children with ASD.

Children with depression often display social withdrawal and limited interest in their environment. These children show a period of relatively normal functioning preceding the onset of symptoms. These children do not usually show development delay and an examination of family history reveals a greater preponderance of mood disorders than would be expected.

Children and adolescents with anxiety disorders can display extreme social withdrawal, sleep problems, agitation and worry that interfere with social and academic functioning. Children with anxiety disorders show extreme shyness and social avoidance. These children often have normal relationships with their parents and other familiar people. Their deficits become apparent in interactions with peers and/or other situations of which they are extremely fearful or uncomfortable. These children rarely display the developmental delays characteristic of ASD. The social impairment of ASD is apparent throughout the child's relationships.

Selective mutism is sometimes confused with ASD. In selective mutism the child speaks normally in some situations but not others. Children with autism may be mute but their mutism is not selective in nature.

Several features of Obsessive-Compulsive Disorder (OCD) have considerable overlap with behaviors seen in ASD. A fine line often separates obsessions and compulsions from stereotypic movements and restricted/repetitive interests and activities. But other features necessary for the diagnosis of ASD are not present in OCD such as lack of social skills or language/communication skills.

Stereotypic movement disorder is characterized by motor mannerisms (stereotypies) and the presence of mental retardation. A diagnosis of stereotypic movement disorder is not made if the child meets criteria for one of the ASD.

Occasionally a dementia has its onset in childhood. The typical pattern in dementia of childhood onset is one of progressive deterioration in functioning.

In schizoid personality disorder, the child is relatively isolated but has the ability to relate normally in some contexts.

Avoidant personality disorder is characterized by anxiety in dealing with social situations.

In reactive attachment disorders, there is usually a history of marked or very severe neglect. The social deficits of reactive attachment disorder tend to remit dramatically in response to a more appropriate environment.

Attention-Deficit/Hyperactivity Disorder (ADHD) can be confused with ASD in some children. Children with ADHD often have the capacity for social relationships but because of their behavior may be socially isolated from peers. Children with ADHD are able to display typical social and communicative behaviors in structured and, often times, novel settings. In contrast children with ASD continue to display nonverbal deficits in social communication in familiar, comfortable and structured situations. Children with ASD are often able to focus on activities that are particularly interesting to them. This is less likely with ADHD children.

Persons with ASD may appear to have Oppositional Defiant Disorder (ODD) or Conduct Disorder. These disorders involve a lack of respect for or willingness to follow norms. Children with these disorders act out purposefully. Physical aggression in persons with ASD is more common in persons who are functioning at lower developmental levels where they are unable to communicate their needs and who have poor comprehension of the environment. In contrast to children with CD, children with ASD rarely exhibit malicious intent or aggression on another person with explicit intent to cause harm. Children and adolescents with ASD rarely try to conceal or lie about their aggressive or criminal-type behaviors.

Other psychiatric disorders that require clinical attention can be co-morbid with ASD.

With the exception of Asperger's disorder, mental retardation frequently co-occurs with autism and other PDDs. The more severe the mental retardation, the more symptoms of autism occur.

Numerous studies have described the co-occurrence of affective disorders in children and adolescents with ASD. The etiology of risk in persons with ASD for coexisting affective disorders is unclear. Children at higher levels of functioning often are included academically with socially adept, typical peers. Children with ASD are at risk for social rejection which can lead to depression and

stress. (Some studies show bipolar disorder is more common in persons with Asperger's disorder).

Anxiety disorders are also more common in persons with ASD.

OCD symptoms are often seen in persons with ASD.

ADHD symptoms are often seen in persons with ASD.

Tourette's Disorder, or motor and vocal tics are common in persons with ASD.

Circadian rhythm sleep disorder or dyssomnia-not otherwise specified may be seen in persons with ASD.

SOURCES

1. Volkmar F., Cook E., Jr., Pomeroy J, Realmuto G., Tanguay P., Summary of the Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults with Autism and other Pervasive Developmental Disorders, American Academy of Child and Adolescent Psychiatry. Journal of American Academy of Child/Adolescent Psychiatry, 1999; 38:1-59
2. Mattila M.L., Hurtig T., Haap Samott, et al. Comorbid Psychiatric Disorders Associated with Asperger Syndrome/ High-functioning Autism: A Community and Clinic-based Study. Journal for Autism Developmental Disorders; 2010
3. Johnson C.P., Myers S.M., Identification and Evaluation of Children with Autism Spectrum Disorders. Pediatrics, 2007; 120: 1183-215
4. Autistic Spectrum Disorders Best Practice Guidelines for Screening Diagnosis, and Assessment; California Department of Developmental Services, 2002.

Standard	Check all that Apply		
	Service:	***Recipient:***	***Location:***
All children suspected of having an autism spectrum disorder should have a comprehensive audiological evaluation that includes a case history, otoscopic exam, pure tone testing, speech audiometry, immitance testing, otoacoustic emissions, and/or an auditory brainstem response (ABR).	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School X Community

Check One: ___Minimum Standard X Best Practice Standard ___Gold Standard

Citation(s) for Evidence-base:

1. American Speech-Language-Hearing Association. (2006). Roles and Responsibilities of Speech-Language Pathologists in Diagnosis, Assessment and Treatment of Autism Spectrum Disorders Across the Life Span (Position Statement). Available from www.asha.org/policy
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4. Davis, R. & Stiegler, L. (2010) Behavioral Hearing Assessment for Children with Autism. The ASHA Leader.
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7. Englehof, K. et al. What Audiologists Need to Know About Autism Spectrum Disorders. *Seminars in Hearing*: 2005; Vol 26, no 4.
8. Rabidoux, P. Early Identification of Autism: Roles of the Speech Language Pathologist and Audiologist on a Transdisciplinary Team. *Seminars in Hearing*: 2005; vol 26, no 4.
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10. Cloppert, P et al. Evaluating an Enigma: What People with Autism Spectrum Disorders and their Parents Would Like Audiologists to Know. *Seminars in Hearing*: 2005; vol 26, no 4.
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Minimal Standards for Audiological Assessment In Children Suspected of Autism

NOTE: Ultimate goal is to obtain ear specific and frequency specific information

1. Infants and young children (birth – 3 years developmental age) who cannot be tested behaviorally
   a. Otoscopy for both ears.
   b. Tympanometry for both ears (1000Hz probe tone for ages birth to 6 months developmental age – 226 Hz probe tone for 7 months and older)
   c. Acoustic Reflexes, measured ipsilaterally at 1000 Hz
   d. DPOAEs @ 1000-6000Hz.
2. Older children (i.e. 3 years & older developmental age) who can be tested behaviorally for individual ear thresholds.
   NOTE: This could also be applicable for younger children who can be tested behaviorally, although air conduction screening levels may vary, depending on age and developmental level. In the case of older verbal children a hearing test is recommended to rule out the possibility of a late on-set hearing loss, as even a mild loss may have deleterious effects for development.
   a. Otoscopy for both ears
   b. Tympanometry for both ears with 226 Hz probe tone
   c. Acoustic Reflexes, measured ipsilaterally at 1000 Hz
   d. Air conduction screening for both ears at 15 dB HL for 500, 1000, 2000, and 4000H via headphones or insert phones (preferable) using VRA, conditioned play audiometry, or conventional response
   e. Speech Reception Thresholds (SRT's) for both ears
3. Children who will not cooperate for individual ear testing with inserts or headphones
   a. Otoscopy for both ears
   b. Tympanometry (if possible) for both ears with 226 Hz probe tone
   c. Minimum responses to warbled tones or fresh noise in sound field at 500, 1000, 2000, and 4000Hz, or screen at 25 dB HL.
4. For infants and children who cannot be tested or will not cooperate for any type of behavioral or objective testing, a threshold Auditory Brainstem Response (ABR) test for both ears with at least a click stimulus should be scheduled. Non-verbal children should always have a comprehensive audiologic assessment to rule out hearing loss.

   NOTE: For additional information, please refer to the more comprehensive flow chart.

Best Practices Standard for a comprehensive audiological evaluation includes the following:

1. **Case history** – To include the following: birth and developmental information; medical history, including history of ear infections and ear problems; family prevalence of hearing loss and patterns of decreased cognitive skills, behavioral concerns; auditory symptoms; and academic performance (when applicable).
2. **Otoscopic Exam –** To include the following: visualization of both ear canals and tympanic membranes; assure that both ear canals are unobstructed and free from foreign objects or excessive cerumen (i.e. earwax) buildup.
3. **Pure Tone Testing** – Depending on the age and developmental level of the child, may include the following: Behavioral Observation Audiometry (BOA), Visual Reinforcement Audiometry (VRA), Conditioned Play Audiometry (CPA) or Conventional Pure Tone Threshold Assessment. Individual ear assessment should be attempted, but, if the child is resistant to wearing headphones/inserts, responses to warbled tones or narrow band noise in sound field should be recorded. Responses should be obtained at 250, 500, 1000, 2000, 4000 and 8000 Hz, with the ultimate goal to obtain thresholds for each ear. If a conductive hearing loss is suspected, masked pure tone bone conduction thresholds should be recorded at 500, 1000, 2000 and 4000 Hz for both ears.
4. **Speech Audiometry** – Keeping language function/verbal abilities in mind, may include the following: Speech Awareness/Detection Threshold, Speech Reception Threshold and Word Recognition/Discrimination Testing. As with pure tone testing, individual ear assessment should be attempted, but, if the child is resistant to wearing headphones/inserts, responses

should be recorded in sound field, preferably obtaining responses from both right and left sides. As with pure tone testing, the ultimate goal is to obtain thresholds for each ear.

5. **Immittance Testing** – To assess middle ear function, as well as auditory nerve function up to the level of the SOC, tests should include the following: tympanometry, static compliance, and measurement of ipsilateral and contralateral acoustic reflexes at 500, 1000 and 2000 Hz.
6. **Otoacoustic Emissions (DPOAE or TOAE)** – To assess cochlear function and predict the presence of normal or reduced hearing for both ears. May include either Distortion Product or Transient OAE's, measured at 1000-6000 Hz.
7. **Auditory Brainstem Response (ABR)** – If behavioral assessment is not feasible or is inconclusive in ruling out hearing loss for both ears, ABR can be used to estimate hearing thresholds and to assess function beyond the periphery. Auditory neuropathy/auditory dys-synchrony should also be ruled out at the time of ABR testing. In many children suspected of autism, sedation may be required for ABR assessment. ABR assessment should include the following: minimum responses to clicks and tone bursts at 500, 1000, 2000 and 4000 Hz,; a graph of Wave V latency/intensity function using click stimuli; using click stimuli, measurement of absolute latency of Wavelets I, III and V, as well as interpeak latency between Wavelets I and V, and minimum response for a bone conduction click. If auditory neuropathy/dys-synchrony is suspected, verification of a cochlear microphonic should be made using condensation and rarefaction clicks at 80-90 dBnHL.
8. **Monitoring / Follow up** - Children with ASD or suspected of ASD may require subsequent hearing evaluations to monitor hearing status for the following reasons: ***1) Risk*** factor(s) for delayed onset or progressive hearing loss have been identified in the case history; ***2)*** A co-morbid condition of hearing loss has been identified; 3) Individual ear information to confirm normal hearing status bilaterally has not been obtained.

Standard	**Check all that Apply**		
	Service:	***Recipient:***	***Location:***
All children referred for an autism diagnostic evaluation should have an age-appropriate eye examination and vision assessment.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___ Family ___School District ___Other / List:	___Home ___School X Community

Check One: **X** Minimum Standard

Exam conducted by a pediatric ophthalmologist **X** Best Practice Standard **X** Gold Standard

Citation(s) for Evidence-base:

1. Eye examination in infants, children, and young adults by pediatricians: organizational principles to guide and define the child health care system and/or improve the health of all children. Ophthalmology 2003; 110:860-5.
2. TINGLEY DH. Vision screening essentials: screening today for eye disorders in the pediatric patient. Pediatr Rev 2007; 28:54-61.

Children referred for an autism diagnostic evaluation should have an age-appropriate eye examination and vision assessment. Vision problems, e.g., major refractive errors, strabismus, and amblyopia, occur in 5% to 10% of all preschool children. Children with developmental delays and neurological problems are at even higher risk.[1, 2]

For children under 3 years of age, an ocular history, external inspection of the eye and lids, ocular motility assessment, pupillary and red reflex examinations, and vision assessments should be performed by a pediatrician or other primary healthcare provider. Vision assessment in children younger than 3 years of age can be accomplished by evaluating the child's ability to fixate on an object, maintain fixation, and then follow the object into various gaze positions. The assessment should be performed binocularly and then monocularly. For children older than age 3, visual acuity testing should be attempted. If an adequate eye examination cannot be obtained or if a visual acuity assessment cannot be accomplished by age 4, then the child should be referred promptly to an ophthalmologist experienced in the care of children.

Because children with who have significant developmental delays or neurological problems are at higher risk for eye problems, autism diagnostic clinics should have a low threshold for referring children with autism to a pediatric ophthalmologist or other

ophthalmologist who is experienced in treating young children. Autism diagnostic clinics should develop a working relationship with such ophthalmologists so that these children can receive prompt, specialized eye examinations.

Standard	Check all that Apply		
	Service:	***Recipient:***	***Location:***
As part of an interdisciplinary team assessment for autism spectrum disorders, a qualified Speech-Language Pathologist should provide evaluation of the following aspects of communication: **Minimum Standard:** • A thorough ***case history*** of language should be obtained that includes information regarding babbling (age began and description), age and descriptions of first words, and any noted regression in language and/or social skills. • A standardized measure of ***receptive and expressive language*** that encompasses all areas of language structure (phonology/morphology/syntax/semantics) • Informal or formal evaluation of ***social communication*** skills, appropriate for age and/or cognitive level, such as rate and use of gestures, eye gaze, gaze shifts, joint attention, conversational turn-taking, topic maintenance etc. These skills may be observed during autism-specific assessments such as the ADOS-G (Lord et al., 2000) or by obtaining a natural language sample. • Evaluations of ***articulation, oral motor skills, intelligibility, fluency, and voice*** should be completed if warranted The SLP is considered qualified by the following characteristics: • Holds the ASHA Certificate of Clinical Competence in Speech-Language Pathology (CCC SLP) • Demonstrates continued professional development in the area of autism spectrum disorders • As mandated by ASHA standards, "Each practitioner must evaluate his or her own experiences with preservice education, clinical practice, mentorship and supervision, and continuing professional development . . . Speech-language pathologists may engage in only those aspects of the profession that are within their scope of competence." (ASHA 2007).	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community

Check One: X Minimum Standard ___Best Practice Standard ___Gold Standard

Citation(s) for Evidence-base:

1. American Speech-Language-Hearing Association. (2007). (*Scope of practice in speech-language pathology*. Available from http://www.asha.org/policy.
2. American Speech-Language-Hearing Association. (2006a). *Guidelines for speech-language pathologists in diagnosis, assessment, and treatment for autism spectrum disorders across the life span*. Available from http://www.asha.org/policy
3. American Speech-Language-Hearing Association. (2006b). *Knowledge and skills needed by speech-language pathologists for diagnosis,*

assessment, and treatment for autism spectrum disorders across the life span. Available from http://www.asha.org/policy.

4. American Speech-Language-Hearing Association. (2006c). *Roles and responsibilities of speech-language pathologists in diagnosis, assessment, and treatment of autism spectrum disorders across the life span: Position statement*. Available from http://www.asha.org/policy.
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7. Tager-Flusberg et al., (2009). Defining spoken language benchmarks and selecting measures of expressive language development for young children with autism spectrum disorders. *Journal of Speech, Language, and Hearing Research, 52*, 643-652. Available from http://www.nidcd.hih.gov/funding/programs/vsl/language_benchmarks.htm.

Standard	**Check all that Apply**		
	Service:	***Recipient*:**	***Location:***
As part of an interdisciplinary team assessment for autism spectrum disorders, a qualified Speech-Language Pathologist should provide evaluation of the following aspects of communication: **Best Practice Standard:** • A thorough ***case history*** of language should be obtained that includes information regarding babbling (age began and description), age and descriptions of first words, and any noted regression in language and/or social skills. • A standardized measure of ***receptive language*** that encompasses all areas of language structure • A standardized measure of ***expressive language*** that encompasses all areas of language structure (phonology/morphology/syntax/semantics) • Informal or formal evaluation of ***social communication*** skills, appropriate for age and/or cognitive level, such as rate and use of gestures, eye gaze, gaze shifts, joint attention, conversational turn-taking, topic maintenance etc. These skills may be observed during autism-specific assessments such as the ADOS-G (Lord et al., 2000) or by obtaining a natural language sample. • In individuals who are verbal, standardized evaluation of ***articulation,*** including statement regarding overall intelligibility. • Evaluation of ***oral motor skills.*** • In individuals who are verbal, statement regarding ***fluency*** should be made. A descriptive statement of ***prosody*** should be included. • In individuals who are verbal, descriptive statement regarding ***vocal pitch, quality and loudness*** should be made.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community

The SLP is considered qualified by the following characteristics: • Holds the ASHA Certificate of Clinical Competence in Speech-Language Pathology (CCC SLP) • Demonstrates continued professional development in the area of autism spectrum disorders • As mandated by ASHA standards, "Each practitioner must evaluate his or her own experiences with preservice education, clinical practice, mentorship and supervision, and continuing professional development . . . Speech-language pathologists may engage in only those aspects of the profession that are within their scope of competence." (ASHA 2007).			

Check One: __Minimum Standard X Best Practice Standard ___Gold Standard

Citation(s) for Evidence-base:

1. American Speech-Language-Hearing Association. (2007). (*Scope of practice in speech-language pathology*. Available from http://www.asha.org/policy.
2. American Speech-Language-Hearing Association. (2006a). *Guidelines for speech-language pathologists in diagnosis, assessment, and treatment for autism spectrum disorders across the life span*. Available from http://www.asha.org/policy
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6. Paul, R., & Wilson, K. (2008). Assessment of communication in autism spectrum disorders. In S. Goldstein, Naglieri, & S. Ozonoff (Eds.) Assessment in Autism Spectrum Disorders. NY: Guilford Press.
7. Tager-Flusberg et al., (2009). Defining spoken language benchmarks and selecting measures of expressive language development for young children with autism spectrum disorders. *Journal of Speech, Language, and Hearing Research, 52*, 643-652. Available from http://www.nidcd.hih.gov/funding/programs/vsl/language_benchmarks.htm.

Standard	Check all that Apply		
	***Service*:**	***Recipient*:**	***Location*:**
As part of a comprehensive interdisciplinary diagnostic evaluation, it is essential that all children referred to a Regional Autism Diagnostic Clinic receive an assessment of their cognitive/developmental functioning. Intellectual assessments should be conducted under the supervision of a licensed psychologist. Developmental assessments for toddlers and preschool-aged children can be conducted under the supervision of a licensed psychologist or a credentialed professional in a related developmental field (e.g., education). In accordance with the Alabama State Department of Education requirements, a measure of adaptive behavior is also considered essential.	X Direct __Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	___Home X School X Community

Check One: COGNITIVE ASSESSMENT: X Minimum Standard ___Best Practice Standard ___Gold Standard

ADAPTIVE ASSESSMENT: X Minimum Standard ___Best Practice Standard ___Gold Standard
Citation(s) for Evidence-base: 1. Klinger, L.G., O'Kelley, S.E., & Mussey, J.L. (2009). Assessment of Intellectual Functioning in Autism Spectrum Disorders. In S. Goldstein, J.A. Naglieri, & S. Ozonoff (Eds.), Assessment of Autism Spectrum Disorders (pp. 209-252). New York: Guilford.
Professional preparation and training: The examiner is considered qualified by the following characteristics: o The examiner/supervisor is licensed as a psychologist (clinical, counseling, or school psychology) by the Alabama Board of Examiners in Psychology (i.e., earned a doctoral degree and completed one year clinical internship) or the examiner has been credentialed by their respective discipline. o At least two years previous experience working with individuals with autism spectrum disorders including individuals within the age range and developmental level of the person being evaluated.

Cognitive/Developmental Assessment Instruments:

Cognitive/developmental testing is an essential part of an ASD interdisciplinary diagnostic evaluation (Filipek et al., 1999; Johnson et al., 2007). Klin, Saulnier, Tsatsanis, & Volkmar (2005) described developmental testing for infants and preschool-aged children and intellectual assessment for school-aged children as a frame for interpreting the results of diagnostic testing. This "frame" can be used to evaluate whether a child's social and communication delays are greater than expected given the child's developmental level or whether they are equivalent to the child's developmental level. In order to receive a diagnosis of ASD, a child's social and communicative skills must be delayed below a child's developmental level.

The traditional standardized assessment paradigm is often a challenge for children with ASD and for the examiner administering the assessment. Thus, the examiner often needs to structure the session using schedules and rewards to maintain motivation and decrease behavioral difficulties (see Klinger et al., 2009 for ideas on how to structure an intellectual assessment). At a minimum, the examiner should have experience administering intellectual assessments to children and have some knowledge about how the symptoms of ASD may interfere with test administration and performance. Ideally, the examiner will have experience interacting with individuals with ASD, and additional understanding of the symptoms and treatment approaches for ASD will assist the examiner in choosing an appropriate test and structuring the testing session to ensure that the child's performance is representative of his or her true abilities. The choice of an intellectual/developmental assessment depends on the child's chronological age, mental age, language abilities, and severity of autism symptoms. The attached list of recommended intellectual assessment instruments is based on Klinger et al. (2009) although other measures may also be considered appropriate. ***A comprehensive cognitive/developmental evaluation is essential (i.e., minimal standards) as part of an interdisciplinary diagnostic evaluation.***

Adaptive Behavior Assessment Instruments:

A measure of adaptive behavior is recommended for both diagnostic and clinical reasons. First, in order to diagnose ASD and concomitant Intellectual Disability, delays must be present in intellectual ability and in adaptive behaviors. Second, poor adaptive behaviors are common among even individuals with high functioning ASD. These delays in adaptive behaviors including daily living skills such as self-care, money management, and employment skills often interfere with long-term success of individuals with ASD. Thus, a measure of adaptive behavior is considered important for making recommendation to insure long-term outcome. Finally, the State of Department of Education requires a measure of adaptive behavior to determine eligibility for services under the diagnostic category of Autism.

The attached list of recommended intellectual assessment instruments is based on Klinger et al. (2009) although other measures may also be considered appropriate. ***An adaptive behavior evaluation is considered best practices in an autism spectrum disorder evaluation, is required by the Alabama State of Department of Education, and is essential in order to diagnose Intellectual Disability.***

Recommended Cognitive and Adaptive Measures for Use with Individuals with ASD

COGNITIVE MEASURES

Measure	Age range	Standard Score Range	Administration Time (minutes)	Required Level of Verbal Ability
Preschool Age				
Bayley-III	1 to 42 m	40 to 160	30 to 90	V & NV
DAS-II (Early Years)	2 y, 6 m to 3 y, 5 m	30 to 170	20	V & NV
WPPSI-III (young level)	2 y, 6 m to 3 y, 11 m	45 to 155	25 to 35	V
Mullen	Birth to 5 y, 8 m	49 to 155	15 to 60	V
School Age				
DAS-II (School-Age)	3 y, 6 m to 17 y, 11 m	30 to 170	30	V & NV
WPPSI-III (older level)	4 y, 0 m to 7 y, 3 m	45 to 160	40 to 50	V
WISC-IV	6 y, 0 m to 16 y, 11 m	40 to 160	65 to 80	V
Leiter-R	2 y, 0 m to 20 y, 11 m	30 to 170	25 to 40	NV
Adult				
WAIS-IV	16 to 89 y	45 to 155	65 to 95	V
Lifespan				
SB5	2 to 85 y	40 to 160	45 to 75	V & NV

ADAPTIVE MEASURES

Measure	Age range		Administration Time	Administration Format
Vineland-II	Birth to 90 y	XX	20 to 60	Interview or Checklist
ABAS-II	Birth to 89 y	40 to 120	20	Checklist
SIB-R	Infancy to over 80 y	XX	15 to 60	Interview or Checklist
BASC-II	2 to 21 y	10-100 (mean of 50)	10 to 20	Checklist

Note: Bayley-III = Bayley Scales of Infant and Toddler Development – Third Edition; DAS-II = Differential Ability Scales – Second Edition; WPPSI-III = Wechsler Preschool and Primary Scale of Intelligence – Third Edition; Mullen = Mullen Scales of Early Learning; WISC-IV = Wechsler Intelligence Scale for Children – Fourth Edition; Leiter-R = Leiter International Performance Scale Revised; WAIS-III = Wechsler Adult Intelligence Scale – Fourth Edition; SB5 = Stanford Binet Intelligence Scales – Fifth Edition; Vineland-II = Vineland Adaptive Behaviors Scales – Second Edition; ABAS-II = Adaptive Behavior Assessment System – Second Edition; SIB-R = Scales of Independent Behavior Revised ; BASC-II = Behavior Assessment System for Children – Second Edition; m = months; y = years; NV = Nonverbal; V = Verbal; Unless otherwise noted, mean of all instruments if 100 with a standard deviation of 15.

Standard	**Check all that Apply**		
	***Service*:**	***Recipient*:**	***Location*:**
As part of a comprehensive interdisciplinary diagnostic	X Direct	X Individual w/ASD	___Home

evaluation, it is essential that all children referred to a Regional Autism Diagnostic Clinic receive an assessment of their autism symptoms including: 1. Autism Diagnostic Observation Schedule (ADOS) - a standardized, validated instrument that includes direct observation. 2. DSM based clinical interview with a caregiver. The Autism Diagnostic Interview-Revised (ADI-R) is considered best practice. 3. In accordance with the Alabama State Department of Education requirements, a norm-referenced autism-specific rating scale is considered essential (i.e., minimal standards) to an interdisciplinary diagnostic evaluation in the state of Alabama. **4.** Consider whether an alternative or comorbid diagnosis is appropriate.	___Technical Assist ___Consultation	X Family ___School District ___Other / List:	X School X Community
Check One: Autism Diagnostic Observation Schedule: X Minimum Standard ___Best Practice Standard ___Gold Standard DSM-IV Based Caregiver Interview: X Minimum Standard ___Best Practice Standard ___Gold Standard Autism Specific Rating Scale: X Minimum Standard ___Best Practice Standard ___Gold Standard			
Professional preparation and training: ○ Autism diagnostic and screening instruments should be administered by or under the supervision of a professional licensed within their respective field. ○ Diagnoses should be made by a licensed professional with at least two years "hands on" experience working with individuals with autism spectrum disorder including those within the age range and developmental level of the person being tested. ○ Diagnoses should be made by a licensed professional with at least one year of previous experience in conducting autism diagnoses, including "hands on" training and onsite mentoring with the instruments being administered to make the diagnosis.			

Diagnostic and Symptom Screening Instruments:
Autism Spectrum Disorder diagnostic evaluation should include ASD-specific diagnostic instruments. Until recently, the diagnosis of ASD has been based on clinician observation and intuition rather than a score on a standardized instrument. However, more objective diagnostic measures are now available. Best practices autism diagnostic evaluations go beyond caregiver rating scales to include standardized assessments including a structured play observation and a caregiver interview.

Autism Diagnostic Observation Schedule (ADOS-G; Lord et al., 2000)
The ADOS is a semi-structured play session (or conversation for adults) that creates an environment in which to assess an individual's social skills, communication skills, and the presence of restricted or repetitive behaviors. The ADOS takes approximately 30-45 minutes to administer and is appropriate for individuals from two years of age through adulthood; a developmental level of 18 months is necessary for standardized use and interpretation. There are 4 different ADOS modules based on the individual's developmental level and current language skills. Module 1 is appropriate for nonverbal individuals, Module 2 is appropriate for individuals using phrase speech, Module 3 is appropriate for children and adolescents with fluent language, and Module 4 is designed for adults with fluent language. Based on behaviors during the session, a series of algorithm items are rated to yield a classification of either Autism, Autism Spectrum, or non-spectrum. The original ADOS scoring algorithm and classifications were based only on social and communication skills because repetitive behaviors and restricted interests were less likely to be observed during a short period of time. During ADOS observation, if repetitive behaviors and restricted interests are observed, the examiner can feel confident that they are present. If behaviors in this symptom area are not observed, a caregiver interview is necessary to assess these behaviors rather than incorrectly assuming these behaviors do not occur, thereby limiting diagnostic accuracy. However, a recent revised scoring algorithm includes scores related to

repetitive behaviors and interests (Gotham et al., 2008). This revised algorithm has a greater predictive value (i.e., sensitivity of the measure to yield a classification predictive of eventual diagnosis) than the previous algorithm. Because of the difficulty in assessing repetitive behaviors and interests, a parent interview is an important component of making an accurate diagnosis and it is not recommended that the ADOS be used in isolation for diagnosing ASD. A fifth module, the ADOS Toddler Module (2006), has recently been developed for use in children younger than 30 months of age and will soon be available for clinician use. **The use of the ADOS as part of a diagnostic evaluation is considered to be essential (i.e., minimal requirement).**

Autism Diagnostic Interview – Revised (ADI-R; Lord, Rutter, & LeCouteur, 1994).
The ADI-R is a semi-structured caregiver interview appropriate for individuals between the ages of 18 months of age and adulthood. The interview focuses on the individual's social skills, communication skills, and the presence of any restricted and repetitive behaviors. Because diagnostic symptoms change across the lifespan, an ADI-R classification of ASD is based on caregiver report of symptoms during the preschool years when symptoms tend to be the most severe and differentiated from other developmental disorders. However, current behaviors are also assessed to obtain an accurate picture of each individual's current skills. This is a lengthy interview; the short version takes approximately 1 ½ hours to administer. Because it is so lengthy, many general practitioners find the ADI-R difficult to administer in their daily practice. However, it is typically included in an ASD assessment in clinical settings specializing in ASD. **While a DSM-IV based caregiver interview is considered essential (i.e., minimal standards), the use of the ADI-R is considered best practices.**

ASD-Specific Rating Scales
An autism-specific norm-referenced rating scale is required by the Alabama Department of Education criteria for an ASD diagnosis. It is important to note that these rating scales were intended as screening instruments and are never intended as stand-alone diagnostic tools. **Because of the Alabama State Department of Education requirements, a norm-referenced autism-specific rating scale is considered essential (i.e., minimal standards) to an interdisciplinary diagnostic evaluation in the state of Alabama.** As with other parts of the evaluation, clinical judgment should be exercised in interpreting the results of these rating scales.

Childhood Autism Rating Scale - Second Edition (CARS-2). The CARS-2 actually consists of two separate scales---the original standard (ST) form which includes the same items from the first edition of the CARS, and the new scale which includes items relevant to verbally fluent individuals (CARS-HF). The CARS-ST may be used with children younger than 6, as well as lower functioning older individuals. The CARS-HF is appropriate for use with verbally fluent persons over the age of 6, with IQ scores above 80. While there is a Questionnaire for Parents or Caregivers (CARS2-QPC), this is a non-scored tool to assist the clinician in making clinical judgments on the CARS-ST or the CARS-HF with regard to a particular individual. The latter instruments should not be completed by parents. While it may only take 5 to 10 minutes to complete the CARS-2, it can require a much longer time to gather the information necessary to do so in a valid manner. Immediately following completion of intellectual or behavioral observation measures may be the most beneficial time to make these clinical judgments. Cut-off scores and percentiles may be obtained for the CARS-2.

Autism Spectrum Rating Scales (ASRS). These teacher and parent rating scales are available in two separate forms---one for preschoolers and the other for elementary and high school students. Using a 5-point Likert response scale, parents and teachers rate the frequency of specific behaviors. Completion time for the full scales is approximately 20 minutes, and the ASRS is normed on children from 2 to 18 years of age. Scoring yields standard scores and percentile ranks for the overall score, as well as the following subscales: Peer Socialization, Adult Socialization, Social/Emotional Reciprocity, Atypical Language, Stereotypy, Behavioral Rigidity, Sensory Sensitivity, Attention/Self-Regulation (ages 6-18) and Attention (ages 2-5).

Gilliam Autism Rating Scales - Second Edition (GARS-2). This 42-item scale takes 5-10 minutes to complete, the GARS-2 can be used for ages 3 to 22 years. Separate scores are obtained for Stereotyped Behaviors, Communication, and Social Interaction, as well as a total Autism Index to estimate severity of impairment. Instructional objectives to assist

in educational planning for students who are rated by the GARS-2.

Gilliam Asperger's Disorder Scale (GADS). Similar to the GARS-2, the GADS may be used with ages 3 to 22 and can be administered and scored in 5 to 10 minutes. The GADS, however, has a unique norm reference group of individuals diagnosed with Asperger's Disorder. This normative basis facilitates discrimination between Asperger's Disorder and other autism spectrum disorders, with standard scores and percentiles ranking the subject in comparison to persons diagnosed with Asperger's.

Social Responsiveness Scale (SRS). The SRS (Constantino & Gruber, 2005) is a 65-item questionnaire developed to measure social skills, communication, and repetitive or stereotyped behavior. The SRS is appropriate for children between the ages of 4 and 18 years of age and a preschool version is currently being developed. There are separate caregiver and teacher rating scales that each take approximately 15 minutes to complete. Behaviors are rated on a Likert scale. Cut-off scores are provided for use of the SRS as either a population-based screening measure or for use as a screening and diagnostic tool when children are suspected of having ASD. In addition to a total T score, subscale scores of Social Awareness, Social Cognition, Social Communication, Social Motivation, and Autistic Mannerisms may be calculated. Constantino and colleagues (2003) reported that all children receiving ADI-R scores above the clinical cut-off also had elevated SRS scores. Thus, the SRS is useful as a screening instrument and as a measure of ASD symptom severity (see Naglieri & Chambers, 2009 for a more comprehensive review).

Recommended Autism Spectrum Rating Scales

Measure	Age range	Scores provided	Administration Time (minutes)	Rater
Autism Spectrum Rating Scale	2-18 years	Standard scores and percentiles	20 minutes	Parent, Teacher
Childhood Autism Rating Scale, Second Edition	2+ years	Cut-off scores, percentiles	5-10 minutes after observation completed	Teacher, Clinician
Gilliam Autism Rating Scale, Second Edition	3-22 years	Cut-off scores and percentiles	5-10 minutes	Parent, Teacher, Clinician
Gilliam Asperger's Disorder Scale	3-22 years	Standard scores and percentiles	5-10 minutes	Parent, Teacher, Clinician
Social responsiveness Scale	4-18 years	Standard scores and percentiles	15 minutes	Parent, Teacher

Assessment of Alternative and Comorbid Disorders

It is the role of a licensed psychologist, ideally with the support of an interdisciplinary team, to examine whether social communication difficulties and repetitive behaviors can be better explained by alternative diagnoses (e.g., selective mutism) or whether a comorbid diagnosis exists (e.g., anxiety, depression). It may be helpful to consider whether other behavioral and/or emotional rating scales (e.g., BASC-II) or caregiver interviews (e.g., Diagnostic Interview Schedule for Children) should be administered to differentiate between ASD and other diagnoses or to determine comorbidity.

Making a Diagnosis: Integrating Interdisciplinary Results

It is the role of the diagnostician to integrate information from the autism specific measures discussed above, with the information provided by other disciplines in order to make a clinical diagnosis. That is, a diagnosis of an autism spectrum disorder should never be made based on a single score on a single measure. Instead, information about the

individual's developmental history, intellectual/developmental ability, language ability, health/physical concerns, and mental health concerns should be integrated with the autism measures to make a final diagnosis.

Standards	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
As part of a comprehensive interdisciplinary diagnostic evaluation, all children suspected of having an autism spectrum disorder should, as a minimum, have an occupational therapy screening for fine motor and sensory processing delays. Best practice consists of a comprehensive occupational therapy evaluation that includes the following: • Occupational Profile • Motor skills • Sensory processing abilities • Play • Self-care skills. The assessment should include structured interview, observation, direct assessment that include multiple measures which include standardized instruments. Occupational therapy intervention decisions will be based on evidence-based best practices, individualized analysis of the child, and the premise that caregivers are central to the intervention process. Interventions will promote active engagement of the child.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community

Check One: **X** Minimum Standard **X** Best Practice Standard ___Gold Standard

Citation(s) for Evidence-base:

1. AOTA (2009). Occupational Therapy Practice Guideline for Children and Adolescents with Autism.
2. Cohen, H., Amerine-Dickens, M. & Smith, T. (2006). Early intensive behavioral treatment: Replication of the UCLA model in a community setting. *Developmental and Behavioral Pediatrics, 27*, S145-S155.
3. Dunst, C., Hamby, D., Trivett, C. M., Raab, M. & Bruder, M.B. (2000). Everyday family and community life and children's naturally occurring learning opportunities. *Journal of Early Intervention, 23*, 151-164.
4. Greenspan, S. I. & Wieder, S. (1997). Developmental patterns and outcomes in infants and children with disorders of relating and communicating: A chart review of 200 cases of children with autism spectrum diagnoses. *Journal of Developmental and Learning Disorders,1*,87-142
5. Rogers, S. & DiLalla, D. L. (1991). A comparative study of the effects of a developmentally based instructional model on young children with autism and young children with other disorders of behavior and development *Topics in Early Childhood Special Education, 11*(2), 29-47.
6. Turnbull, A.P., Turbiville, V. & Turnbull, H.R. (2000).Evolution of family-professional partnership models: Collective empowerment as the model for the early 21st century. In S. J. Meiseld J.P. Shonkoff (Eds.) *Handbook of early intervention* (pp. 640-650). New York: Cambridge University Press.

Professional training and preparation: All occupational therapists who are on a Regional Diagnostic Clinic Interdisciplinary Diagnostic Team will have graduated from at least a bachelor's degree OT program accredited by ACOTE, have passed the nationally recognized NBCOT examination, and fulfill state license requirements for the Alabama State Board of Occupational Therapy

These recommendations are based on best practice from the American Occupational Therapy Association, The California Best Practices, and in consideration of the logistical limitations for the evaluation process, and the needs of the families.

A proposed change to the diagnostic criteria for autism spectrum disorders in DSM V reads as follows:

"Hyper-or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment; (such as apparent indifference to pain/heat/cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects."
(http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=94)

Sensory processing disorders are well documented in the literature (Ornitz, 1989, Ornitz, Lane, Sugiyama, & de Traversay, 1993, Yenug-Courchesne & Courchesne, 1997. Ertmer & Dunn, 1998; Kientz & Dunn, 1997; Watling, Deitz, & White, 2001) as well as supported by first-person accounts (Cesaroni & Garber, 1991; Grandin, 1995). Children being evaluated for possible autism spectrum disorders should be screened for fine motor and sensory processing delays. The Sensory Profile Short Form is one instrument that can be used for screening. However, best practice dictates that if the Sensory Profile Short Form identifies dysfunction in any subsection and/or in the total score, a referral should be made to an occupational therapist for a thorough evaluation and therapeutic recommendations.

The Short Sensory Profile is a 38-item caregiver report measure that takes about 10 minutes to administer to parents. Items are scored on a five-point scale. There are seven sections: tactile sensitivity, taste/smell sensitivity, movement sensitivity, under responsive/seeks, sensation, auditory filtering, low energy/weak, and visual/auditory sensitivity. The total score is the most sensitive indicator of sensory dysfunction, however, section scores are interpreted as independent variables. The SSP isolates sensory processing from social and motor items. Validity is at >95% in identifying children with and without sensory modulation difficulties (McIntosh et al, 1999). Tomchek and Dunn (2007) found that children with ASD performed differently than normally developing children on the SSP .

The Best Practice Occupational Therapy evaluation should include all of the following:

Play Skills- Play is the child's primary occupation and is an essential component of the occupational therapy evaluation. Observation of play often provides a rich amount of information regarding performance skills of a child. Assessment of play is an essential component of the diagnostic process because children with autism spectrum disorders lack spontaneous, varied make-believe play (DSM-IV). Observations should describe the child's level of play skills, qualitative aspects of the play performance, social and interactive aspects of the play performance, as well as variability of play skills, transitions from one activity to another, and ability to engage in creative and pretend scenarios. Information related to play preferences, routines, engagement, environments, ability to play with peers, ability to engage in pretend play, imitation, initiation, and shared enjoyment should be noted. Evaluation includes direct assessment, observation, caregiver interview, and structured and unstructured play opportunities. Frequently used assessment tools include the Revised Knox Preschool Play Scale (Knox, 2008), Test of Playfulness (Skard & Bundy, 2008), and the Transdiciplinary Play Based Assessment 2nd Edition (Linder, 2008). The information gathered during the evaluation should be interpreted to determine play levels, typical and preferred play activities, ability to engage in play interactivity, and hindrances to play skills.

Occupational Profile-The occupational profile identifies the child's occupational history, current occupations in various contexts, discusses typical routines, and the child's interests and motivations. The profile also explores problematic daily routines, social supports, and parent concerns. Assessment tools commonly used include the

Canadian Occupational Performance Measure (Law et all, 2005), Perceived Efficacy and Goal Setting System (PEGS; Missiune, Pollock, & Law, 2004), Children's Assessment of Participation and Enjoyment and Preferences for Activities (CAPE/ PAC; King et al., 2005) and caregiver interview. If the child is school age, additional communication may be needed to determine school based performance and concerns and may include additional testing.

Motor skills- A motor skills evaluation includes fine motor, gross motor, and visual motor skills. Observation of motor performance should include postural stability, mobility, neuromotor development, and skill performance. The evaluation can include observations of play as well as structured or standardized assessments. Performance of typical age appropriate skills such as walking, running, stair climbing, hopping, skipping, kicking a ball, riding a bicycle, swimming, and participation in structured activities (i.e., recreational sports, team sports, etc.) should be included. The evaluation should assess both the quality of movements and the precision of skills. Fine motor and visual motor evaluation should include typical grasp and prehension patterns, hand dominance, finger dexterity, and manipulation of play items. Performance of typical age appropriate skills such as block play, coloring, writing, cutting, puzzle play, catching, throwing, and manipulation and activation of various toys should be included. Assessment tools commonly used include the Peabody Developmental Motor Scales- Second Edition (Folio & Fewell, 2000) , the Bruninks-Oseretsky Test of Motor Proficiency-Second Edition (Bruininks & Bruininks, 2005),the Miller Function and Participation Scales (Miller, 2006), the Developmental Test of Visual Motor Integration 5th Edition (Berry et al, 2004), Test of Visual-Motor Skills Revised (Gardner, 1998), The Evaluation Tool of Children's Handwriting (Amundson, 1995), Minnesota Handwriting Assessment (Reisman, 1999) and the Test of Handwriting Skills (Gardner, 1998). The evaluation should include an interpretation of motor abilities and underlying issues impacting performance.

Sensory processing abilities- Evaluation of sensory processing abilities includes gathering information regarding sensory processing within daily life situations, measuring the child's responsiveness to varied sensory experiences, and include assessment of behavior, praxis, and emotional lability. Assessment tools commonly used include the Sensory Profile (Dunn, 1999); Infant Toddler Sensory Profile (Dunn et al, 1999), Adolescent/ Adult Sensory Profile (Dunn et al, 1999), Sensory Integration Inventory-Revised (Reisman & Hanschu, 1992), Sensory Professing Measure, Home Form (Parham & Ecker, 2007), Main Classroom and School Environment (Miller-Kuhaneck et al., 2007). The evaluation should include an interpretation of the sensory processing, including a description of sensory behaviors with hyper and hypo sensitivities clearly indicated.

Self-care skills- An assessment of self-care skills should include feeding, grooming, dressing, bathing, and toileting. Particular emphasis should be placed on the feeding performance when this is a concern. Feeding assessments should include feeding history, and typical performance related to volume and variety of foods and preference for particular textures, flavors or temperatures of foods or rituals related to feeding and mealtimes. Typical assessment tools utilized include the Pediatric Evaluation of Disability Inventory (Haley et al, 1992), parent interview, BAMBI and Vineland Adaptive Behavior Scale-Second Edition (Sparrow et al, 2005). The assessment should include a description of any specific rituals that are currently followed for completion of specified self-care skills. An interpretation of the child's current status should be included to prioritize skills that will be targeted for intervention.

Behaviors during the Evaluation- From initial contact with the family and throughout the evaluation process, the child's behaviors are noted.

Observations should note the following: (a) ritualistic and rigid behaviors, (b) vocalizations (echolalia, sounds, humming, high pitched screams, non-purposeful noise), (c) quality of eye contact, (d) response to name calling, (e) self-stimulating behaviors, (f) self-injurious behaviors, (g) ability to remain seated when requested, (h) frustration

tolerance, (I) ability to handle transitions, (j) withdraw or aversive responses to touch or auditory stimuli, (k) distractibility, and (l) social appropriateness.

Best Practice Occupational Therapy for evaluation of ASD should include:

Area:	***Include:***	***Recommended tools:***
Occupation	Occupational profile- occupational history and current occupations in various contexts, typical routines, interests, and motivations, problematic routines and social functions, family concerns, questions and priorities	Parent/caregiver interview Chart review Observations during evaluation
Self-care	Feeding Grooming Undressing and dressing Bathing Toileting	Pediatric Evaluation of Disability Inventory Skilled Clinical Observation BAMBI (optional) Parent interview to probe for details that promote participation and hindrances in the process
Sensory Processing	Full evaluation of sensory processing abilities	Sensory Profile or Infant/Toddler Sensory profile Or Adolescent/adult sensory profile as age appropriate And description of sensory behaviors with hyper and hypo sensitivities clearly indicated and interpreted
Motor	Gross motor Fine motor Visual Motor (if appropriate)	Peabody Developmental Motor Scales -2 (PDMS-2) or Bunininks-Osteretsky Test of Motor Development-2 (BOT-2) And if appropriate: Berry-Buktenica Developmental Test of Visual- Motor Integration
Leisure/play	Assessment of play is an essential part of this diagnostic process and should include play preferences, routines, engagement, environments, peers as much as possible, ability to engage in pretend play or only routine play behaviors -requesting -shared enjoyment -level of play -quality/appropriateness of play -imitation -initiation -etc.	Analysis of information gathered to determine play behaviors that are typical and preferred for this child, those that are indicative of stereotypical behaviors or routines, interaction with others, play environments available, ability to engage
General Behaviors	Observation of ritualistic, rigid, and self-stimulating behaviors should be noted including: • hand flapping • humming • non-purposeful noise production vocally • eye contact or lack of • odd eye gazes • rocking • other non-purposeful movements such as tics. • Ability or inability to transition between tasks	Observations should be made during both structured (with expectations and desired outcome) and unstructured play (without expectations and no particular desired outcome) opportunities

	• tolerates/acknowledges unfamiliar person	
Other	At times, other concerns are identified and therefore may be addressed during the OT Evaluation Concerns regarding handwriting, visual perceptual skills, sensory integration and other concerns within the domain of occupational therapy are appropriate to be addressed when needed	Choose as needed and appropriate: Sensory Integration and Praxis Test Test of Visual Perceptual Skills Evaluation Tool of Children's Handwriting Others as developed may be appropriate

Standard	**Check all that Apply**		
	Service:	***Recipient:***	***Location:***
Alabama Regional Autism Network providers will encourage and assist pediatricians and other primary healthcare providers who care for young children to implement and provide universal surveillance and screening for developmental delays/disabilities and for autism spectrum disorders.	**X** Direct **X** Technical Assist **X** Consultation	**X** Individual w/ASD **X** Family ___School District ___Other / List:	**X** Home **X** School **X** Community

Check One: X Minimum Standard ___Best Practice Standard ___Gold Standard

Citation(s) for Evidence-base:

1. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics 2006; 118:405-20.
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4. BARBARO J, DISSANAYAKE C. Prospective identification of autism spectrum disorders in infancy and toddlerhood using developmental surveillance: the social attention and communication study. J Dev Behav Pediatr 2010; 31:376-85.
5. WETHERBY AM, ALLEN L, CLEARY J, KUBLIN K, GOLDSTEIN H. Validity and reliability of the communication and symbolic behavior scales developmental profile with very young children. J Speech Lang Hear Res 2002; 45:1202-18.
6. WETHERBY AM, BROSNAN-MADDOX S, PEACE V, NEWTON L. Validation of the Infant-Toddler Checklist as a broadband screener for autism spectrum disorders from 9 to 24 months of age. Autism 2008; 12:487-511.
7. ROBINS DL, FEIN D, BARTON ML, GREEN JA. The Modified Checklist for Autism in Toddlers: an initial study investigating the early detection of autism and pervasive developmental disorders. J Autism Dev Disord 2001; 31:131-44.
8. KLEINMAN JM, ROBINS DL, VENTOLA PE, et al. The modified checklist for autism in toddlers: a follow-up study investigating the early detection of autism spectrum disorders. J Autism Dev Disord 2008; 38:827-39.
9. Ages & Stages Questionnaires: Social-Emotional, A parent-completed child-monitoring system for Social-Emotional behaviors. Jane Squires, Dian Bricker, & Elizabeth Twombly. 2002. Paul H Brookes Publishing Co.

Alabama Regional Autism Network providers will encourage and assist healthcare practitioners who provide primary care to young children to implement and provide universal surveillance and screening for developmental delays/disabilities and for autism spectrum disorders (ASD), in accordance with American Academy of Pediatrics (AAP) recommendations (AAP, 2006; Johnson and Myers, 2007). The AAP currently recommends that physicians provide developmental surveillance at all well-child health supervision visits and conduct general developmental screening at the 9-, 18-, and 30-month visits, and whenever surveillance demonstrates that a child may be at risk for developmental delay. In addition, ASD-specific screening is recommended at the 18 and 24 month well-child visits.

The AAP views surveillance and screening in the primary care physician's office as the appropriate mechanisms to identify ASD early and to refer children for the appropriate intervention services. The AAP defines surveillance as "the ongoing process of identifying children who may be at risk of developmental delays" and screening as "the use of standardized tools at specific intervals to support and refine the risk." Both mechanisms offer opportunity to observe the developmental

trajectory and potential unfolding of developmental concerns, including ASD, over the first years of life. The routine use of developmental surveillance and screening tools increases the chance of earlier ASD diagnosis and earlier intervention (Carbone et al., 2010).

Surveillance

Alabama Regional Autism Network providers will conduct and promote developmental surveillance that includes the following components: eliciting and attending to the parents' concerns about their child's development; documenting and maintaining a developmental history; making accurate observations of the child; identifying risk and protective factors; and maintaining an accurate record of documenting the process and findings. Use of longitudinal developmental surveillance has been shown to increase the accuracy of identifying children with an ASD at 2 years of age and younger (Barbaro et al., 2010).

Screening

Alabama Regional Autism Network providers will encourage health care practitioners to conduct ASD-specific screening at the 18 and 24 month well-child visits using instruments with good sensitivity, specificity, and positive predictive value. Currently, three instruments that meet these criteria are: *The Communication and Symbolic Behaviors Scales Infant Toddler Checklist* (ITC), the *Modified Checklist for Autism in Toddlers* (M-CHAT) with the associated caregiver interview, and the *Ages and Stages Social-Emotional Questionnaire* (ASQ-SE).

The *Communication and Symbolic Behavior Scales Infant Toddler Checklist* (*CSBS ITC*; Wetherby & Prizant, 2002) is currently the most accurate ASD screening instrument. In a recent study of approximately 5,000 children, the CSBS ITC successfully identified children with communication delays including those later diagnosed with ASD at high rates during the 15-24 month well-child visits (Wetherby et al., 2008). The CSBS ITC measures developmental milestones of social communication, sounds and words, understanding, and object use.

- Age Range: 6-24 months of age
- Positive Predictive Value (accurately identifying children with autism without incorrectly identifying children who do not have autism) at 15-24 months: 76%
- Availability: Free to providers and is a brief (5-10 minutes, 24 items) caregiver checklist (www.firstwords.fsu.edu/toddlerChecklist.html).

The *Modified Checklist for Autism in Toddlers* (*M-CHAT*; Robins et al., 2001) is another successful screening instrument. In a recent study of approximately 3,800 16-30 month old children, the *M-CHAT* was most successful at screening for ASD during a well-child visit *if* it was combined with a follow-up caregiver interview (Kleinman et al., 2008). Robins is currently investigating a new approach for scoring the M-CHAT, which may reduce the need for the follow up interview. (IMFAR, 2010; oral presentation by Diana Robins) The *M-CHAT* specifically measures symptoms associated with ASD.

- Age range: 16-30 months of age
- Positive Predictive Value without interview: 11%
- Positive Predictive Value with Interview: 65%
- Availability: Free to providers and is a brief (5-10 minutes, 23 items) caregiver checklist. The follow-up interview takes about 15 minutes (www.firstsigns.org/downloads/m-chat.PDF).

The *ASQ: Social Emotional Questionnaires* (ASQ:SE; Squires, Bricker, & Twombly, 2002) assess social emotional abilities in children ages 6-60 months across 7 areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. Sensitivity of the ASQ:SE to detect social-emotional delays ranged from 71% to 85% and specificity ranged from 90% to 98% when results of approximately 3,000 children were analyzed (www.agesandstages.com). Ninety-seven percent of parents rated the questionnaire as easy to use. The ASQ:SE is available commercially at a reasonable cost.

Standard: Care Coordination	**Check all that Apply**

	***Service*:**	***Recipient:***	***Location*:**
Agency is able to provide evidence that demonstrates a care coordination/medical home model in which there is a single point of entry to access services, develop a centralized plan of care, and implement organized treatment by those serving the child and family. Services (1) are comprehensive, planned, and asset based, (2) strengthen families and promote self-management skills, (3) are family centered and based in the community in which all providers work together and share responsibility and (4) promote cross-organizational linkages and partnerships to ensure that practices are individualized and address medical, social, developmental, educational, behavioral/emotional, and financial needs. Agency is also able to demonstrate that care coordination efforts are fiscally efficient and outcome oriented.	X Direct ___Technical Assist X Consultation	X Individual w/ASD X Family ___School District X Other / List: Community Providers	___Home ___School X Community

Check One: ___Minimum Standard **X** Best Practice Standard ___Gold Standard

Citation(s) for Evidence-base:

1. Best Practice Guidelines for Screening, Diagnosis, and Assessment _CA_2002. http://www.ddhealthinfo.org/documents/ASD_Best_Practice.pdf
2. DEC Recommended Practices in Early Intervention and Early Childhood Special Education: Chapter 4: Recommended Practices in Family Based Practices by Carol Trivelle and Carl Dunst.
3. *Washington State Autism Diagnostic Teams Survey of Service Models* sponsored by the Washington State Combating Autism Advisory Council Training Subcommittee.
4. "Family-Centered Care Coordination for Children and Youth with ASD," Power Point Presentation by Richard Antonelli, Children's Hospital Boston, Harvard Medical School, AMCHP Teleconference, October 2009.
5. Waisman Center's National Medical Home Autism Initiative, Medical Home System Guidelines for ASD
6. http://www.waisman.wisc.edu/nmhai/.
7. National Center for Medical Home Implementation. American Academy of Pediatrics. www.medicalhomeinfo.org.
8. Tools for assessing and improving quality of care delivery, including the Medical Home Index, and Medical Home Family Index.www.medicalhomeimprovement.org

Because ASD is a multifactorial condition, optimal care coordination and service processes should be holistic, multifaceted, family-centered and culturally sensitive. *Pediatric care coordination* is defined as a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families. Care coordination, using a centralized medical home model, addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes and maximize community and provider utilization and linkages.

Care coordination for ASD should focus on the following 2 strategies:

1. Linking access to a family-centered, community-based Medical Home system of primary care, integrated with necessary service delivery components
2. Develop and sustain collaborative care models aligning families, Medical Homes, and various community providers, including mental/ behavioral health providers

Core components of care coordination:

- Family-centered and based in the community in which all providers work together and share responsibility
- Proactive, planned, asset based comprehensive care
- Care strengthens families and promotes the development of self-management skills
- Facilitation of cross-organizational linkages and partnerships to ensure that practices are individualized yet centralized

A family-centered frame of reference reinforces the concept of parents and caregivers as the most knowledgeable source of information about the child, acknowledges that the child is part of a larger family system and sets the stage for ongoing collaboration and communication between professionals and family members. The needs, priorities and resources of the family should be the

primary focus and be respectfully considered. Social-emotional factors must be considered because they influence coping and conceptualization of the individual with ASD.
Care Coordination efforts must serve as a bridge between service providers in order to minimize service delays and duplication. Parental stress is heightened as parents worry about their child while also spending time and energy trying to arrange for needed intervention services. Often, information is extremely difficult for families to find, locate and use. Timely referral, integration, and coordination of services lead to more streamlined and efficient service delivery.

Care coordination efforts need to offer families both informal and formal resources, including intrafamily, peer to peer, and community supports. Having a social support has a positive effect on parental well-being – which can have a positive effect on the parent's interaction with the child and child development/behavior. Providing or helping families negotiate supports and services, ensures that they have the resources necessary for time and physical/mental energy to engage in good child rearing. Practices should strengthen the parent's competency and empower rather than build dependency on professionals and systems.

Care coordinators need to meet regularly and work collaboratively with families and share information in a way that matches the family's style of understanding, literacy, and overall intellectual functioning so they can make informed choices. All efforts should be strength based to increase family functioning which in turn will increase compliance with recommendations and interventions. This means obtaining a comprehensive profile of strengths, skills and deficits soon after diagnosis. Practices should also be individualized to the specific family in order to minimize stress and assumptions as to what and how interventions are provided. Flexible resources should match each family's priorities and values.

EXAMPLE: if a diagnosis of ASD is confirmed after the intake, screening, and evaluation, a Care Coordinator would be assigned to meet with the family. Evaluation results should be shared verbally and in writing with the parent. The family and Care Coordinator would attend a separate conference with the family and Developmental Pediatrician, Pediatric Psychologist, etc.

Care Coordination should provide the following to families in a clinic, community, and/or home based setting/visit:

- Family education, training, and coaching (both written and verbal) during and after appointments based on service needs/assessment and a written service care plan
- Delivery or arrangement of clinically necessary transportation
- Manages continuous communications, linkage and monitors usage of community supports and providers
- Referrals for special education evaluation with documentation of diagnosis
- Referrals to community providers for supplemental speech, occupational therapy, social skills
- On-going follow-up/management/coordination of care with a Developmental Pediatrician, including psychopharmacologic treatment and medication monitoring/compliance
- Referrals for behavior problems to Pediatric Psychology/Counseling
- Consultation with Peds Neurology, Genetics, Psychiatry if warranted
- Information on family support groups in the community
- Supports/facilitates care transitions and team meetings
- Uses health information technology

Some providers offer care coordination (referrals and resources) if a diagnosis of ASD is not confirmed but there are other developmental delays of a different etiology, but this should be carefully considered due to the volume of referrals and financial implications.

Example/Missouri:

The Missouri Rapid Response Project was created out of a need to help parents of autistic children access comprehensive and coordinated care. Parents and providers reported that service systems were fragmented and families faced significant problems in navigating the system of care. In 2008, Missouri was one of six states to be awarded a State Implementation grant to improve comprehensive and

coordinated care for children and youth with ASD and other developmental disorders (Health Resources and Services Administration [HRSA] funding from 2008-2011).

The focus areas of the project included creating and implementing a care coordination and family support model that included:
Family Resource Specialists to

- identify unmet child and family needs,
- link families to needed information and resources, and
- support effective communication among families, primary and specialty care providers, and other community professionals.

Family Mentors to

- provide emotional support through parent-to-parent mentoring
- partner with the statewide *Sharing-Our-Strengths* (SOS) program at the University of Missouri-Kansas City for sustainability. SOS is Missouri's parent to parent/peer support network for parents of children with developmental disabilities or special healthcare needs, individuals with disabilities, and professionals.

Another focus was building family and professional partnerships in which the project created a model program to enhance family-professional partnerships through:

- ASD Family-Centered Care Survey developed and tested.
- ASD Family-Professional Task Force formed to identify common goals for quality improvement in clinical settings.
- ASD Quality Improvement strategies under development that measure outcomes of activities that aim to improve child- and family-centered care.
- preparing families for leadership and advocacy roles

The *Thompson Center,* which was a result of this project, offers a range of health, educational and behavioral services in one location for individuals with autism and other developmental concerns.
Source: http://thompsoncenter.missouri.edu/morr/MORR.php#Care

Example/Wisconsin:

The *National Medical Home Autism Initiative* is a project at the University of Wisconsin's Waisman Center and uses a medical home model in order to identify, serve and integrate autistic children and families into the community and services. Families reported frustration trying to obtain a timely and accurate diagnosis while gaining entry info and negotiating appropriate intervention programs. Professionals also reported feeling challenged in knowing what services were available, where to go, criteria for admission, etc. Like others, this model was created in order to address these struggles. The medical home model offers a single point of entry is used for access to services and a specific plan of care and treatment is designed and implemented in an organized way among all those that are serving the family and child. As a result, no matter where the family enters the system, they will connected to a medical home that will provide medical care, support and care coordination.
For instance, a pediatric clinician works in partnership with the family and child to assure that the entire medical and non-medical needs of the child/family are met. The provider helps the family/child access and coordinate specialty care, educational services, out of home care, family support, and other community resources that are available.
Source: **http://www.waisman.wisc.edu/nmhai/**

Example/Maryland:

Founded in 1983, *The Coordinating Center for Home and Community Care, Inc.,* (CCHCC) is nonprofit corporation was first organized as a consortium and was initially funded by a federal Maternal Child Health Bureau (MCHB) Special Projects of Regional and National Significance (SPRANS) grant. The original purpose of this grant was to develop a care coordination model designed to effect the transition from hospital to home of children who were then hospitalized with complex medical diagnoses requiring ventilator support. However, it quickly expanded to other areas and programs, *including* an Autism Waiver program, which provides necessary community services to children with severe autism at risk for institutionalization.
Maryland was the first state to implement an autism waiver, which covers intensive family support and training, therapeutic integration services, respite care and home modifications. Maryland's waiver also covers intensive individual support in the home, at school or in the community.
The program is built on care coordination principles and designed to help members and their families receive early

intervention and support while navigating services and benefits. The program is designed to increase overall well-being of the family as a whole.

The Coordinating Center's prototype model for care coordination reflects the following characteristics, including

- Family and person centered practice
- Comprehensive, holistic perspective
- Multidisciplinary team function
- Community resource utilization
- Fiscal and resource efficiency

The core service at The Coordinating Center, care coordination, is characterized by

- A person and family centered approach
- Individualized planning
- Personal contacts between clients, families and the professional care coordinator
- Interdisciplinary team expertise
- Community resource development
- Quality improvement tracking and evaluation
- Outcome oriented strategies

The Center offers a holistic approach by coordinating all of the services a person needs to be fully included at home and in the community. Because coordinators use appropriate community resources to help people build networks of support, the staff is able to promote more effective, more cost efficient strategies to reach positive outcomes.

Based on the child's needs and the requirements of the program, families and children may be eligible to receive the following supportive services:

• Respite care
• Environmental accessibility adaptations
• Family training
• Supported employment
• Intensive Individual Support Services
• Residential habilitation
• Targeted case management, including working with several school systems to provide care management through this program

Source: http://www.coordinatingcenter.org/index.html

Part 2: Services for Ages 6-21 Workgroup

Outline of Quality Indicators

1. Developmental Instructional Plan
2. Instructional Activities
3. Instructional Methods
4. Instructional Environment
5. Review and Monitoring of Progress
6. Family Involvement and Supports
7. Social Behaviors
8. Transition
9. Personnel Development
10. Program Evaluations

Quality Indicators/Standards

Area 1: Development of Instructional Plan

Includes the following topics:

Medical Conditions & Medications; Sensory Issues; Curriculum Areas; Evaluation & Assessment; Self Determination; Supports & Related Services; Least Restrictive Environment/Inclusion; Frequency of Team Meetings; Data Collection, Analysis, & Decision Making; Participants in Plan Development; Case Coordination; Advocacy

Medical Conditions and Medications

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency or school makes an effort to communicate with parents to determine what psychoactive medications the child is prescribed and documents efforts to communicate and determine if medications are prescribed. If It is known that medications are prescribed data is collected on effects of medications.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community
Check One: X Minimum Standard ___Progressive ___ Best Practice Citation(s) for Evidence-base: National Standards			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency or school works collaboratively with the family and, the prescribing physician to develop a medication plan that regularly monitors and evaluates therapeutic and side effects of medications and that includes an associated staff training program.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community
Check One: ___ Minimum Standard X Progressive ___ Best Practice Citation(s) for Evidence-base: National Standards			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency or schools works collaboratively with the family and, the prescribing physician to develop a medication plan that regularly monitors and evaluates therapeutic and side effects of medications, includes an associated staff training program and the school or agency has a proactive or systematic plan to reduce reliance on such medications and replace them with positive behavioral supports.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community

Check One: ___ Minimum Standard ___ Progressive X Best Practice
Citation(s) for Evidence-base: National Standards

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
The agency or school prohibits non-medical professionals from making recommendations regarding medications beyond providing data and information about observed effects or side effects of medications and any data requested from a prescribing physician.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community

Check One: X Minimum Standard ___Progressive ___ Best Practice
Citation(s) for Evidence-base: National Standards

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
The agency or school prohibits non-medical professionals from making recommendations regarding medications beyond providing data and information about observed effects or side effects of medications and any data requested from a prescribing physician and has consultation with a nurse to communicate with a physician.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community

Check One: ___ Minimum Standard X Progressive ___ Best Practice
Citation(s) for Evidence-base: National Standards

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
The agency or school prohibits non-medical professionals from making recommendations regarding medications beyond providing data and information about observed effects or side effects of medications and any data requested from a prescribing physician and has a nurse employed who acts as a liaison to interact with physicians.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home X School X Community

Check One: ___ Minimum Standard ___Progressive X Best Practice
Citation(s) for Evidence-base: National Standards

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
The agency or school follows the nurse delegation act regarding requirements for administration of medications. Only prescriptions labeled and prescribed by a licensed physician are administered at school by properly trained and supervised staff.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community

Check One: X Minimum Standard ___Progressive ___ Best Practice
Citation(s) for Evidence-base: National Standards

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
The agency or school follows the nurse delegation act regarding requirements for administration of medications. Only prescriptions labeled and prescribed by a licensed physician are administered at school by properly trained and supervised staff and the agency has ongoing training and monitoring by a nurse at least on a consultative basis.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community

Check One: ___ Minimum Standard X Progressive ___ Best Practice
Citation(s) for Evidence-base: National Standards

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
The agency or school follows the nurse delegation act regarding requirements for administration of medications. Only prescriptions labeled and prescribed by a licensed physician are administered at school by properly trained and supervised staff and the agency has ongoing training and monitoring by a nurse employed by the agency or school.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School ___Community

Check One: ___ Minimum Standard ___Progressive X Best Practice
Citation(s) for Evidence-base: National Standards

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
The agency or school makes an effort to determine if a child has been diagnosed with medical conditions and has a system of regular communication among school or agency personnel, family and medical professionals regarding the status and treatment of medical conditions. Documentation of efforts is completed at least annually.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community

Check One: X Minimum Standard ___Progressive ___ Best Practice
Citation(s) for Evidence-base: National Standards

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
The agency or school makes an effort to determine if a child has been diagnosed with medical conditions and has a system of regular communication among school or agency personnel, family and medical professionals regarding the status and treatment of medical conditions. Documentation of efforts is completed at least twice per year.. Qualified school or agency personnel as defined by the nurse delegation act work collaboratively with the family and medical professionals to develop a health plan and associated staff training program through which status and treatments are monitored and evaluated on a regular basis.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community

Check One: ___ Minimum Standard ___Progressive X Best Practice
Citation(s) for Evidence-base: National Standards

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
The agency or school makes an effort to determine if a child has been diagnosed with medical conditions and has a system of regular communication among school or agency personnel, family and medical professionals regarding the status and treatment of medical conditions. Documentation of efforts is completed at least quarterly. Qualified school or agency personnel as defined by the nurse delegation act work collaboratively with the family and medical professionals to develop a health plan and associated	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community

staff training program through which status and treatments are monitored and evaluated on a regular basis.			
Check One: ___ Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: National Standards			

Sensory Issues

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location:*
Only treatments coded "Emerging" or "Established" per the National Autism Center's most recent national standard report on Sensory Motor Processing will be employed. Treatments coded "Unestablished" will not be employed as a treatment. If preference assessments identify sensory activities as reinforcing, they may be utilized as a reward for completion of instructional tasks and/or following appropriate behavior. Sensory consequences (including breaks) are not used following aberrant behavior. (For appropriate treatment techniques for aberrant behavior refer to sections on Functional Analysis of Behavior.)	___Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: National Standards			

Curriculum Areas and Assessment

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Areas addressed in the IEP/PCP include as determined by the IEP/PCP team as appropriate: 1. Regular curriculum or extended standards (modified curriculum) 2. Communication skills 3. Social skills 4. Functional skills (self-care, care of home and personal environment at school, vocational skills, community living skills) 5. Skills for integration into school and community. 6. Instruction in making choices.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Areas addressed in the IEP/PCP include as determined by the IEP/PCP team with consultation with an Autism specialist such as a Special Education Teacher with Autism Credential, BCBA, or SLP include: 1. Regular curriculum or extended standards (modified curriculum) 2. Communication skills 3. Social skills 4. Functional skills (self-care, care of home and personal environment at school, vocational skills, community living	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	___Home X School ___Community

skills) 5. Skills for integration into school and community. 6. Instruction in making choices.			
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base: National Standards			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Areas addressed in the IEP/PCP include as determined by the IEP/PCP team with ongoing services and consultation with an Autism specialist such as a Special Education Teacher with Autism Credential, BCBA, or SLP include: 1. Regular curriculum or extended standards (modified curriculum) 2. Communication skills 3. Social skills 4. Functional skills (self-care, care of home and personal environment at school, vocational skills, community living skills) 5. Skills for integration into school and community. **6.** Instruction in making choices.	___Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community
Check One: __Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: National Standards			

Self Determination

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:

Through intentional and systematic instruction enhance the individual's ability/opportunity to make choices and exercise options regarding the following areas (designed for individual skill level and age): self-advocacy, social relationships, activities of daily living, daily routine, and leisure/recreation. Intentional and systematic instruction includes the following:
• Enhancing the individual's ability to communicate
  ○ Establishing ability to communicate needs
  ○ Establishing ability to communicate interests
  ○ Establishing ability to communicate preference
• Assessing individual's preferences
  ○ Exposing individual to opportunities and choice items so informed decisions can be made.
  ○ Recording outcomes, and review with the individual his/her experiences to develop preference
• Enhancing the individual's opportunities to exercise choices
	X Direct
	___Technical Assist
	___Consultation
		X Individual w/ASD
		___Family
		___School District
		___Other / List:
			___Home
			X School
			___Community

Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Through intentional and systematic instruction enhance the individual's ability/opportunity to make choices and exercise options regarding the following areas (designed for individual	X Direct ___Technical Assist	X Individual w/ASD ___Family	___Home X School

skill level and age): self-advocacy, social relationships, activities of daily living, daily routine, leisure/recreation, employment, community involvement, and utilizing community resources. Intentional and systematic instruction includes the following:
• Enhancing the individual's ability to communicate
  ○ Establishing ability to communicate needs
  ○ Establishing ability to communicate interests
  ○ Establishing ability to communicate preference
• Assessing individual's preferences
  ○ Exposing individual to opportunities and choice items so informed decisions can be made.
  ○ Recording outcomes, and review with the individual his/her experiences to develop preference
• Enhancing the individual's opportunities to exercise choices
	___Consultation	___School District
		___Other / List:
			X Community

Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base:			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:

Through intentional and systematic instruction enhance the individual's ability/opportunity to make choices and exercise options regarding the following areas (designed for individual skill level and age): self-advocacy, social relationships, activities of daily living, daily routine, leisure/recreation, employment, community involvement, utilizing community resources, continued education, living arrangements, and health & medical services. Intentional and systematic instruction includes the following:
• Enhancing the individual's ability to communicate
  ○ Establishing ability to communicate needs
  ○ Establishing ability to communicate interests
  ○ Establishing ability to communicate preference
• Assessing individual's preferences
  ○ Exposing individual to opportunities and choice items so informed decisions can be made.
  ○ Recording outcomes, and review with the individual his/her experiences to develop preference
• Enhancing the individual's opportunities to exercise choices
	X Direct
	___Technical Assist
	___Consultation
		X Individual w/ASD
		___Family
		___School District
		___Other / List:
			X Home
			X School
			X Community

Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base:			

Supports and Related Services

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Members of the multidisciplinary team, including			

professionals with documentable education and experience working with individuals diagnosed with Autism Spectrum Disorders, use information about the individual's learning style, academic abilities, and sensory motor skills to guide in the identification and implementation of therapeutic services and special education interventions that will support students' functional independence and academic success in the general education or alternative curriculum. The team will meet on an annual basis and review data collected over the previous school year to evaluate the effectiveness and continued implementation of supports and related services that are included in the student's IEP/support plan.	___Direct ___Technical Assist X Consultation	___Individual w/ASD ___Family X School District ___Other / List:	___Home X School ___Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Members of the multidisciplinary team, including professionals with documentable education and experience working with individuals diagnosed with Autism Spectrum Disorders, use information about the individual's learning style, academic abilities, and sensory motor skills to guide in the identification and implementation of therapeutic services and special education interventions that will support students' functional independence and academic success in the general education or alternative curriculum. The team will meet on a bi-annual basis and review data collected over the completed portion of the school year to evaluate the effectiveness and continued implementation of supports and related services that are included in the student's IEP/support plan.	___Direct ___Technical Assist X Consultation	___Individual w/ASD ___Family X School District ___Other / List:	___Home X School ___Community
Check One: ___Minimum Standard X Progressive Standard ___ Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Members of the multidisciplinary team, including, but not limited to, a Board Certified Behavior Analyst, Speech and Language Pathologist, Occupational Therapist, Physical Therapist, and/or other highly qualified professionals, use information about the individual's learning style, academic abilities, and sensory motor skills to guide in the identification and implementation of therapeutic services and special education interventions that will support students' functional independence and academic success in the general education or alternative curriculum. The team will meet on a bi-annually basis and review data collected over the completed portion of the school year to evaluate the effectiveness and continued implementation of supports and related services that are included in the student's IEP/support plan.	X Direct ___Technical Assist X Consultation	___Individual w/ASD ___Family X School District ___Other / List:	___Home X School ___Community

Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base:

Least Restrictive Environment and Inclusion

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Areas outside of specialized instruction should be fully included with typically developing peers. All other times when an individual has been placed in a more restrictive environment, the following criteria will be met: needs of student assessed annually, IEP team develops inclusion plan based off of student's unique needs, and placement shall not be permanent.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family X School District ___Other / List:	___Home X School ___Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: Individuals with Disabilities Education Act (IDEA)			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Areas outside of specialized instruction should be fully included with typically developing peers. All other times when an individual has been placed in a more restrictive environment, the following criteria will be met: needs of student assessed every 6 months, plan developed to attain full inclusion within 6 months and if not obtained then student must be reassessed, and professional(s) with documentable education and experience to address problem area assist in development of an inclusion plan after review of data.	X Direct __Technical Assist ___Consultation	___Individual w/ASD ___Family X School District ___Other / List:	___Home X School ___Community
Check One: ___Minimum Standard X Progressive Standard ___ Best Practice Citation(s) for Evidence-base: Individuals with Disabilities Education Act (IDEA)			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Areas outside of specialized instruction should be fully included with typically developing peers. All other times when an individual has been placed in a more restrictive environment, the following criteria will be met: needs of student assessed every 90 days, plan developed to attain full inclusion within 90 days and if not obtained then student must be reassessed, Board Certified Behavior Analyst assist in development of an inclusion plan after review of data and in comparison with evidence based and peer reviewed practices.	X Direct ___Technical Assist X Consultation	___Individual w/ASD ___Family X School District ___Other / List:	___Home X School ___Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base:			

Frequency of Team Meetings

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Individualized Education Plan/Support plan will be reviewed by the approval committee at least annually and approved by said committee. Progress reports will be sent out every 9	X Direct ___Technical Assist	__Individual w/ASD ___Family	___Home X School

weeks.	___Consultation	X School District ___Other / List:	___Community

Check One: X Minimum Standard ___Progressive Standard ___Best Practice
Citation(s) for Evidence-base: State Department of Education Regulations

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Individualized Education Plan /Support plan will be reviewed by the approval committee at least annually and approved by said committee. A bi-annual review will occur to discuss data, including progress/hold backs of skills, and develop strategies to address any of the hold backs.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family X School District ___Other / List:	___Home X School ___Community

Check One: ___Minimum Standard X Progressive Standard ___Best Practice
Citation(s) for Evidence-base: State Department of Mental Health Standards

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Individualized Education Plan /Support plan will be reviewed by the approval committee at least annually and approved by said committee. A quarterly review will occur to discuss data, including progress/hold backs of skills, and develop strategies to address any of the hold backs.	X Direct ___Technical Assist ___Consultation	__Individual w/ASD ___Family X School District ___Other / List:	___Home X School ___Community

Check One: ___Minimum Standard ___Progressive Standard X Best Practice
Citation(s) for Evidence-base:

Case Coordination

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
(Administration): A designated party maintains a student file that contains designated components based on AICC checklist of required components.	__Direct X Technical Assist ___Consultation	__Individual w/ASD ___Family X School District X Other / List:	___Home X School ___Community

Check One: X Minimum Standard ___Progressive Standard ___Best Practice
Citation(s) for Evidence-base: Mastering the Maze

Standard	Check all that Apply		
	Service:	*Recipient*:	Location:
(Administration): A designated party ensures • Student file contains designated components based on AICC checklist of required components. • File is complete w/ current signatures • All relevant parties have received copies of proper documentation	__Direct X Technical Assist ___Consultation	__Individual w/ASD ___Family X School District X Other / List:	___Home X School __Community

Check One: ___Minimum Standard X Progressive Standard ___Best Practice
Citation(s) for Evidence-base:

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location*:
(Administration): A designated party ensures • student file contains designated components based on AICC checklist of required components.	X Direct ___Technical Assist	__Individual w/ASD ___Family	__Home X School

• file is complete w/ current signatures • All relevant parties have received copies of proper documentation • The designation of the coordination of meetings to occur to ensure that plan remains in compliance with time lines	___Consultation	X School District X Other / List:	__Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base:			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
(Implementation): The Individual writing plan regularly interacts with student and ensures the objectives are appropriate for students, including monitoring student progress.	X Direct ___Technical Assist ___Consultation	__Individual w/ASD ___Family X School District X Other / List:	___Home X School ___Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base:			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
(Implementation): The Individual writing plan regularly interacts with student and ensures the objectives are appropriate for students, is responsible for objective implementation and monitors student progress.	__Direct X Technical Assist ___Consultation	__Individual w/ASD ___Family X School District X Other / List:	___Home X School __Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base:			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
(Implementation): The Individual developing the plan, ensures appropriate assessments are completed, writes the plan based on regularly interacting with the student and ensures the objectives are appropriate for students, is responsible for objective implementation and monitors student progress.	__Direct X Technical Assist ___Consultation	__Individual w/ASD ___Family X School District X Other / List:	__Home X School __Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base:			

Participation in Plan Development

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
The following individuals will participate in Plan Development: • Individual who is going to receive services • Guardian • Plan implementers(s) (i.e. Teacher, Case Manager) • Someone who can ensure appropriate resources can be made available will be present at the meeting.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	___Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: Mastering the Maze; DHR state standards			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location:*
The following individuals will participate in Plan Development: • Individual who is going to receive services • Guardian • Plan implementers(s) (i.e. Teacher, Case Manager) • Someone who can ensure appropriate resources can be made available will be present at the meeting. The following individuals will provide input to the plan development: • Individuals responsible for the implementation of services (OT, SLT, Analyst)	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	___Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: Mastering the Maze; DHR state standards			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Prior to the development of the plan, parties invested in the individual's growth and life direction will meet to discuss the 'whole life' meaning for the student and prioritize actions that need to be taken prior to the plan development to ensure there is a direction for goal development and the necessary parties are invited for input The following individuals will participate in Plan Development: • Individual who is going to receive services • Guardian • Plan implementers(s) (i.e. Teacher, Case Manager) • Someone who can ensure appropriate resources can be made available will be present at the meeting. • Individuals who will be responsible for service implementation (OT, SLT, Analyst)	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	__Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: Mastering the Maze; DHR state standards			

Rights: Treatment and Civil

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
(Advocacy and Guardianship): Organization will provide information to families about guardianship options. Student will participate in class exercises related to advocacy.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home __School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: UCP guide for transition			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
(Advocacy and Guardianship): The student will			

participate in class exercises related to advocacy. Organization will provide information to families about • guardianship options. • specific information on how to pursue the different options available in their specific region	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home __School X Community
Check One: ___Minimum X Progressive Standard ___Best Practice Citation(s) for Evidence-base: UCP guide for transition			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
(Advocacy and Guardianship): The student will participate in class exercises related to advocacy. Organization will provide information to families about • guardianship options. • specific information on how to pursue the different options available in their specific region Organization will provide training to families about • Information about advocacy	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home __School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: UCP guide for transition			

Data Collection, Analysis, and Decision Making

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location:*
Data is collected and input in a organizational system (i.e. Excel); It will be reviewed in compliance with agencies progress report timelines	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	___Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: Alabama State Department of Education, focused monitoring checklist; abama.webs.com			

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
Data is collected, reviewed monthly and input in a organizational system (i.e. Excel); If there is a lack of progress, a decision is made: Continue to implement the objective and change procedure(s) or stop objective (if objective is stopped must adhere to other procedures such as holding another meeting to replace stopped objective).	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	___Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: abama.webs.com			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Data is reviewed monthly by an Interdisciplinary Team w/ case manager (i.e. Teacher) as a member of the team. If there is a lack of progress, a decision is made: Continue to implement the objective and change procedure(s) or stop objective (if objective is stopped must adhere to other procedures such as	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	__Home X School X Community

holding another meeting to replace stopped objective). A follow-up timeline is developed for implementation of change based on Interdisciplinary Team discussion that also adheres to a reasonable time.			
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: abama.webs.com			

Area 2: Instructional Activities

Includes the following topics:

Learning Styles, Teaching Strategies, Communication, Engagement, Gross Motor Skill Development, Recreation, Leisure Skills

Learning Styles

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
Teacher reports of preferred learning styles of students are considered within instructional activities	___Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
Observations of teachers and input from the family and student on the students preferred learning style is used to determine instructional activities for students.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	___Home X School ___Community
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
In addition to teacher reports and student and family input on the student's preferred learning style, assessments comparing student performance and rate of acquisition of material are considered when planning instructional activities.	___Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family ___School District ___Other / List:	___Home ___School ___Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: National Standards			

Teaching Strategies

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
Only teaching strategies coded "Emerging" or "Established" per the National Autism Center's most recent national standard report will be used. Teaching strategies incorporate the	X Direct ___Technical Assist	X Individual w/ASD ___Family	X Home X School

following strategies listed as Evidence Based Practice by the National Professional Development Center on Autism Spectrum Disorders, and are implemented under the supervision of an Autism specialist as appropriate that may include a BCBA, Certified teacher with Autism Credentials, or an SLP. Strategies that require individualized and 1:1 instruction are used initially with a movement toward strategies that can be incorporated in inclusive environments as students make progress. 1. Discrete trial training 2. Computer aided instruction 3. Differential Reinforcement 4. Extinction 5. Functional Behavioral Assessment 6. Functional Communication Training 7. Naturalistic Intervention (Incidental teaching) 8. Parent Implemented Intervention 9. PECS 10. Peer Mediated Instruction & Intervention 11. Pivotal response training 12. Prompting 13. Reinforcement Response Interruption/Redirection 14. Self-management 15. Social narratives 16. Social skills groups 17. Speech generating devices 18. Stimulus control 19. Structured work systems 20. Task analysis 21. Time delay 22. Video Modeling 23. Visual supports	___Consultation	___School District ___Other / List:	X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: National Standards			

Communication

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
Formal and informal assessment will be completed by qualified personnel to identify current communication skills and develop a baseline from which to compare status of student's progress. The IEP/multidisciplinary team will develop individualized goals based on effective and established methodology.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	___Home X School ___Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: Principles for Speech-Language Pathologists in Diagnosis, Assessment, and Treatment of Autism Spectrum Disorders Across the Life Span, American Speech-Language-Hearing Association (ASHA), 2005.			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
Formal and informal assessment will be completed by qualified personnel to identify current communication skills and develop	X Direct	X Individual w/ASD	___Home

a baseline from which to compare status of student's progress. The IEP/multidisciplinary team will develop individualized goals based on effective and established methodology. The primary service provider who will be implementing the methods and initially teaching the communication skills to the student will have completed professional development in the area of the methodology that was selected. Data will be collected during teaching sessions to evaluate student performance.	X Technical Assist ___Consultation	___Family ___School District ___Other / List:	X School ___Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: Principles for Speech-Language Pathologists in Diagnosis, Assessment, and Treatment of Autism Spectrum Disorders Across the Life Span, American Speech-Language-Hearing Association (ASHA), 2005.			

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
Formal and informal assessment will be completed by qualified personnel to identify current communication skills and develop a baseline from which to compare status of student's progress. The IEP/multidisciplinary team will develop individualized goals based on effective and established methodology. The primary service provider who will be implementing the methods and initially teaching the communication skills to the student will have completed professional development in the area of the methodology that was selected. Data will be collected during teaching sessions to evaluate student performance. Primary service provider will train parents and professional staff who work with the student in the natural setting to a level of competency on selected methodology for teaching communication skills. These individuals will then provide opportunities for generalization of the communication skills with peers and other individuals in the student's environment throughout the day. Data will be collected during incidental communication opportunities to evaluate student performance.	X Direct X Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: Principles for Speech-Language Pathologists in Diagnosis, Assessment, and Treatment of Autism Spectrum Disorders Across the Life Span, American Speech-Language-Hearing Association (ASHA), 2005.			

Engagement

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
The term "engagement" will be used to refer to students' cognitive investment, active participation, and emotional engagement with specific learning tasks. Rates of engagement will be collected using self-report measures, checklists and rating scales, direct observation, work sample analysis, focus case study, or a combination of these methods. Student engagement ratings will be collected once every three months across a variety of school settings by school	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family X School District ___Other / List:	___Home X School ___Community

administration.			

Check One: X Minimum Standard ___Progressive Standard ___Best Practice

Citation(s) for Evidence-base: Chapman, E. (2003). Alternative Approaches to Assessing Student Engagement Rates. Practical Assessment, Research, and Evaluation.

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
The term "engagement" will be used to refer to students' cognitive investment, active participation, and emotional engagement with specific learning tasks. Rates of engagement will be collected using self-report measures, checklists and rating scales, direct observation, work sample analysis, focus case study, or a combination of these methods. Student engagement ratings will be collected at least twice a month across a variety of school settings by school administration and other personnel designated by administration. Findings from student/classroom engagement measures will be used to determine a plan of action/correction included in the school's/program's continuous improvement plan.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family X School District ___Other / List:	___Home X School ___Community

Check One: ___Minimum Standard X Progressive Standard ___ Best Practice

Citation(s) for Evidence-base: Chapman, E. (2003). Alternative Approaches to Assessing Student Engagement Rates. Practical Assessment, Research, and Evaluation.

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
The term "engagement" will be used to refer to students' cognitive investment, active participation, and emotional engagement with specific learning tasks. Rates of engagement will be collected using self-report measures, checklists and rating scales, direct observation, work sample analysis, focus case study, or a combination of these methods. Student engagement ratings will be collected at least once a week across a variety of school settings by school/program administration and other personnel designated by administration. Findings from student/classroom engagement measures will be used to determine a plan of action/correction included in the school's/program's continuous improvement plan.	X Direct ___Technical Assist ___Consultation	___Individual w/ASD ___Family X School District ___Other / List:	___Home X School ___Community

Check One: ___Minimum Standard ___Progressive Standard X Best Practice

Citation(s) for Evidence-base: Chapman, E. (2003). Alternative Approaches to Assessing Student Engagement Rates. Practical Assessment, Research, and Evaluation.

Gross Motor Skill Development

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
Organization will provide structured activities geared towards gross motor movement, the progress with these activities will be monitored and tracked.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	___Home X School X Community

Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: Center for Disease Control and Prevention			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The individual will participate in 30 minutes of structured gross motor movement activities per day . The organization will provide structured activities geared towards gross motor movement, the progress with these activities will be monitored and tracked. Progress of the activities will guide additional/increased activities and progress	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	___Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: Center for Disease Control and Prevention			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The individual will participate in 60 minutes of structured gross motor movement activities per day . The organization will provide structured activities geared towards gross motor movement, the progress with these activities will be monitored and tracked. Progress of the activities will guide additional/increased activities and progress. Gross motor skills will be applied to structured group activities (in and out of PE), such as independently transitioning through the hallways, walking on stairs, etc.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	__Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: Center for Disease Control and Prevention			

Recreation

Standard	**Check all that Apply**		
	Service: :	*Recipient*	*Location:*
Expose the individual to new activities through various forms of access (i.e. watching videos about an activity; learning about an activity; watching an activity in the community)	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
Expose the individual to new activities • through various forms of learning (i.e. watching videos about an activity; learning about an activity; watching an activity in the community) • through participation	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
Expose the individual to new activities			

• through various forms of learning (i.e. watching videos about an activity; learning about an activity; watching an activity in the community) • through participation • On a regular basis (as deemed appropriate for environment) • Through choice making opportunities of activities to participate in	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	__Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base:			

Leisure Skills

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Individual will have access to leisure activities such as games and books	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Individual will have access to • leisure activities such as games and books • structured group leisure activities	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Individual will have access to • leisure activities such as games and books • structured group leisure activities • competitive activities (i.e. special Olympics; community basketball teams)	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	__Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base:			

Area 3: Instructional Methods

Individual Schedules

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
To support independence in daily routines, choice making and to provide a visual representation of the day, individual	X Direct	X Individual w/ASD	X Home

schedules are used for students. Schedules may vary based on the student's needs. Examples of schedules may include: 1. A daily planner with written schedule 2. An electronic planner like a palm or some other electronic device 3. A picture schedule or picture symbol schedule 4. An auditory schedule (a recording or other electronic vocal schedule) 5. A first then picture schedule.	___Technical Assist ___Consultation	X Family X School District X Other / List:	X School X Community
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
To support independence in daily routines, choice making and to provide a visual representation of the day, individual schedules are used for students. As students gain skills, schedules are modified to reflect those used by same age peers. Schedules may vary based on the student's needs. Examples of schedules may include: 1. A daily planner with written schedule 2. An electronic planner like a palm or some other electronic device 3. A picture schedule or picture symbol schedule 4. An auditory schedule (a recording or other electronic vocal schedule) 5. A first then picture schedule.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
To support independence in daily routines and choice making and to provide a representation of the day, individual schedules are used for students. As students gain skills, schedules are modified to reflect those used by same age peers. Schedules incorporate tasks from the daily routine of students and may include breaks and provide a visual representation of tasks and reinforcement. Schedules vary based on the students' needs. Examples of schedules may include: 1. A daily planner with written schedule 2. An electronic planner like a palm or some other electronic device 3. A picture schedule or picture symbol schedule (this may also be electronic) 4. An auditory schedule (a recording or other electronic vocal schedule) 5. A first then picture schedule.	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**

	Service:	*Recipient*:	*Location*:
Modification to a student's daily routine that is different from same age peers is justified by the IEP or ISP and need for instruction. Efforts are made to increase skills and move toward following a schedule like the schedule same age peers follow. Efforts are made to schedule students with same age peers at least monthly.	X Direct __Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District __Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location*:
Modification to a student's daily routine that is different from same age peers is justified by the IEP or ISP and need for instruction. Efforts are made to increase skills and move toward following a schedule like the schedule same age peers follow. Student's individual schedules provide opportunities for involvement with same age peers without disabilities across a variety of instructional and community settings on at least a weekly basis.	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Modification to a student's daily routine that is different from same age peers is justified by the IEP or ISP and need for instruction. Efforts are made to increase skills and move toward following a schedule like the schedule same age peers follow. Student's individual schedules provide opportunities for involvement with same age peers without disabilities across a variety of instructional and community settings on a daily basis.	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
To support independence in daily routines, choice making and to provide a visual representation of the day, individual schedules are used for students. Schedules may vary based on the student's needs. Examples of schedules may include: 1) A daily planner with written schedule 2) An electronic planner like a palm or some other electronic device 3) A picture schedule or picture symbol schedule 4) An auditory schedule (a recording or other electronic vocal schedule) 5) A first then picture schedule.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**

	Service:	*Recipient:*	*Location:*
To support independence in daily routines, choice making and to provide a visual representation of the day, individual schedules are used for students. As students gain skills, schedules are modified to reflect those used by same age peers. Schedules may vary based on the student's needs. Examples of schedules may include: 1) A daily planner with written schedule 2) An electronic planner like a palm or some other electronic device 3) A picture schedule or picture symbol schedule 4) An auditory schedule (a recording or other electronic vocal schedule) 5) A first then picture schedule.	X Direct __Technical Assist ____Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: ____Minimum Standard X Progressive ____Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
To support independence in daily routines and choice making and to provide a representation of the day, individual schedules are used for students. As students gain skills, schedules are modified to reflect those used by same age peers. Schedules incorporate tasks from the daily routine of students and may include breaks and provide a visual representation of tasks and reinforcement. Schedules vary based on the students' needs. Examples of schedules may include: 1. A daily planner with written schedule 2. An electronic planner like a palm or some other electronic device 3. A picture schedule or picture symbol schedule (this may also be electronic) 4. An auditory schedule (a recording or other electronic vocal schedule) 5. A first then picture schedule.	X Direct __Technical Assist ____Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: ____Minimum Standard ____Progressive X Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Modification to a student's daily routine that is different from same age peers is justified by the IEP or ISP and need for instruction. Efforts are made to increase skills and move toward following a schedule like the schedule same age peers follow. Efforts are made to schedule students with same age peers at least monthly.	X Direct ____Technical Assist ____Consultation	X Individual w/ASD ____Family ____School District __Other / List:	X Home X School X Community
Check One: X Minimum Standard ____Progressive ____Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Modification to a student's daily routine that is different from			

same age peers is justified by the IEP or ISP and need for instruction. Efforts are made to increase skills and move toward following a schedule like the schedule same age peers follow. Student's individual schedules provide opportunities for involvement with same age peers without disabilities across a variety of instructional and community settings on at least a weekly basis.	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Modification to a student's daily routine that is different from same age peers is justified by the IEP or ISP and need for instruction. Efforts are made to increase skills and move toward following a schedule like the schedule same age peers follow. Student's individual schedules provide opportunities for involvement with same age peers without disabilities across a variety of instructional and community settings on a daily basis.	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: National Standards			

Routines

Standard	Check all that Apply		
	Service:	Recipient:	Location:
When planning for students' instructional needs, natural routines for teaching skills are considered when possible, recognizing some students may need additional practice to gain skills in other instructional settings. Natural routines and areas of instruction may include: 1. Daily living skills are taught at natural times for students to engage in those activities, for example dressing is taught at natural opportunities such as when students change for physical education, use the restroom or at other natural times for dressing, instruction for holding and using utensils or eating appropriately would occur at snacks and meals. 2. Social skills instruction with peers occurs during natural opportunities like lunch, breaks, after school clubs, sports ,and other events that occur naturally. 3. Opportunities for communication occur across all daily routines based on the student's wants, needs and interests. 4. Instruction in academic areas occurs at the same time as other students in the classroom whenever possible though instruction may be individualized to address a student's needs. 5. Instruction for skills needed in the community occur during natural routines like grocery shopping, using public transportation, accessing community leisure and recreation or during after school jobs or volunteering. 6. Instruction in and opportunities for making choices are	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community

incorporated across all areas and through all daily routines. 7. Routines that the student participates in are those that same age peers without autism participate in. 8. Issues that are barriers to participation in typical, age appropriate activities are addressed to minimize the effects on the student with Autism's access to typical routines.			

Check One: X Minimum Standard ___Progressive ___Best Practice

Citation(s) for Evidence-base: National Standards

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
When planning for students' instructional needs, natural routines for teaching skills are utilized when possible, recognizing some students may need additional practice or simulation of routines to gain skills in other instructional settings. Natural routines and areas of instruction may include: 1. Daily living skills are taught at natural times for students to engage in those activities, for example dressing is taught at natural opportunities such as when students change for physical education, use the restroom or at other natural times for dressing, instruction for holding and using utensils or eating appropriately would occur at snacks and meals. 2. Social skills instruction with peers occurs during natural opportunities like lunch, breaks, after school clubs, sports ,and other events that occur naturally. 3. Opportunities for communication occur across all daily routines based on the student's wants, needs and interests. 4. Instruction in academic areas occurs at the same time as other students in the classroom whenever possible though instruction may be individualized to address a student's needs. 5. Instruction for skills needed in the community occur during natural routines like grocery shopping, using public transportation, accessing community leisure and recreation or during after school jobs or volunteering. 6. Instruction in and opportunities for making choices are incorporated across all areas and through all daily routines. 7. Routines that the student participates in are those that same age peers without autism participate in. 8. Issues that are barriers to participation in typical, age appropriate activities are addressed to minimize the effects on the student with Autism's access to typical routines.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community

Check One: ___Minimum Standard X Progressive ___Best Practice

Citation(s) for Evidence-base: National Standards

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
When planning for students' instructional needs, natural			

routines for teaching skills are utilized recognizing some students may need additional practice or simulation of routines to gain skills in natural instructional settings.. Natural routines and areas of instruction may include: 1. Daily living skills taught at natural times for students to engage in those activities, for example dressing is taught at natural opportunities such as when students change for physical education, use the restroom or at other natural times for dressing, instruction for holding and using utensils or eating appropriately would occur at snacks and meals. 2. Social skills instruction with peers occurs during natural opportunities like lunch, breaks, after school clubs¸ sports ¸and other events that occur naturally. 3. Opportunities for communication occur across all daily routines based on the student's wants, needs and interests. 4. Instruction in academic areas occurs at the same time as other students in the classroom whenever possible though instruction may be individualized to address a student's needs. 5. Instruction for skills needed in the community occur during natural routines like grocery shopping, using public transportation, accessing community leisure and recreation or during after school jobs or volunteering. 6. Instruction in and opportunities for making choices are incorporated across all areas and through all daily routines. 7. Routines that the student participates in are those that same age peers without autism participate in. 8. Issues that are barriers to participation in typical, age appropriate activities are addressed to minimize the effects on the student with Autism's access to typical routines.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: National Standards			

Evidence Based Practice

Standard	Check all that Apply		
	Service:	Recipient:	Location:
The education or habilitation efforts for individuals with Autism Spectrum Disorders will consist of scientifically established or supported (i.e. emerging) technologies as evidenced in peer reviewed literature. From these available procedures or technologies, specific procedures may be selected based on a convergence of information from preferences of the individual being served, preferences of the individual's legal guardian, and the experience of duly qualified members of the individual's habilitation or educational team. Should there be any question of the validity of a particular procedure or technology, the most recent release of the *National Standards Report* by The National Autism Center will be referenced by the habilitation or educational team when	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community

selecting procedures. Instructional methods incorporate the following listed as Evidence Based Practice by the National Professional Development Center on Autism Spectrum Disorders: 1. Discrete trial training 2. Computer aided instruction 3. Differential Reinforcement 4. Extinction 5. Functional Behavioral Assessment 6. Functional Communication Training 7. Naturalistic Intervention (Incidental teaching) 8. Parent Implemented Intervention 9. PECS 10. Peer Mediated Instruction & Intervention 11. Pivotal response training 12. Prompting 13. Reinforcement Response Interruption/Redirection 14. Self-management 15. Social narratives 16. Social skills groups 17. Speech generating devices 18. Stimulus control 19. Structured work systems 20. Task analysis 21. Time delay 22. Video Modeling 23. Visual supports			
Check One: X Minimum Standard ___Progressive Standard __Best Practice Citation(s) for Evidence-base: National Standards Report, National Autism Center			

Promotion of Independence

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The IEP team/multidisciplinary team will engage in ongoing review of progress to identify student abilities and select strategies to use to maximize independence and minimize prompt dependency.	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School ___Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: The Educational Aspects of Autism Spectrum Disorders, 2008			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location*:
The IEP team/multidisciplinary team will conduct ongoing assessment to identify student abilities and select strategies to use to maximize independence and minimize prompt dependency. The IEP team/multidisciplinary team will provide opportunities in a variety of natural settings—home, school, community—to demonstrate independence and	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community

promote responsible decision making.			

Check One: ___Minimum Standard X Progressive Standard ___ Best Practice

Citation(s) for Evidence-base: The Educational Aspects of Autism Spectrum Disorders, 2008

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
The IEP team/multidisciplinary team will conduct ongoing assessment to identify student abilities and select strategies to use to maximize independence and minimize prompt dependency. The IEP team/multidisciplinary team will provide opportunities in a variety of natural settings—home, school, community—to demonstrate independence and promote responsible decision making. Efforts will be made to gather information regarding how the individual defines outcomes of independence across significant areas (i.e. support networks, safety, health, rights, fair treatment, choosing priorities, use their environment, social roles, participate in the life of the community, friends, choosing goals)and the IEP team/multidisciplinary team provides services and supports to promote the individual outcomes.	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community

Check One: ___Minimum Standard ___Progressive Standard X Best Practice

Citation(s) for Evidence-base: The Educational Aspects of Autism Spectrum Disorders, 2008 and Personal Outcome Measures for Children and Youth; The Council on Quality and Leadership

Generalization of Skills

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
Individual will be introduced to items/objectives outside of the specific learning environment that encourage incidental teaching/learning (i.e. learning colors as individual has interest in M&M's)	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community

Check One: X Minimum Standard ___Progressive Standard ___Best Practice

Citation(s) for Evidence-base: Stokes, T. F., & Baer, D. M. (1977). An implicit technology of generalization. Journal of Applied Behavior Analysis, 10, 349-367; www.drchris.teachtown.com

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
Individual will be • introduced to items/objectives outside of the specific learning environment that encourage incidental teaching/learning (i.e. learning colors as individual has interest in M&M's) • provided systematic step by step objectives to increase generalization in the specific learning environment using o different teachers o a variety of materials	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community

Check One: ___Minimum Standard X Progressive Standard ___Best Practice

Citation(s) for Evidence-base: Stokes, T. F., & Baer, D. M. (1977). An implicit technology of generalization. Journal of Applied Behavior Analysis, 10, 349-367; www.drchris.teachtown.com

Standard	**Check all that Apply**

	Service:	*Recipient*:	*Location*:
Individual will be • introduced to items/objectives outside of the specific learning environment that encourage incidental teaching/learning (i.e. learning colors as individual has interest in M&M's) • provided systematic step by step objectives to increase generalization in the specific learning environment using ○ different teachers ○ a variety of materials ○ different settings	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	__Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: Stokes, T. F., & Baer, D. M. (1977). An implicit technology of generalization. Journal of Applied Behavior Analysis, 10, 349-367; www.drchris.teachtown.com			

Area 4: Instructional Environment

Classroom Organization

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency or school maintains organization of learning environments which: 1. Are free of identified distracting stimuli. 2. Supports movement within the learning environment of individuals that promotes the efficacy of learning and does not impede on the rights of others. 3. Include instructional areas appropriate for specific instructional and therapeutic activities. 4. Represent a continuum from highly structured to natural environments to allow for programmed generalization. 5. Represent least restrictive environments. 6. Promote interaction with nondisabled peers.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: 1. http://idea.ed.gov/ 2. nichcy.org/disability/specific/**autism**			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency or school maintains organization of learning environments which: 1. Are free of identified distracting stimuli. 2. Supports movement within the learning environment of individuals that promotes the efficacy of learning and does not impede on the rights of others. 3. Include instructional areas appropriate for specific instructional and therapeutic activities. 4. Represent least restrictive environments 5. Promote interaction with nondisabled peers	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base: http://idea.ed.gov/			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
The agency or school maintains organization of learning environments which: 1. Supports movement within the learning environment of individuals that promotes the efficacy of learning and does not impede on the rights of others. 2. Include instructional areas appropriate for specific instructional and therapeutic activities. 3. Represent least restrictive environments 4. Promote interaction with nondisabled peers	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base: http://idea.ed.gov/			

Environmental Safeguards

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
The agency or school has a general and individual specific plan for safety to address areas of concern. Staff is given training on environmental safeguards implemented by the agency and those to protect individual students. Safeguards may include but are not limited to locks, alarms on doors and windows, posting of allergy concerns and restricting presence of allergens, and locking away chemicals. Safeguards that may be restrictions of rights are reviewed and approved by the agency, parents or guardians and an HRC. Individualized plans are developed to teach safety skills. Areas to be addressed include: 1. Wandering away or elopement. 2. Pica (eating inedible items/drinking non potable liquids) 3. Allergies (food, insect bites, medications, environmental allergies) 4. Fire and severe weather safety 5. Other safety emergencies (bomb threats, violence, etc). 6. Vehicle safety. 7. Personal safety (i.e., bullying, sexual exploitation, interactions with strangers)	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: http://www.spencerfane.com/News/Headline.asp?Ref=edrelatedlegislation; www.nccdp.org/**Elopement**Manual.doc · DOC file; www.schoolbusfleet.com/…/Student-Transportation-introduces-autism-education-program.aspx; www.nfpa.org/itemDetail.asp?categoryID=1953&itemID=46172&URL=Safety%20Information/For… Jones, R. T., Kazdin, A. E., & Haney, J. I. (1981). Social validation and training of emergency fire safety skills for potential injury prevention and life saving. *Journal of Applied Behavior Analysis,* 14, 249-260. Kelly A. Dancho, Rachel H. Thompson, & Melissa M. Rhoades. Teaching preschool children to avoid poison hazards. *Journal of Applied Behavior Analysis, 2008,* 41, 267-271.			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
The agency or school has a general and individual specific plan for safety to address areas of concern. Staff is given	___Direct	___Individual w/ASD	___Home

training on environmental safeguards implemented by the agency and those to protect individual students. Safeguards may include but are not limited to locks, alarms on doors and windows, posting of allergy concerns and restricting presence of allergens, and locking away chemicals. Safeguards that may be restrictions of rights are reviewed and approved by the agency and, parents or guardians. Areas to be addressed include: 1. Wandering away or elopement. 2. Pica (eating inedible items/drinking non potable liquids) 3. Allergies (food, insect bites, medications, environmental allergies) 4. Fire and severe weather safety 5. Other safety emergencies (bomb threats, violence, etc). 6. Vehicle safety. **7.** Personal safety (i.e., bullying, sexual exploitation, interactions with strangers)	___Technical Assist ___Consultation	___Family ___School District ___Other / List:	___School ___Community
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base: http://www.spencerfane.com/News/Headline.asp?Ref=edrelatedlegislation, www.nccdp.org/**Elopement**Manual.doc · DOC file; www.schoolbusfleet.com/…/Student-Transportation-introduces-autism-education-program.aspx; www.nfpa.org/itemDetail.asp?categoryID=1953&itemID=46172&URL=**Safety**%20Information/For…			

Standard	Check all that Apply		
	Service:	Recipient:	Location:
The agency or school has a general plan for safety to address areas of concern. Staff is given training on environmental safeguards implemented to protect individual students. Safeguards may include but are not limited to locks, alarms on doors and windows, posting of allergy concerns and restricting presence of allergens, and locking away chemicals. Safeguards that may be restrictions of rights are reviewed and approved by the agency and parents or guardians.. Areas to be addressed include: 1. Wandering away or elopement. 2. Pica (eating inedible items/drinking non potable liquids) 3. Allergies (food, insect bites, medications, environmental allergies) 4. Fire and severe weather safety 5. Other safety emergencies (bomb threats, violence, etc). 6. Vehicle safety. **7.** Personal safety (i.e., bullying, sexual exploitation, interactions with strangers)	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base: http://www.spencerfane.com/News/Headline.asp?Ref=edrelatedlegislation; www.nccdp.org/**Elopement**Manual.doc · DOC file; www.schoolbusfleet.com/…/Student-Transportation-introduces-autism-education-program.aspx; www.nfpa.org/itemDetail.asp?categoryID=1953&itemID=46172&URL=**Safety**%20Information/For…			

Peer Awareness

Standard	Check all that Apply		
	Service:	Recipient:	Location:
Without violating rights of individuals, qualified agency or school personnel provide minimally monthly information about characteristics of ASD and instruction, including guided practice (role modeling) that demonstrates appropriate interaction with students with ASD to peers. Peers are provided monthly support to monitor and evaluate peers' social interactions with students with ASD in the program.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District ___Other / List:	__ Home X School ___ Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: Evidence-base: http://asa.confex.com/asa/2010/webprogram/Session4675.html, ; A multicomponent Autism awareness training for typical peers; iseesam.com/wordpress/wp-content/uploads/2008/03/social… Serene H.-J. Choi and Timo A. Nieminen, Improved social interaction by children with autism by training of peers. pp. 46–53 in Fiona Bryer (ed) *Making meaning: Creating connections that value diversity*. Australian Association of Special Education (2005)			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Without violating rights of individuals, qualified agency or school personnel provides information minimally quarterly about characteristics of ASD and instruction, including guided practice (role modeling) that demonstrates appropriate interaction with students with ASD to peers. Peers are provided support to monitor and evaluate peers' social interactions with students with ASD in the program.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District ___Other / List:	__Home X School ___Community
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base: Evidence-base: http://asa.confex.com/asa/2010/webprogram/Session4675.html, ; A multicomponent Autism awareness training for typical peers; iseesam.com/wordpress/wp-content/uploads/2008/03/social… Serene H.-J. Choi and Timo A. Nieminen, Improved social interaction by children with autism by training of peers. pp. 46–53 in Fiona Bryer (ed) *Making meaning: Creating connections that value diversity*. Australian Association of Special Education (2005)			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Without violating rights of individuals, qualified agency or school personnel provide information annually about characteristics of ASD and instruction that demonstrates appropriate interaction with students with ASD to peers. Peers are provided support as needed to monitor and evaluate peers' social interactions with students with ASD in the program.	X Direct ___Technical Assist X Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School ___Community
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base: http://asa.confex.com/asa/2010/webprogram/Session4675.html, ; A multicomponent Autism awareness training for typical peers; iseesam.com/wordpress/wp-content/uploads/2008/03/social… Serene H.-J. Choi and Timo A. Nieminen, Improved social interaction by children with autism by training of peers. pp. 46–53 in Fiona Bryer (ed) *Making meaning: Creating connections that value diversity*. Australian Association of Special Education (2005)			

Personnel

Standard	Check all that Apply

	Service:	*Recipient*:	*Location*:
1. The agency or school hires personnel who meet minimal qualifications for their role according to agency guidelines. 2. Personnel have pre-service training specific to the persons they support. 3. The agency has a specific inservice training programs to address: a. Implementation of instructional and behavioral programming b. Ethical treatment of persons they support c. Responsiveness to cultural diversity 4. The agency has a program for continuous quality monitoring that includes assessment and evaluation of treatment fidelity, and appropriate interactions with persons they support.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base:			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
1. The agency or school hires personnel who meet minimal qualifications for their role according to agency guidelines. 2. Personnel have pre-service training specific to the persons they support. 3. The agency has a specific inservice training programs to address: a. Implementation of instructional and behavioral programming b. Ethical treatment of persons they support c. Responsiveness to cultural diversity 4. The agency has a program for continuous quality monitoring that includes assessment and evaluation of staff effectiveness and appropriate interactions with persons they support.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base:			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
1. The agency or school hires personnel who meet minimal qualifications for their role according to agency guidelines. 2. The agency has a specific in-service training programs to address: 1. Implementation of instructional and behavioral programming 2. Ethical treatment of persons they support 3. Responsiveness to cultural diversity 3. The agency has a program for periodic quality monitoring that includes assessment and evaluation of staff effectiveness and appropriate interactions with persons they support.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base:			

Predictability and Structure

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
The agency or school utilizes explicit classroom and individual schedules, including: 1. Constructs and maintains schedules to increase the likelihood that activity sequences are predicable for students. 2. Assigned roles and responsibilities for school or agency staff, 3. Instructs students to follow schedules, 4. Develops contingency plans that are responsive to disruptions or interruptions in schedules that minimize their effects. 5. Implements teaching of specific coping strategies for students.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base:			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
The agency or school utilizes explicit classroom and individual schedules, including: 1. Constructs and maintains schedules to increase the likelihood that activity sequences are predicable for students. 2. Assigned roles and responsibilities for school or agency staff 3. Instructs students to follow schedules, 4. Develops contingency plans that are responsive to disruptions or interruptions in schedules that minimize their effects.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base:			

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
The agency or school utilizes explicit classroom and/or individual schedules, including: 1. Constructs and maintains schedules to increase the likelihood that activity sequences are predicable for students. 2. Assigned roles and responsibilities for school or agency staff	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base:			

Instructional Accommodations and Support

Standard	Check all that Apply		
	Service:	Recipient:	Location:
Academic accommodations and modifications: • Those accommodations and modifications that have been identified to be effective by multidisciplinary team	X Direct ___Technical Assist	X Individual w/ASD X Family	X Home X School

members are included in the student's plan. • Accommodations and modifications are individualized and implemented across all applicable learning environments. • They are reviewed annually in multidisciplinary team meetings.	___Consultation	___School District ___Other / List:	X Community

Check One: X Minimum Standard ___Progressive Standard ___Best Practice

Citation(s) for Evidence-base: Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Academic accommodations and modifications: • Those accommodations and modifications that have been identified to be effective by multidisciplinary team members are included in the student's plan. • Accommodations and modifications are individualized and implemented across all applicable learning environments. • They are reviewed annually in multidisciplinary team meetings • Data collection system is developed to track the student's performance and the uses of accommodations/modifications are assessed on a quarterly basis for effectiveness.	X Direct X Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community

Check One: ___Minimum Standard X Progressive Standard ___Best Practice

Citation(s) for Evidence-base: Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Academic accommodations and modifications: • Those accommodations and modifications that have been identified to be effective by multidisciplinary team members are included in the student's plan. • Accommodations and modifications are individualized and implemented across all applicable learning environments. • They are reviewed annually in multidisciplinary team meetings • Data collection system is developed to track the student's performance and the uses of accommodations/modifications are assessed on a monthly basis for effectiveness. • If data collected on student performance does not demonstrate a progression of more accurate, fluent, or correct responding over a three month time span, the multidisciplinary team will meet to reevaluate instructional accommodations/modifications and make necessary adjustments to improve student performance. • If data collected on student performance does demonstrate a progression of more accurate, fluent, or correct responding over a six month time span, the multidisciplinary team will meet to reevaluate	X Direct X Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community

instructional accommodations/modifications and determine if the student is able to maintain that performance using a less restrictive modality of instruction.			
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).			

Rules

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Learning environment rules: • Learning environment rules are positively stated and posted clearly in the learning environment. • Rules are presented in a manner that is understandable to the students. • Visual supports accompany written rules.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base : Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).			

Standard	**Check all that Apply**		
	*Service***:**	*Recipient*:	*Location*:
Learning environment rules: • Learning environment rules are positively stated and posted clearly in the learning environment. • Rules are presented in a manner that is understandable to the students. • Visual supports accompany written rules. • Expectations are explicitly taught through review of the rules and demonstration of following the rules across the day and in a variety of learning environments.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base : Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).			

Standard	**Check all that Apply**		
	*Service***:**	*Recipient*:	*Location*:
Learning environment rules: • Learning environment rules are positively stated and posted clearly in the learning environment. • Rules are presented in a manner that is understandable to the students. • Visual supports accompany written rules. • Expectations are explicitly taught through review of the rules and demonstration of following the rules across the day and in a variety of learning environments. • If a student breaks a rule, the instructor will inform the student in a positive manner of what they should have done	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community

and further prompt the student to follow the rule to demonstrate the correct behavior before acknowledging their need/want.			
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base : Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).			

Activity Transitions

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
A daily schedule of activities is used by students and staff and individual schedules are used as necessary. • Students check their own schedule between each activity to prepare of the transition. • Students transition as independently as possible. • Adults may cue students with a generic phrase such as "check your schedule" or "what's next?"	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence base: Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
A daily schedule of activities is used by students and staff and individual schedules are used as necessary. • Students check the schedule between each activity to prepare of the transition. • Transitions are suitably structured as determined by student's needs (e.g. transition item that represents next activity; verbal cue). • Students are prepared for transitions through predictable activities/signals (e.g. timer, song). • Transition cues are followed consistently (e.g. when timer goes off the student's transition).	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence base: Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
A daily schedule of activities is used by students and staff and individual schedules are used as necessary. • Students check their own schedule between each activity to prepare of the transition. • Students transition as independently as possible. • Transitions are suitably structured as determined by student's needs (e.g. transition item that represents next activity; verbal cue). • Students are prepared for transitions through predictable	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community

activities/signals (e.g. timer, song). • Transition cues are followed consistently (e.g. when timer goes off the student's transition). • Transitions occur quickly to minimize wait time. • Unnecessary transitions are minimized.			
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence base: Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).			

Behavior Support Plan

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Development of a Behavior Support Plan (BSP) includes the following: • Completion of a functional behavioral assessment (FBA), including direct and indirect methods with consideration to the function of the behavior. • A collaborative team approach including parents, teachers, therapists, and administration is established to conduct and analyze information gathered from the FBA and establish a behavior plan. • Comprehensive intervention plans are developed based upon hypotheses that result from a current and appropriate functional behavior assessment. • Developed behavior intervention plans include antecedent strategies (proactive strategies intended to prevent behaviors from occurring), strategies for teaching and prompting new skills (e.g. communication, social skills, independence, choice making, etc.), and non-emotional, nonverbal, and non-punitive strategies for responding to behavior when it occurs. • Strategies are developed for teaching replacement behaviors that serve the same function as the inappropriate behavior. • Reinforcement strategies are incorporated into the student's typical day and behavior plans to include contrived and natural reinforcement. • BSP is implemented consistently in all environments and with all instructors. • Behavior data is collected using specifically designed data sheets based and used to guide effectiveness of the intervention plan. Data is reviewed in multidisciplinary team meetings in a graphical format on a quarterly basis.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence base: Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Development of a Behavior Support Plan includes the following: • Completion of a functional behavioral assessment, including	X Direct X Technical Assist	X Individual w/ASD X Family	X Home X School

direct and indirect methods with consideration to the function of the behavior. • A collaborative team approach including parents, teachers, therapists, and administration is established to conduct and analyze information gathered from the FBA and establish a behavior plan. • Comprehensive intervention plans are developed based upon hypotheses that result from a current and appropriate functional behavior assessment. • Developed behavior intervention plans include antecedent strategies (proactive strategies intended to prevent behaviors from occurring), strategies for teaching and prompting new skills (e.g. communication, social skills, independence, choice making, etc.), and non-emotional, nonverbal, and non-punitive strategies for responding to behavior when it occurs. • Strategies are developed for teaching replacement behaviors that serve the same function as the inappropriate behavior. • Reinforcement strategies are incorporated into the student's typical day and behavior plans to include contrived and natural reinforcement. • BSP is implemented consistently in all environments and with all instructors. • Behavior data is collected using specifically designed data sheets based and used to guide effectiveness of the intervention plan. Data is reviewed in IEP/multidisciplinary team meetings in a graphical format on a quarterly basis. • Staff and families implementing behavior support plans are provided with ongoing training and support regarding the implementation of strategies in the plan.	___Consultation	X School District ___Other / List:	X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence base: Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Development of a Behavior Support Plan includes the following: • Completion of a functional behavioral assessment, including direct and indirect methods with consideration to the function of the behavior. • A collaborative team approach including parents, teachers, therapists, administration, and an individual(s) with specialized training in applied behavior analysis and/or a board certified behavior analyst is established to conduct and analyze information gathered from the FBA and establish a behavior plan. • Comprehensive intervention plans are developed based upon hypotheses that result from a current and appropriate functional behavior assessment. • Developed behavior intervention plans include antecedent strategies (proactive strategies intended to prevent behaviors from occurring), strategies for teaching and prompting new skills (e.g. communication, social skills, independence, choice	X Direct X Technical Assist X Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community

making, etc.), and non-emotional, nonverbal, and non-punitive strategies for responding to behavior when it occurs. • Strategies are developed for teaching replacement behaviors that serve the same function as the inappropriate behavior. • Reinforcement strategies are incorporated into the student's typical day and behavior plans to include contrived and natural reinforcement. • BSP is implemented consistently in all environments and with all instructors. • Behavior data is collected using specifically designed data sheets based and used to guide effectiveness of the intervention plan. Data is reviewed in IEP/multidisciplinary team meetings in a graphical format on a monthly basis. • Staff and families implementing intervention plans are provided ongoing training and support regarding the implementation of strategies in the plan from an individual(s) with specialized training in applied behavior analysis and/or a board certified behavior analyst			
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence base: Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).			

Instructor Modeling for Academics

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Instructor/aide provides students with a clear, multi-sensory model of a skill, using the following elements: 1. Concept/skill is broken down into critical features/elements. 2. Instructor clearly describes concept/skill. 3. Instructor clearly models concept/skill. 4. Instructor will probe learner for understanding 5. Instructor prompts, as necessary	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home __School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence base: http://fcit.usf.edu/mathvids/strategies/em.html			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Instructor/aide provides students with a clear, multi-sensory model of a skill, using the following elements: 1. Concept/skill is broken down into critical features/elements. 2. Instructor clearly describes concept/skill. 3. Instructor clearly models concept/skill. 4. Instructor will probe learner for understanding, and if client lacks understanding, will provide additional instruction 5. Multi-sensory instruction (visual, auditory, tactile, kinesthetic) 6. Instructor prompts, as necessary	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home __School X Community

7. High levels of Instructor-student interaction			
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: http://fcit.usf.edu/mathvids/strategies/em.html			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Instructor/aide provides students with a clear, multi-sensory model of a skill, using the following elements: 1. Concept/skill is broken down into critical features/elements. 2. Instructor clearly describes concept/skill. 3. Instructor clearly models concept/skill. 4. Instructor will probe learner for understanding, and if client lacks understanding, will provide additional instruction 5. Multi-sensory instruction (visual, auditory, tactile, kinesthetic) 6. Instructor thinks aloud as she/he models. 7. Instructor models examples and non-examples. 8. Instructor prompts, as necessary 9. Instructor reinforces correct behaviors 10. High levels of Instructor-student interaction	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home __School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence base: http://fcit.usf.edu/mathvids/strategies/em.html			

Instructor Modeling for Social Behavior

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Instructor/aide provides students with a clear definition of social behavior by: 1. Instructor labels targeted social behavior 2. Instructor clearly models concept/skill. 3. Instructor clearly prescribes display of behavior 4. Repeated practice	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Instructor/aide provides students with a clear definition of social behavior by: 1. Instructor labels targeted social behavior 2. Instructor clearly models concept/skill. 3. Instructor clearly prescribes display of behavior 4. Repeated practice 5. Instructor prompts, as necessary 6. Instructor reinforces display of behavior	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community

Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Instructor/aide provides students with a clear definition of social behavior by: 1. Instructor labels targeted social behavior 2. Instructor clearly models concept/skill. 3. Instructor clearly prescribes display of behavior 4. Instructor prompts, as necessary 5. Repeated practice 6. Instructor reinforces display of behavior 7. Social behavior is trained for generalization across a variety of settings	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base:			

Instructor Modeling for Staff

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Instructor will model the following for staff: 1. Instructor clearly describes concept/skill. 2. Instructor clearly models concept/skill. 3. Multi-sensory instruction (handouts, verbal review, physical demonstration) 4. Instructor thinks aloud as she/he models. 5. Instructor models examples and non-examples.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home __School ___Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	*Service***:**	*Recipient*:	*Location*:
Instructor will model the following for staff: 1. Instructor clearly describes concept/skill. 2. Instructor clearly models concept/skill. 3. Multi-sensory instruction (handouts, verbal review, physical demonstration) 4. Instructor thinks aloud as she/he models. 5. Instructor models examples and non-examples. 6. Instructor provides a review after demonstration	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home __School __Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	*Service***:**	*Recipient*:	*Location*:
Instructor will model the following for staff:	X Direct	X Individual w/ASD	X Home

1. Instructor clearly describes concept/skill. 2. Instructor clearly models concept/skill. 3. Multi-sensory instruction (handouts, verbal review, physical demonstration) 4. Instructor thinks aloud as she/he models. 5. Instructor models examples and non-examples. 6. Instructor provides a review after demonstration 7. Instructor observes staff behavior in naturalized setting and provides feedback on performance at that time	___Technical Assist ___Consultation	___Family ___School District ___Other / List:	__School __Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base:			

Feedback to Staff

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Instructor/supervisor will demonstrate the following characteristics: 1. Provide specific information for behavior displayed 2. Provide feedback immediately following the performance 3. Ensure feedback is easily understood 4. Individualize feedback 5. Provide strategies for self-monitoring 6. Follow-up, through specific actions, after providing feedback	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	___Home X School ___Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: **Performance Management: Changing Behavior That Drives Organizational Effectiveness** – Daniels and Daniels, 2004			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Instructor/supervisor will demonstrate the following characteristics: 1. Provide specific information for behavior displayed 2. Provide feedback immediately following the performance 3. Ensure feedback is easily understood 4. Individualize feedback 5. Provide strategies for self-monitoring 6. Follow-up, through specific actions, after providing feedback, within one month period 7. Provide specifics about how performance can improve	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	___Home X School __Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: **Performance Management: Changing Behavior That Drives Organizational Effectiveness** – Daniels and Daniels, 2004			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Instructor/supervisor will demonstrate the following			

characteristics: 1. Provide specific information for behavior displayed 2. Provide feedback immediately following the performance 3. Ensure feedback is easily understood 4. Individualize feedback 5. Provide strategies for self-monitoring 6. Follow-up, through specific actions, after providing feedback, within one week period 7. Provide specifics about how performance can improve 8. Provide specific standard for measurement of improvement 9. Provide reinforcement, if improvement had been demonstrated	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	__Home X School __Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: **Performance Management: Changing Behavior That Drives Organizational Effectiveness** – Daniels and Daniels, 2004			

Lesson Plans

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
A lesson plan will contain the following: 1. Describes objective of lesson 2. Describes materials required 3. Describes teaching procedure for lesson 4. Consideration is made of efficacy of lesson plans, and changes are made, as necessary through change of procedures, new activities, new technologies etc. 5. Data collected on lesson plan 6. Describes prompting used in lesson 7. Covers applicable curriculum areas	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base:			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
A lesson plan will contain the following: 1. Describes objective of lesson 2. Describes materials required 3. Describes teaching procedure for lesson 4. Consideration is made of efficacy of lesson plans, and changes are made, as necessary through change of procedures, new activities, new technologies etc. 5. Data collected on lesson plan 6. Data is summarized 7. Describes prompting used in lesson 8. Covers applicable curriculum areas	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice			

Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
A lesson plan will contain the following: 1. Describes objective of lesson 2. Describes materials required 3. Describes teaching procedure for lesson 4. Consideration is made of efficacy of lesson plans, and changes are made, as necessary through change of procedures, new activities, new technologies etc. 5. Data collected on lesson plan 6. Data is summarized 7. Describes prompting used in lesson 8. Describes reinforcement for lesson 9. Covers applicable curriculum areas 10. Covers social areas	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base:			

Area 5: Review and Monitoring of Progress

Modification of Plan

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency's staff schedule allows for sufficient time for review of data and monthly meetings to evaluate progress. The schedule allows attendance at meetings by persons involved in design and implementation of the plan. There is at least a monthly review of data by the teacher or QDDP. Modification of the plan is made based on the following considerations: 1. Presentation and analysis of reliable data related to progress 2. Considerations of variables related to the individual such as medical conditions or medications. **3.** Considerations of variables related to the individuals environment such as living arrangements or treatment settings.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base: http://ed.gov/parents/needs/speced/iepguide/index.html#review			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency's staff schedule includes time for review of data and monthly meetings to evaluate progress, based on the need of the caseload. The schedule allows attendance at meetings by persons (including parents and guardians as involved in design and implementation of the plan. There is at least a bi-weekly review of data by the teacher or QDDP Modification of the plan is made based on the following	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community

considerations: 1. Presentation and analysis of reliable data related to progress and treatment fidelity. 2. Considerations of variables related to the individual such as medical conditions or medications. **3.** Considerations of variables related to the individuals environment such as living arrangements or treatment settings.			
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base: http://ed.gov/parents/needs/speced/iepguide/index.html#review			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency's staff schedule allows time for review of data and monthly meetings to evaluate progress, based on the need of the caseload. The schedule allows attendance at meetings by persons involved in design and implementation of the plan. There is at least a weekly review of data by the teacher or QDDP. There are criteria for more frequent progress evaluation meetings should the need for modification be indicated. Modification of the plan is made based on the following considerations: 1. Presentation and analysis of reliable data related to progress and treatment fidelity. 2. Considerations of variables related to the individual such as medical conditions or medications. 3. Considerations of variables related to the individuals environment such as living arrangements or treatment settings. 4. A component analysis of complex treatment packages.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: http://ed.gov/parents/needs/speced/iepguide/index.html#review			

Reporting

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Reports documenting progress are provided to all relevant persons or agencies involved in the care of the individual. These reports include: 1. Presentation of treatment data. 2. Summary analysis of relevant variables related to the individual such as medical conditions or medications, the person's environment including living arrangements and treatment settings. 3. Changes made to program during reporting period.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community
Check One: X Minimum Standard ___ Progressive Standard ___Best Practice Standard Citation(s) for Evidence-base: http://ed.gov/parents/needs/speced/iepguide/index.html#review			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Reports documenting progress are provided to all relevant			

persons or agencies involved in the care of the individual. These reports include: 1. Presentation of treatment data. 2. Summary analysis of relevant variables related to the individual such as medical conditions or medications, the person's environment including living arrangements and treatment settings. 3. Changes made to program during reporting period. 4. Long range plans for individual plan direction including plans for generalization and maintenance of skills. 5. Documentation of review by a Peer Review/IDT/IEP team.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community
Check One: ___Minimum Standard __X_ Progressive Standard ___Best Practice Standard Citation(s) for Evidence-base: http://ed.gov/parents/needs/speced/iepguide/index.html#review			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Reports documenting progress are provided to all relevant persons or agencies involved in the care of the individual. These reports include: 1. Presentation of treatment data. 2. Summary analysis of relevant variables related to the individual such as medical conditions or medications, the person's environment including living arrangements and treatment settings. 3. Changes made to program during reporting period. 4. Long range plans for individual plan direction including plans for generalization and maintenance of skills. 5. Documentation of review by a Peer Review Committee/IDT/IEP committee and Rights Protection committees.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: http://ed.gov/parents/needs/speced/iepguide/index.html#review			

Assessment Tools

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Assessment tools used in the review and monitoring of progress include the following: • Vision/hearing evaluation • Communication/language evaluation • Behavior rating scale and/or an adaptive behavior rating scale • State and district-wide assessments • Observation in both a structured and an unstructured learning environment or natural setting • Structured interview with parent/primary caregiver • Reliable data related to progress	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for evidence base: Rules of the Alabama State Board of Education, State Department of Education, Chapter 290-8-9, Special Education Services			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Assessment tools used in the review and monitoring of progress			

include the following: • Vision/hearing evaluation • Communication/language evaluation • Behavior rating scale and/or an adaptive behavior rating scale • State and district wide assessments • Observation in both a structured and an unstructured school environment or natural setting • Structured interview with parent/primary caregiver • Reliable data related to progress • Additional performance measures including developmental, intellectual, achievement, motor, criterions-referenced tests, curriculum based assessments, work samples, portfolios, and observation	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for evidence base: Rules of the Alabama State Board of Education, State Department of Education, Chapter 290-8-9, Special Education Services			

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location*:
Assessment tools used in the review and monitoring of progress include the following: • Vision/hearing evaluation • Communication/language evaluation specific to assessing students diagnosed with Autism Spectrum Disorder (for example, ABLLS and VB-Mapp) • Behavior rating scale and/or an adaptive behavior rating scale • State and district wide assessments • Observation in both a structured and an unstructured school environment or natural setting • Structured interview with parent/primary caregiver • Additional performance measures including developmental, intellectual, achievement, motor, criterions-referenced tests, curriculum based assessments, work samples, portfolios, and observation • Regularly collected and reliable data collected on student performance related to the goals/objectives included in the plan and used to report progress across the year	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for evidence base: Rules of the Alabama State Board of Education, State Department of Education, Chapter 290-8-9, Special Education Services			

Participants

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Participants to be included in the review and monitoring of student progress include the following: • Participants required by accredited/certifying agencies	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice			

Citation(s) for evidence base: Rules of the Alabama State Board of Education, State Department of Education, Chapter 290-8-9, Special Education Services

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Participants to be included in the review and monitoring of student progress include the following: • Participants required by accredited/certifying agencies • Professionals trained in autism specialty, including but not limited to behavior modification, communication skills, social skills	X Direct X Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community

Check One: ___Minimum Standard X Progressive Standard ___Best Practice

Citation(s) for evidence base: 1) Rules of the Alabama State Board of Education, State Department of Education, Chapter 290-8-9, Special Education Services 2) Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Participants to be included in the review and monitoring of student progress include the following: • Participants required by accredited/certifying agencies • Certified personnel in autism specialty areas	X Direct X Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community

Check One: ___Minimum Standard ___Progressive Standard X Best Practice

Citation(s) for evidence base: 1) Rules of the Alabama State Board of Education, State Department of Education, Chapter 290-8-9, Special Education Services 2) Adapted from Enhancing Instructional Contexts for Students with Autism Spectrum Disorders (EIC-ASD), PDA Center/Idaho Autism Strand Program Assessment, & Universal Supports Assessment and Planning Tool (USAPT).

Data Collection (Updated and Edited version)

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
Program ensures data is consistent, accurate and collected on a data sheet that contains definitions. Program ensures staff that are collecting data, have been trained on data collection forms and ensure materials that are required to run training session (adaptive or maladaptive) are present in the teaching environment.	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community

Check One: X Minimum Standard ___Progressive Standard ___Best Practice

Citation(s) for Evidence-base: Alabama State Department of Education, focused monitoring checklist; abama.webs.com

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location:*
Program ensures data is consistent, accurate and collected on a data sheet that contains definitions. Proper measurements are used (i.e. partial interval v. whole interval recording). Program ensures staff that are collecting data, have been trained on data collection forms and ensure materials that are required to run training session (adaptive or maladaptive) are present in the teaching environment. Instructions for how to provide instruction	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community

are clearly labeled. Checks are conducted by professionals responsible for overseeing students' progress (i.e. teachers, QDDP, worker) to ensure that proper instruments are present to collect data.			
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: Alabama State Department of Education, focused monitoring checklist; abama.webs.com			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Program ensures data is consistent, accurate and collected on a data sheet that contains definitions. Proper measurements are used (i.e. partial interval v. whole interval recording). Program ensures staff that are collecting data, have been trained on data collection forms and ensure materials that are required to run training session (adaptive or maladaptive) are present in the teaching environment. Instructions for how to provide instruction are clearly labeled. Checks are conducted by professionals responsible for overseeing students' progress (i.e. teachers, QDDP, worker) to ensure that proper instruments are present to collect data. Professionals responsible for overseeing students' progress (i.e. teachers, QDDP, worker), observe staff collecting the data, conduct probes and engage in inter-observatory agreement.	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: Alabama State Department of Education, focused monitoring checklist; abama.webs.com			

Data Analysis (Old Data Collection Standard)

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Data is collected and input in a organizational system (i.e. Excel) with graphic display; It will be reviewed in compliance with agencies progress report timelines	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	___Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: Alabama State Department of Education, focused monitoring checklist; abama.webs.com			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Data is collected, reviewed monthly and input in a organizational system (i.e. Excel), with an organizational display; If there is a lack of progress, as defined by the organization, a decision is made: Continue to implement the objective and change procedure(s) or stop objective (if objective is stopped must adhere to other procedures such as holding another meeting to replace stopped objective).	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	___Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: Alabama State Department of Education, focused monitoring checklist; abama.webs.com			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:

Data is reviewed monthly by an Interdisciplinary Team w/ case manager (i.e. Teacher) as a member of the team. If there is a lack of progress, as based on organizational standards, a decision is made: Continue to implement the objective and change procedure(s) or stop objective (if objective is stopped must adhere to other procedures such as holding another meeting to replace stopped objective). A follow-up timeline is developed for implementation of change based on Interdisciplinary Team discussion that also adheres to a reasonable time.	X Direct __Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	__Home X School __Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: Alabama State Department of Education, focused monitoring checklist; abama.webs.com			

Settings

Standard	Check all that Apply		
	Service:	*Recipient*:	*Location*:
A self-monitoring checklist is completed annually, in each learning environment of the student and discussed in a team meeting.	X Direct __Technical Assist ___Consultation	__Individual w/ASD ___Family X School District X Other / List: comm. placement	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: http://citl.gwu.edu/pdf/Self-Assessment-Guide.pdf			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
A self-monitoring checklist is completed bi-annually, in each learning environment of the student. A supervisor will meet with instructor after completing the checklist and review with the instructor.	X Direct __Technical Assist ___Consultation	__Individual w/ASD ___Family X School District X Other / List: comm. placement	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: http://citl.gwu.edu/pdf/Self-Assessment-Guide.pdf			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
A self-monitoring checklist is completed weekly, in each learning environment of the student. A supervisor will meet with instructor after completing the checklist and review with the instructor. Documentation of meeting with improvements noted with specific timelines will be attached to checklist	X Direct __Technical Assist ___Consultation	__Individual w/ASD ___Family X School District X Other / List: comm. placement	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: http://citl.gwu.edu/pdf/Self-Assessment-Guide.pdf			

Area 6: Family Involvement and Supports

Communication of Information

Standard	Check all that Apply

	Service:	*Recipient*:	*Location*:
The agency or school establishes procedures for regular communication of the status of the individual and program to relevant stakeholders. 1. Intermediate reports are issued at least every nine-weeks 2. Meetings for exchange of information and decision-making are held at least annually. 3. Where appropriate the information is communicated in nontechnical language for nonprofessional consumers. 4. The confidentiality of information is protected.	X Direct X Technical Assist X Consultation	X Individual w/ASD X Family X School District X Other / List: Team members	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency or school establishes procedures for regular communication of the status of the individual and program to relevant stakeholders. 1. Intermediate reports are issued monthly 2. Meetings for exchange of information and decision-making are held at least twice per year. 3. Where appropriate the information is communicated in nontechnical language for nonprofessional consumers. 4. The confidentiality of information is protected.	X Direct X Technical Assist X Consultation	X Individual w/ASD X Family X School District X Other / List: Team members	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	**Recipient:**	**Location:**
The agency or school establishes procedures for regular communication of the status of the individual and program to relevant stakeholders. 1. Intermediate reports are issued weekly 2. Meetings for exchange of information and decision-making are held at least monthly. 3. Where appropriate the information is communicated in nontechnical language for nonprofessional consumers. 4. The confidentiality of information is protected.	X Direct X Technical Assist X Consultation	X Individual w/ASD X Family X School District X Other / List: Team members	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: National Standards			

Family Training

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The school or agency provides training to families that: 1. Includes program overview and rationale	X Direct ___Technical Assist X Consultation	__Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: National Standards			
Standard	**Check all that Apply**		

	Service:	*Recipient*:	*Location*:
The school or agency provides training to families that: 1. Includes program overview and rationale 2. Is competency-based 3. Provides incentives for implementation by families outside of program settings 4. Offers program monitoring by school or agency staff	X Direct ___Technical Assist X Consultation	__Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The school or agency provides training to families that: 1. Includes program overview and rationale 2. Is competency-based 3. Requires implementation by families outside of program settings 4. Includes program monitoring by school or agency staff	X Direct ___Technical Assist X Consultation	__Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: National Standards			

Family Support Groups

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
An agency or school representative will be designated to provide information/printed materials to the family on local, state and national resources available. The information will include specific services to be offered by the provider addressing child's identified needs.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
An agency representative will assist family with the referral process by providing assessment/evaluations information to aid in accessing available resources. The agency representative will also serve as a point of contact until the referral has been completed and services have been established.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: National Standards			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The providing agency will offer and/or coordinate support meetings or trainings informing families of children receiving services information about diagnoses, treatment plans, outcome measures, etc.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: National Standards			

Cultural Sensitivity

Standard-Cultural Sensitivity	**Check all that Apply**		
	Service:	*Recipient:*	*Location*:
Family dynamics, needs, culture, language, values, and parenting style are identified. • Agency or school gather and document relevant information on cultural influences in a manner that is sensitive to those influences.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List: Agencies involved	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: Rodriguez, Diane. 2009 Culturally and linguistically diverse students with autism *The Free Library* (January, 1), http://www.thefreelibrary.com/Culturally and linguistically diverse students with autism.-a0202918136			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
Family dynamics, needs, culture, language, values, and parenting style are identified and respected. • Agency or school gather and document relevant information on cultural influences in a manner that is sensitive to those influences. • Agency or school should identify the barriers such as language and cultural differences of the family, work to build an understanding of linguistic and cultural diversity in order to build it in with the service/treatment plan, and provide support to the family in order to increase their level of participation.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List: Agencies involved	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: Rodriguez, Diane. 2009 Culturally and linguistically diverse students with autism *The Free Library* (January, 1), http://www.thefreelibrary.com/Culturally and linguistically diverse students with autism.-a0202918136			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Family dynamics, needs, culture, language, values, and parenting style are identified, respected, and valued. • Agency or school gather and document relevant information on cultural influences in a manner that is sensitive to those influences. • Agency or school should identify the barriers such as language and cultural differences of the family, work to build an understanding of linguistic and cultural diversity in order to build it in with the service/treatment plan, and provide support to the family in order to increase their level of participation. • Agency or school personnel ensure that sociocultural and language components are addressed in the delivery of instruction and in the daily routine of the student.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District X Other / List: Agencies involved	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: Rodriguez, Diane. 2009 Culturally and linguistically diverse students with autism *The Free Library* (January, 1), http://www.thefreelibrary.com/Culturally and linguistically diverse students with autism.-a0202918136			

Link to Other Agencies

Standard	**Check all that Apply**

	Service:	*Recipient:*	*Location:*
A list of other agencies will be provided.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: www.autismspeaks.com			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
A list of other agencies will be provided and there will be coordination of an initial meeting between identified agency(ies) and guardian/family.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: www.autismspeaks.com			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
A list of other agencies will be provided and there will be coordination of an initial meeting between identified agency(ies) and guardian/family. After meeting, school/organization will identify a person to act as point of contact for guardians/families and identified agency(ies) to oversee process and ensure is complete	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: www.autismspeaks.com			

Assistance to Access Services

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
A list is provided to guardian/family.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: www.autismspeaks.com			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
A list is provided to guardian/family. A meeting is coordinated with guardian/families to identify steps to help guardian/family identify other services and how to gain access to them.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base:			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
A list is provided to guardian/family. Coordination of meetings to identify steps to help guardian/family identify other services and how to gain access to them, as well as overseeing the process of gaining access.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice			

Citation(s) for Evidence-base: www.autismspeaks.org

Area 7: Social Behaviors

Applied Behavior Analysis

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency utilizes Applied Behavior Analysis techniques in a systematic program to address social and functional behavior excesses and deficits. Programs are written and monitored by a BCBA, 1. The agency completes a functional behavioral assessment and other appropriate assessments to determine areas of need for reduction programming and instruction. 2. The agency utilizes the least restrictive treatment that is effective to reduce problem behavior excesses. 3. The agency programs instruction to teach alternative skills to provide a functional alternative to problem behavior. 4. The agency program includes procedures for generalization of skills and criteria for ending the program when criteria are met. 5. The agency commits resources to ensure reliability of data and fidelity of treatment.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: www.**nationalautismcenter**.org/pdf/NAC%20**Standards**%20**Report**.pdf			

Standard	**Check all that Apply**		
	*Service***:**	*Recipient*:	*Location*:
The agency utilizes Applied Behavior Analysis techniques in a systematic program to address social and functional behavior excesses and deficits. Programs are written and monitored in consultation with a BCBA, 1. The agency completes a functional behavioral assessment and other appropriate assessments to determine areas of need for reduction programming and instruction. 2. The agency utilizes the least restrictive treatment that is effective to reduce problem behavior excesses. 3. The agency programs instruction to teach alternative skills to provide a functional alternative to problem behavior. **4.** The agency program includes procedures for generalization of skills and criteria for ending the program when criteria are met.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community
Check One: ___Minimum Standard X Progressive ___Best Practice Citation(s) for Evidence-base: www.**nationalautismcenter**.org/pdf/NAC%20**Standards**%20**Report**.pdf			

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
The agency utilizes Applied Behavior Analysis techniques in a systematic program to address social and functional behavior excesses and deficits. 1. The agency completes a functional behavioral assessment to determine areas of need for reduction programming and instruction. **2.** The agency utilizes the least restrictive treatment that is	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community

effective to reduce problem behavior excesses.			
Check One: X Minimum Standard ___Progressive ___Best Practice Citation(s) for Evidence-base: www.**nationalautismcenter**.org/pdf/NAC%20**Standards**%20**Report**.pdf			

Incidental Teaching

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency programs for incidental teaching of social behavior in natural environment settings thorough out the day. 1. Programming includes opportunities to practice social skills with peers across all daily activities, as a part of proactive generalization strategies including generalization of skills into the home and community. 2. Opportunities for social skills practice are identified before instruction so that as many opportunities as possible are provided. 3. Programming includes procedures for prompting and reinforcing appropriate social behavior in natural environments.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community
Check One: ___Minimum Standard ___Progressive X Best Practice Citation(s) for Evidence-base: www.**nationalautismcenter**.org/pdf/NAC%20**Standards**%20**Report**.pdf			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency programs for incidental teaching of social behavior in natural environment settings thorough out the day. 1. Opportunities for social skills practice are identified before instruction so that as many opportunities as possible are provided. 2. Programming includes opportunities to practice social skills with peers across all daily activities, as a part of proactive generalization strategies including generalization of skills into the community 3. Programming includes procedures for prompting and reinforcing appropriate social behavior in natural environments.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Standard Citation(s) for Evidence-base: www.**nationalautismcenter**.org/pdf/NAC%20**Standards**%20**Report**.pdf			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency programs for incidental teaching of social behavior in natural environment settings thorough out the day. 1. Opportunities for social skills practice are identified before instruction so that as many opportunities as possible are provided.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD ___Family X School District X Other / List:	___Home X School X Community
Check One: X Minimum Standard ___ Progressive Standard ___Best Practice Standard Citation(s) for Evidence-base: www.**nationalautismcenter**.org/pdf/NAC%20**Standards**%20**Report**.pdf			

Discrete Trial Training

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:

The agency utilizes Discrete Trial Training to teach new social skills to students. Programs are written and monitored by a BCBA. 1. An Autism specific assessment is utilized to determine social skills deficits. 2. Specific programs are written to teach ecologically valid social skills or components of those skills. 3. Mastered skills are targeted for incidental teaching in the natural environment.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: ___ Minimum Standard ___ Progressive Standard X Best Practice Standard Citation(s) for Evidence-base: www.**nationalautismcenter**.org/pdf/NAC%20**Standards**%20**Report**.pdf http://www.asatonline.org/intervention/procedures/discrete.htm			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency utilizes Discrete Trial Training to teach new social skills to students. Programs are written and monitored in consultation with a BCBA, as determined by the treatment team. 1. An Autism specific assessment is utilized to determine social skills deficits. 2. Specific programs are written to teach ecologically valid social skills or components of those skills. 3. Mastered skills are targeted for incidental teaching in the natural environment.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: ___ Minimum Standard X Progressive Standard ___ Best Practice Standard Citation(s) for Evidence-base: www.**nationalautismcenter**.org/pdf/NAC%20**Standards**%20**Report**.pdf http://www.asatonline.org/intervention/procedures/discrete.htm			

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The agency utilizes Discrete Trial Training to teach new social skills to students. 1. An Autism specific assessment is utilized to determine social skills deficits. 2. Specific programs are written to teach ecologically valid social skills or components of those skills. 3. Mastered skills are targeted for incidental teaching in the natural environment.	X Direct ___Technical Assist ___Consultation	X Individual w/ASD X Family X School District ___Other / List:	X Home X School X Community
Check One: _X__ Minimum Standard __ _Progressive Standard ___ Best Practice Standard Citation(s) for Evidence-base: www.**nationalautismcenter**.org/pdf/NAC%20**Standards**%20**Report**.pdf http://www.asatonline.org/intervention/procedures/discrete.htm			

Discipline

Standard	**Check all that Apply**		
	Service:	**Recipient:**	**Location:**
Program has group/individual procedures for a positive behavior plan where the focus is on teaching acceptable behaviors, reinforcement procedures are implemented and should there be a problem with the individual's behaviors based on the plan, a team will meet to discuss conducting a FBA and an appropriate intervention would be developed. When student has met criteria for reduction, a team will meet to discuss lesser restrictive	X Direct __Technical Assist __Consultation	X Individual w/ASD __Family __School District __Other / List: Team members	__Home X School X Community

alternatives.			
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: Alabama Administrative Code			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Program has group/individual procedures for a positive behavior plan where the focus is on teaching acceptable behaviors, reinforcement procedures are implemented and should there be a problem with the individual's behaviors based on the plan, a team will meet to discuss conducting a FBA and an appropriate intervention would be developed. The treatment team will collaborate at least quarterly to monitor progress and discuss data, address changes, and develop revisions if needed. When student has met criteria for reduction, a team will meet to discuss lesser restrictive alternatives.	X Direct __Technical Assist __Consultation	X Individual w/ASD __Family __School District __Other / List: Team members	X Home __School __Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: Alabama Administrative Code			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location:*
Program has group/individual procedures for a positive behavior plan where the focus is on teaching acceptable behaviors, reinforcement procedures are implemented and should there be a problem with the individual's behaviors based on the plan, a team will meet to discuss conducting a FBA and an appropriate intervention would be developed. The treatment team will collaborate at least monthly to monitor progress and discuss data, address changes, and develop revisions if needed. When student has met criteria for reduction, a team will meet to discuss lesser restrictive alternatives.	X Direct __Technical Assist __Consultation	X Individual w/ASD __Family __School District __Other / List: Team members	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: Alabama Administrative Code			

Sexuality

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location*:

Assessment of the individual's development and understanding of sexual behaviors be completed. Findings guide skills training and educational programming that addresses human growth and development that will assist the individual to understand and express sexuality in an acceptable and appropriate manner.
This training should focus on the following topics:
• Understand changes in the body and how to manage the changes.
  ○ Developing an understanding of one's body
  ○ Developing an understanding of how the body works
  ○ Developing an understanding of how the body changes
• The development and use of concrete language for body parts and functions.
	X Direct
	__Technical Assist
	___Consultation
		X Individual w/ASD
		X Family
		___School District
		___Other / List:
			X Home
			X School
			X Community

• Develop personal health and hygiene			
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: Autism Guidebook for Washington State, 2008			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Assessment of the individual's development and understanding of sexual behaviors be completed. Findings guide skills training and educational programming that addresses human growth and development and development of friendships that will assist the individual to understand and express sexuality in an acceptable and appropriate manner. This training should focus on the following topics: • Understand changes in the body and how to manage the changes. • The development and use of concrete language for body parts and functions. • Develop personal health and hygiene • Acquire skills which assist in the development of friendship • Special scripts and rules to aid in the understanding of the feelings and needs of others	X Direct __Technical Assist __Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: Autism Guidebook for Washington State, 2008			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Assessment of the individual's development and understanding of sexual behaviors be completed. Findings guide skills training and educational programming that addresses human growth and development, development of friendships, and specific and appropriate outlets to express sexuality. This training should focus on the following topics: • Understand changes in the body and how to manage the changes. • The development and use of concrete language for body parts and functions. • Develop personal health and hygiene • Acquire skills which assist in the development of friendship • Special scripts and rules to aid in the understanding of the feelings and needs of others • Similar scripts and rules for the appropriate time and place for behaviors of sexual expression.	X Direct __Technical Assist ___Consultation	X Individual w/ASD X Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: Autism Guidebook for Washington State, 2008			

Essential Life Skills

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Providing agency will conduct age-appropriate assessment utilizing both formal and informal assessment techniques. The	X Direct	X Individual w/ASD	__Home

guardian/individual will work with agency to identify and prioritize the most critical essential life skills needed.	__Technical Assist __Consultation	__Family __School District __Other / List: Team members	X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: Transition to Adulthood-Guidelines for Individuals with ASD; OCALI			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Providing agency will conduct age-appropriate assessment utilizing both formal and informal assessment techniques. The guardian/individual will work with the agency to identify and prioritize the most critical essential life skills needed. The providing agency will implement training and provide opportunities to practice identified skills.	X Direct __Technical Assist __Consultation	X Individual w/ASD __Family __School District __Other / List: Team members	X Home __School __Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: Transition to Adulthood-Guidelines for Individuals with ASD; OCALI			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
Providing agency will conduct age-appropriate assessment utilizing both formal and informal assessment techniques. The guardian/individual will work with the agency to identify and prioritize the most critical essential life skills needed. The providing agency will implement training and provide opportunities to practice identified skills. Providing agency will promote and plan generalization of essential life skills including providing opportunities to demonstrate use of the identified skills in multiple settings.	X Direct __Technical Assist __Consultation	X Individual w/ASD __Family __School District __Other / List: Team members	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: Transition to Adulthood-Guidelines for Individuals with ASD; OCALI			

Attention

Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The student will participate in activities to increase awareness of items around him/her and also to increase in attending to others around him/her.	X Direct __Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: ddc.ohio.gov/pub/ASDGuide.htm			
Standard	**Check all that Apply**		
	Service:	*Recipient*:	*Location*:
The student will participate in activities to increase • Awareness of items around him/her • Attending to others around him/her • Joint attention	X Direct __Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community

Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: ddc.ohio.gov/pub/ASDGuide.htm			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location*:
The student will participate in activities to increase • Awareness of items around him/her • Attending to others around him/her • Joint attention • Attention shifting (flexibility in attending) event-to-event, object to object, object to person, and person to object	X Direct __Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: ddc.ohio.gov/pub/ASDGuide.htm			

Imitation

Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
The student will participate in skills that focus on manipulating objects through imitation	X Direct __Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: ddc.ohio.gov/pub/ASDGuide.htm			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location*:
The student will participate in skills that focus on • manipulating objects through imitations by a teacher • engaging in imitations led by a peer • motor behavior, with and without objects • vocal behavior, if appropriate for the student	X Direct __Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: ddc.ohio.gov/pub/ASDGuide.htm			
Standard	**Check all that Apply**		
	Service:	*Recipient:*	*Location:*
The student will participate in skills that focus on • manipulating objects through imitations by a teacher • engaging in imitations led by a peer • motor behavior, with and without objects • vocal behavior, if appropriate for the student • reciprocating in interactions	X Direct __Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School X Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: ddc.ohio.gov/pub/ASDGuide.htm			

Cognition

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
Purpose – Enhance conceptual, problem-solving, and academic performance and executive function (flexible, strategic plan of action to solve a problem or attain a future goal) Target Areas: • Utilization of multiple modes of learning (e.g., sorting, matching, classifying, problem-solving, categorizing, comparisons, ordinals, sequencing, temporal understanding, spatial understanding) • Understanding cause/effect • Abstract thinking • Humor • Applying and generalizing skills and information	X Direct __Technical Assist ___Consultation	X Individual w/ASD __Family ___School District ___Other / List:	X Home X School __Community
Check One: X Minimum Standard ___Progressive Standard ___Best Practice Citation(s) for Evidence-base: ddc.ohio.gov/pub/ASDGuide.htm			

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
In progress	X Direct __Technical Assist ___Consultation	X Individual w/ASD __Family ___School District ___Other / List:	X Home X School __Community
Check One: ___Minimum Standard X Progressive Standard ___Best Practice Citation(s) for Evidence-base: ddc.ohio.gov/pub/ASDGuide.htm			

Standard	Check all that Apply		
	Service:	*Recipient:*	*Location:*
In progress	X Direct __Technical Assist ___Consultation	X Individual w/ASD ___Family ___School District ___Other / List:	X Home X School __Community
Check One: ___Minimum Standard ___Progressive Standard X Best Practice Citation(s) for Evidence-base: ddc.ohio.gov/pub/ASDGuide.htm			

Part 3: Transition Services Workgroup

Research has shown that a large proportion of special education students often do not receive post-school support and services (NLTS-2). As these individuals "aged out" (at age 21 students were no longer eligible for a free and appropriate education including services and support) of the educational system, families and individuals with disabilities found themselves with few options and with little guidance. While there are services, families and individuals are forced to discover services and supports on their own. They are confronted with services and resources, each with individual, services, funding sources, forms, and eligibility requirements. In order to assist families and individuals with disabilities in obtaining successful transitions, a collaborative system and or process between school systems and post-secondary life must be created.

The Transition Work Group Committee has extensively researched the transitional process by reviewing literature, research and examining what other states are doing in terms of transition. There are five common elements found in the research, literature, and in programs that assists individuals with disabilities in having successful outcomes in terms of transitioning into life after high school (Kohler, 1996). The five common elements are

- Student Focused Planning
- Student Development
- Family Involvement
- Interagency Collaboration
- Program Structure

Educational Services

Transition planning can provide a framework to assist individuals with disabilities and their families in organizing and ensuring the support necessary to work through the transition process and provide guidance about the resources and/ or support that they will need to be successful in reaching their goals. The federal government mandates that the transitional planning and educational goals addressing transitional needs begin by the age of 16.

In 2011, the Alabama State Department of Education created the Alabama Transitional Standards. The Standards address four areas: 1) Academics/ Trainings, 2) Occupations/ Careers, 3) Personal/ Social, and 3) Daily Living. The Standards were developed to assists schools and communities work together in order that individuals have successful participation in life after high school. Implementation of the Standards can be used in Individualized Education Program (IEP) development or in the implementations as defined in the Standards

Vocational Services

In terms of receiving services from the Alabama Department of Rehabilitative Services (ADRS), it must be understood that services are not mandated by the federal government. This means that a person who applies for ADRS services has to be demined eligible for services. Rehabilitation counselors and/ or job coaches are part of the transitional process; however, there is no systematic referral procedure throughout the state. The logistics of the referral process are determined at the local level (i.e. individual school systems and counselors).

Post-Secondary Education

Individual Schools have specific needs in order to gain entrance. High School Case Managers, School Counselors, Families, and the Individuals' with disabilities must begin discussing college as early as 10th grade in order to meet the enrollment criterion.

Economic Support for Transition

In terms of economic support for individuals with disabilities, people typically have two choices. Either they are supported by private or public (e.g. Medicaid Waiver) means. The Department of Mental Health/ Mental Illness (DMHMI) has specific guidelines in terms of when a person can apply for the Waiver. This process begins on an individual's 18th birthday. Because of DMHMI's limited funds and the growing need for support, the entire process can take 3-5 years. Therefore, it is crucial for individuals with disabilities to begin the process on or near their 18th birthday.

Recommendations for the Future

Because all of the key agencies that are involved in the Transition process (i.e., Alabama Department of Education, ADRS, and DMHMI) have specific guidelines and/or standards, the committee is recommending that the creation of a time-line be introduced to all agencies; thereby not changing their individual standards but streamlining the process in order to create greater collaboration between all agencies.

Sample of Briefs Reviewed (National Center on Secondary Education and Transition):

1. Person-Centered Planning: A Tool for Transition (February 2004) NCSET Parent Brief – This brief provides a concise description of person-centered planning and an explanation of the benefits of this process. The brief also provides action steps for implementing person-centered planning, references within the Individuals with Disabilities Education Act that support the process, and a list of additional resources.
2. Self-Determination: Supporting Successful Transition (April 2003) NCSET Research to Practice Brief • Volume 2 , Issue 1 – This brief outlines research on self-determination suggesting that youth with disabilities who actively direct their own lives are more likely to successfully transition into adult life. In addition, the brief addresses development of self-determination skills and student-led Individualized Education Program meetings. Also included are descriptions and contact information for several self-determination curricula and helpful Web links.
3. Quality Work-Based Learning and Postschool Employment Success (September 2003) NCSET Issue Brief • Volume 2, Issue 2 – This brief highlights the benefits of work-based learning for youth with disabilities and outlines the elements of quality work-based learning. In addition, the brief provides selected evidence-based models of work-based learning and information on further resources.
4. Youth Employment (December 2003) NCSET NLTS2 Data Brief • Volume 2 , Issue 2 – This NLTS2 Data Brief provides a detailed description of employment trends for youth with disabilities documented within the National Study-2. The NLTS2 has recently gathered data on work-study employment and regular paid employment of youth with disabilities, with a focus on hourly pay, disability categories, demographic differences in employment, and individual differences such as gender, age, race/ethnicity, and household income in relation to employment. This brief provides a concise and organized presentation of the results, including descriptive graphs.
5. National Standards & Quality Indicators: Transition Toolkit for Systems Improvement – This document, from the National Alliance for Secondary Education and Transition (NASET), contains information and tools to provide a common and shared framework to help school systems and communities identify what youth need in order to achieve successful participation in postsecondary education and training, civic engagement, meaningful employment, and adult life.
6. IDEA 1997: Implications for Secondary Education and Transition Services NCSET Policy Update • Volume 1 , Issue 1 – This revision of the National Transition Policy Update from January 2000 presents the regulatory language and potential implications in eleven areas of the 1997 Amendments to the IDEA pertaining to the transition of students from school to adult life. This brief is a great resource for parents, teachers, administrators, and community service providers.

Suggested Time Lines

Standard Diploma and pursuing Post-Secondary Education

Age Sixteen

1. Assessments for Transitional Needs Prior to Setting Educational Transition Goals
2. Transitional Goals during IEP
3. Career Exploration (can begin at earlier ages as individuals go into the community)
4. Investigate and Plan to meet the criterion for desired school

Age Eighteen

Apply for Medicaid Waiver if eligible (initial contact to local mental health board should occur at approximately age 17)

AOD or Certificate of Attendance and pursuing Employment

Age Sixteen

1. Assessments for Transitional Needs Prior to Setting Educational Transition Goals,
2. Transitional Goals during IEP
3. Vocational/ Career Exploration (can begin at earlier ages as individuals go into the community)
4. Vocational Experiences and Documentation of Experiences (i.e. create a portfolio of work experiences in order for ADRS and other adult agencies to have examples of work experiences)

Age Eighteen

Apply for Medicaid Waiver if eligible (initial contact to local mental health board should occur at approximately age 17)

Collaboration

Collaboration between School System and ADRS (age/ grade) will be dependent on State Standards. Most adult agencies will not begin working with individuals with significant disabilities prior to their aging out of school (i.e. at age 21). Therefore, for some individuals a non-traditional method of providing educational services should be considered. A good example of this would be for students to receive employment/vocational training and/ or experiences in the community and a focus on daily living and functional skills. This type of education can be obtained for individuals who have received a Certificate of Attendance after the typical four years of secondary education and who are still under the age of 21.

Suggested Trainings for Secondary Educators

- Basic ASD training
- How to provide vocational training, exploration and how to document the experiences
- The need for collaboration to Adult agencies and the processes

Suggested Training for Adult Agencies

- Basic ASD training
- Accommodations and Modifications for the job site

Suggested Assistance to Post-Secondary School

- Provide Basic information about ASD
- Provide self-determination skills to individuals with AS

Part 4: Adult Services Workgroup

Relatively little information exists regarding adults and transition into adulthood. Three surveys were conducted that polled adults with ASD and family members of adults on the spectrum. When asked what was needed in the areas of life skills, social skills, and vocational skills, it was found that the desires were no different than that of the typical population. Adults want to work, have friends, live on their own, and don't want people telling them what to do.

Recommendations will be developed rather than standards since there is so little literature on the subject of adults on the spectrum. The standards that do exist are difficult to generalize among agencies, but some workable standard recommendations were identified.

Findings from Standard Review:

Values and Principles (adapted from the Alabama Council for Developmental Disabilities' Principles Statement)

1. People with ASD are lifelong learners and are capable of growing in independence, productivity, integration and inclusion within the community.
2. Individuals with ASD must have access to opportunities and the necessary supports to be included in community life; to develop and maintain interdependent relationships; to live in homes and communities; and to make contributions to their families, community, state, and nation.
3. With education and support, communities can be responsive to the needs of individuals with ASD and their families and are enriched by the full and active participation and contributions of the individual with ASD and their families.
4. Individuals with ASD and their families are the primary decision makers regarding the services and supports received.
5. Services, supports, and other assistance are provided in a manner that demonstrates respect for individual dignity, personal preference, and cultural differences.

Socialization Standards

- Programs and services recognize the importance of the individual's social relatedness and the need for social interactions in a variety of settings.
- Programs and services use specialized social skills strategies to assess, teach, and promote social skills and to foster the individual's social interests and interactions.
- Programs and services use specialized social skills strategies to assess, teach, and promote social skills in a variety of settings including natural environments, general education and community settings.

NARPPA Housing Standards

- Funding and services
- Funding for adult services in individuals and commensurate with the needs of the person. Services providers have specialized training and recognize that adult with autism are lifelong learners.
- Individuals Right and Responsibilities
- Adults with autism are offered choices that are meaningful and clear. Services providers teach and support creative, individualized choice making.

Individualized Service Planning

- Services providers facilitate a variety of opportunities and experienced for the adult with autism, enabling the person to make informed choices in the development of their services/support plan.

Community Access and Support

- Services providers teach and support community living skills in the areas of mobility and safety.
- Services providers accompany the adult with autism, as needed, to assure an opportunity for personal development.

Residential Options

- Residential options are tailored to the individual's choices and communication, behavioral, socialization, and sensory needs of the person. The adult with autism may require a 1:1 ration to promote safety and an opportunity for personal development.

Employment

- Services providers will understand the unique learning style of the adult with autism and will develop individualizes vocational plan.
- The service provider will work with community employers to develop job accommodations for adult with autism.

Case Management Standards of Practice

1. The Case Manager is a supportive, qualified and motivated professional.
2. The Case Manager identifies and assesses client: strengths; interests; dreams; communication preferences; accomplishments and target behaviors.
3. The Case Manager assesses existing and available supports necessary to accomplish client goals and dreams.
4. When necessary, the Case Manager creates and develops new resources, supports, collaborations and opportunities to accomplish client dreams.
5. The Case Manager considers family and client needs and resources in maximizing resources for each client.
6. The Case Manager reviews all relevant information related to client behavior and collaborates to identify optimal functional environments.
7. The Case Manager collaborates to develop and implement family client life style plans.
8. Case Management is results oriented.
9. Case Management is available for all individuals with ASD.
10. Individuals with ASD are connected to natural support networks.
11. Case Managers protect individuals with ASD from abuse and neglect.
12. Individuals with ASD are offered life choices consonant with their likes, dislikes, health, safety and personal needs.

Part 5: Professional Preparation and Training Workgroup

Current Status: The move toward inclusion has brought more students with ASD into the general education classroom. Frequently, teacher prep programs do not provide teachers with the knowledge necessary to teach these students in their classroom. Teachers training in special education are generally trained in the methodologies but may not have the administ rative and financial support to prepare their students for success

Action Items: *Teachers (and all school personnel) should receive pre-service and in-service training regarding ASD and specific intervention techniques.* There should be a system to *monitor and track this training,* and the training should include the rationale why particular methods are of use to the students.

Teachers should have ongoing *access to model sites and individuals who have worked successfully with students on the spectrum for technical assistance and training.*

Progress: This work group made it their first priority to examine current professional preparation programs for teachers (general and special education) and rehabilitation counselors serving individuals with ASD. Results as of this report are outlined in paragraph 3. The group has developed directories of existing teacher education programs offering behavior management or ASD specific classes and points of contact as well as psychology programs that are autism specific within the state of Alabama. The work group then moved to developing a similar directory for two-year colleges offering courses in childcare, early childhood, elementary, or special education.

Existing Programs (State of the State)

General education- teacher preparation programs, at a minimum, include one undergraduate survey course on exceptionality. ASD and Behavior Management are generally included as part of the curriculum of the survey course and ASD/behavior management is covered for one or two class periods each (approximately 2.5 hours of class time). Most courses do not have a field component in exceptionality.

Undergraduate Special Education- special education teacher preparation programs are collaborative degrees. Graduates of these programs are generalists in special education and coverage of ASD and more severe disabilities depends on who is providing the classroom or practicum training. See Figure 1.

Special Education Master's Programs- currently there are several masters' programs that focus on low incidence, developmental disabilities and/or autism. These programs are offered at the University of Alabama and Auburn University. An Ed.S. degree in collaborative special education with a concentration in autism has recently been approved and will be offered at the University of Alabama in Birmingham. See Figure 1.

Figure 1

Alabama College and University Certificate Programs in Autism Spectrum Disorders

The following classes have been determined to include Developmental Disabilities/Autism (DD/ASD) Skill Competencies. These classes meet professional development requirements for teachers and paraprofessionals who teach students with ASD. They are also included as part of bachelor/master's designated degree programs.

College/ University	Certification Program	Instruction Delivery	Autism Courses Offered	Contact Information
Alabama A & M University	Students may take all coursework offered to complete a collaborative SPED degree (Bachelors/Masters)	In-Class Instruction	SPE326 Behavior Management K-6 SPE431 Behavior Management 6-12 SPE530 Advanced Behavior Mgmt.	Dr. Shirley King 256-372-5522 Shirley.king@aamu.edu
Alabama State	Students may take all coursework offered to	In-Class		Dr. Shirley Barnes 334-538-9343

University	complete a collaborative SPED degree (Bachelors/Masters)	Instruction		lanierbarnes@gmail.com Dr. Joyce Johnson 334-229-6983 jjohnson@alasu.edu
Athens State University	Students may take all coursework offered to complete a collaborative SPED degree (Bachelors)	In-Class instruction Distance Education	SE495 Classroom mgmt.& Discipline	Dr. Kathy Buck 256-216-6610 kathy.buck@athens.edu
Auburn University	Students may take all coursework offered to complete a collaborative SPED degree (Bachelors/Masters) *Collaborative Master's degree with an autism focus	In-class Instruction *Distance Education	RSED 4010- Behavior Management RSED 7400- Curriculum and Teaching Autism *RSED 7230-Advanced Behavior Management RSED7410a-Program Implementation in specialization (secondary) RSED7410b-Program Implementation I Specialization RSED 5060/6060 Severe Disabilities RSED 5140/6140 Severe Curriculum	Dr. Margaret Flores 33-844-7676 mmf0010@auburn.edu
Auburn University-Montgomery	Students may take all coursework offered to complete a collaborative SPED degree or duel certification Elementary Ed. (Bachelors/Masters)	In-Class Instruction Distance Education	4600. Working with Parents of Exceptional and Autistic Children (3). 4050. Behavior Management of Children with exceptionalities (3). Pr., admission to professional education. 4600. Working with Parents of Exceptional and Autistic Children (3). 6600. Advanced Techniques for Working with Parents of Exceptional and Autistic Children (3). Pr., graduate standing.	Dr. Rhonda Morton 334-244-3287 rmorton@aum.edu
Birmingham Southern College	Students may take all coursework offered to complete a collaborative SPED degree with dual certification (Bachelors)			Dr. Clint Bruess 205-226-4811 cbruess@bsc.edu
Jacksonville State University	Students may take all coursework offered to complete a collaborative SPED degree with dual certification (Bachelors/Masters)	In-Class Instruction & Distance Education	SPE385-Curriculum and Behavior Management SPE533-Applying Behavior analysis to Special Populations	Dr. Lawrence Beard 256-782-5078 lbeard@jsu.edu Dr. Robyn Taylor 256-782-5351 rwtaylor@jsu.edu

	(Ed.S. degree offered)			
Samford University	Students may take all coursework offered to complete a collaborative SPED degree with dual certification (Bachelors)	In-Class Instruction	EDUC418 Collaboration in educational practices EDUC586 Managing Challenging Behavior	Dr. Mandy Hilsmier 205-726-4047 acstrong@samford.edu
Troy University	Students may take all coursework offered to complete a collaborative SPED degree with dual certification (Bachelors/Masters)	In-Class Instruction & Distance Education	EDU4400 Classroom Mgmt. EDU6600 SED4400 Classroom Mgmt.	Dr. Rebecca Ingram 334-808-6218 rvingram@troy.edu
University of Alabama	Students may take all coursework offered to complete a collaborative SPED degree with dual certification (Bachelors/Masters) *Severe & Multiple Disabilities Program	In-Class Instruction & *Distance Education	SPE435: Behavior Management *SPE502: Advanced Behavior Management *Elective in Autism (I, II, III) *SPE 593: Introduction to Severe SPE 594: Methods Severe	Dr. Sandra Nichols 205-348-6226 scnichols@bamaed.ua.edu
University of Alabama-Birmingham	Students may take all coursework offered to complete a collaborative SPED degree with dual certification (Bachelors/Masters) *Ed.S in Collaborative with ASD concentration	In-Class Instruction & *Distance Education	ECT676: Survey of Pervasive Developmental Disorders ECT454: Positive Behavior Supports *ECT700: ASD: Introduction *ECT701 ASD: Application of assessment information *ECT702: ASD: Methods for moderate to severe functioning *ETC 703: ASD: Methods for higher functioning learners and Asperger's *ECT704: ASD: Collaboration and consultation *ECT705: ASD: Seminars in advanced methods and strategies	Dr. Karen Dahle 205-613-3913 kbdahle@uab.edu
University of Montevallo	Students may take all coursework offered to complete a collaborative SPED degree (Bachelors)	In-Class Instruction	ED416: Behavior Management in the classroom	Dr. Holly Cost 205-665-6367 costhc@montevallo.edu
University of Alabama Huntsville	Students may take all coursework offered to complete a collaborative SPED degree with dual certification	In-Class Instruction	ED351: Behavioral Analysis and Intervention	Dr. Mary Piersma 256-824-2325 mary.piersmam.uah.edu
University of North Alabama	Students may take all coursework offered to complete	In-Class Instruction	EEX635: Applied Behavior Management	Dr. Pamela Fernstrom Chaney 256-765-4264

	a collaborative SPED degree (Masters)			pjfernstrom@una.edu
University of South Alabama	Students may take all coursework offered to complete a collaborative SPED degree with dual certification (Bachelors/Masters)	In-Class Instruction & *Distance Education	EDU362: Behavior Management *SPE512: Ecological Curr. & Mthds. *SPE515: Data Based Behavior Mgmt. *SPE591: Multi-Categorical Practicum SPE609: Advanced Study of Exceptional Children SPE642: Clinical Teaching I SPE643: Clinical Teaching II	Dr. Dave Ellis 251-380-2769 dellis@usouthal.edu
University of West Alabama	Students may take all coursework offered to complete a collaborative SPED degree with dual certification (Bachelors/Masters)	In-Class Instruction	EE303/SE303: Behavior Management	Dr. Adele Moriarty 205-652-3753 amoriarty@uwa.edu

Psychology Programs- several universities offer courses focused on behavior management, autism and other developmental disabilities. Auburn University and Jacksonville State University offer courses leading to master's level board certification as a behavior analyst. The University of South Alabama offers a preapproved coursework sequence for the associate behavior analyst (bachelor's level). See Figure 2.

Figure 2

Psychology Curricula - Alabama Colleges and Universities
Courses in Autism Spectrum Disorders and Behavior Analysis/Management

College/ University	Description	Type of Instruction	Courses Offered	Contact Information
Alabama A & M*	3 Undergraduate electives	On-campus lecture	PSY 325 Behavior Disorders in Children PSY 340 Principles of Learning PSY 350 Conditioning of Behavior	N/A
Alabama State University	No information available	N/A	N/A	N/A
Athens State University*	1 Undergraduate elective	On-campus lecture	Psychology of Learning	N/A
Auburn University	Undergraduate courses and practica in autism and applied behavior analysis M.S. program in applied behavior analysis and developmental disabilities Preapproved coursework sequence and practicum by	On campus face-to-face lecture courses and practica	PSYC 3500 Applied Behavior Analysis (4 cr, lecture with lab) PSY 3940 Experiential Learning (3 cr, practicum) PSYC 4110 Intro to Dev Dis (3 cr, lecture) PSYC 4910 Human Service Practicum (3 cr, practicum) PSYC 6960 Seminar in Autism And Developmental Disabilities (3 cr, lecture) PSYC 7910 Practicum in Applied Psychology (I and II) (6 cr, 6 cr, practicum) PSYC 8560 Human Operant Behavior (3 cr, lecture) PSYC 8550 Applied Behavior Analysis I and II (3 cr, 3 cr, lecture) PSYC 7260 Ethical and Professional Issues in	Jennifer Gillis jengillis@auburn.edu 334-844-6477 (Undergraduate) Linda LeBlanc: leblanc@auburn.edu 334-844-6627 (Graduate)

	BACB		Behavior Analysis	
Auburn University – Montgomery	Undergraduate courses in applied behavior analysis	On campus face to face instruction	PSY 3123. Behavior Analysis (4 cr). PSY 4623. Behavior Modification (4 cr).	Dr. Clarissa Arms-Chavez 334-244-3595 cchavez@aum.edu
Jacksonville State University	Undergraduate courses in applied behavior analysis M.S in Psychology BACB preapproved course sequence (511, 521, 528, 529, 530)	On campus face to face instruction	PSY 220 Principles of Behavior Analysis (3 cr) PSY 221 Behavior Analysis Lab (1 cr) PSY 363 Behavior Modification (3 cr) PSY 490/491 Applied Behavior Analysis practicum (3 cr) PSY 504 Graduate Behavior Analysis Lab (1 cr) PSY 511 Conceptual Foundations of Behavior Analysis (3 cr). PSY 521 Functional Assessment (3 cr). PSY 528 Applied Behavior Analysis I (3 cr). PSY 529 Applied Behavior Analysis II (3 cr). PSY 530 Single-Subject Research Methods (3). PSY 540 Analysis of Child Development (3 cr). PSY 565 Experimental Analysis of Behavior (3 cr). PSY 580/581 ABA Practicum (3 cr)	Paige McKerchar, PhD, BCBA-D 256-782-5808 pmckerchar@jsu.edu
Troy University-Troy Campus Only	Undergraduate courses in applied behavior analysis and autism	On-campus face to face lecture courses	PSY 4459 Applied Behavior Analysis (3) PSY 3322 Abnormal Child Psychology (3)	Frank Hammonds, PhD 377 Hawkins Hall hammonds@troy.edu 334-670-3325
University of Alabama Birmingham	Undergraduate courses in autism, other developmental disabilities, behavior modification Ph.D. in: 1) Medical Clinical 2) Lifespan Developmental	On-campus face to face lecture courses	PY 320- The Cognitive Neuroscience of Autism (3 cr. Lecture) PY 354 – Autism: Brain and Cognition (3 cr., lecture) PY 397 – Practicum: Applied Behavior Analysis – Autism (3 cr. Practicum) PY 415 – Mental Retard/Dev Disabilities – (3 cr. Lecture) PY 418 – Psychotherapy/Behavior Change – (3 cr. Lecture) PY 783. Developmental Disabilities (3 cr. Seminar)	Fred Biasini, Ph.D. fbiasini@uab.edu Rajesh Kana, Ph.D. rkana@uab.edu
University of Alabama Huntsville	No opportunities identified	N/A	N/A	N/A
University of Alabama Tuscaloosa* Primary faculty departed – unclear what opportunities will be impacted	Undergraduate courses in autism Ph.D. in Clinical Psychology	On campus face to face courses	PY 358 Abnormal Psychology. 3 cr. PY 491-10 Autism Spectrum Disorders: Diagnosis and Treatment Across the Lifespan UA Autism Spectrum Disorders Research Clinic – Practicum in outpatient diagnosis and treatment	Michelle DeRamus, mkderamus@as.ua.edu 205-348-3140
University of Montevallo	No opportunities identified	N/A	N/A	N/A
University of	No opportunities	N/A	N/A	N/A

North Alabama	identified			
University of South Alabama	B.A. in Psychology Preapproved coursework sequence for BCaBA – bachelor's level		PSY 395 Psychology Practicum 3 cr practicum PSY 417 Applied Behavior Analysis I: Introduction 3 cr lecture PSY 418 Applied Behavior Analysis II: Methods 3 cr lecture PSY 419 Applied Behavior Analysis III: Advanced Applications 3 cr. lecture	Lisa Turner laturner@usouthal.edu Kim Zlomke zlomke@usouthal.edu
University of West Alabama	No opportunities identified	N/A	N/A	N/A

Rehabilitation counseling programs- these programs incorporated autism, as a general rule, into the curriculum to the same degree as other disabilities. See Figure 3.

Figure 3

Alabama College and University Certificate Programs in Rehabilitation Counseling

The following universities offer credentialing in rehabilitation counseling. They include bachelor & master designated degree programs.

College/ University	Certification Program	Instruction Delivery	Autism Courses Offered	Contact Information
Alabama A & M University	Students may take all coursework offered to qualify for credentialing in rehabilitation counseling	In-class instruction	No specific ASD course offering	Dr. Joan Fobbs-Wilson 256-372-8623 joan.wilson@aamu.edu
Alabama State University	Students may take all coursework offered to qualify for credentialing in rehabilitation counseling	In-class Instruction Distance Education	No specific ASD course offering	Dr. Dothel Edwards 334-229-8858 dedwards@alasu.edu
Auburn University	Students may take all coursework offered to qualify for credentialing in rehabilitation counseling	In-class Instruction Distance Education	Yes	Dr. Rebecca Curtis 334-844-2091 curtirs@auburn.edu Dr. E. Davis Martin 334-844-7676 martiev@auburn.edu
Troy University	Students may take all coursework offered to qualify for credentialing in rehabilitation counseling	In-Class Instruction Distance Education	No specific ASD course offering	Dr. Mary Anne Templeton 334-808-6218 mtempleton@troy.edu Dr. Suzanne Tew Washburn 706-594-4733 stew-washburn@troy.edu Dr. Emma Peden 334-983-6556 epeden@troy.edu Dr. Cozetta Shannon 334-241-9594 edshannon@troy.edu
University of Alabama	Students may take all coursework offered	Distance Education	No specific courses	Dr. Michael Becerra mbecerra@bamaed.ua.edu

	to qualify for credentialing in rehabilitation counseling			205 348.1346 Dr. Jamie Satcher 205-348-1178 jsatcher@bamaed.ua.edu John Adam Page Page003@ccs.ua.edu 205.348.0089 1-800.467.0227 Codie Davis aoinfo@ccs.ua.edu
University of Alabama-Birmingham	Students may take all coursework offered to qualify for credentialing in rehabilitation counseling	In-Class Instruction Distance Education		Dr. Michael Brooks 205-996-7908 drmike@uab.edu Dr. Larry Tyson 205-975-uab.edu ltyson@uab.edu Dr. Solange Ribeiro 205-975-9392 smfribeiro@aol.com *The contact information for UAB cannot be confirmed. This is referencing a PhD program effective in fall combining two programs.*

Community College programs- twenty-three of twenty-five community colleges were identified as having curriculum in special education, childcare, ASD and or/behavior analysis/management. Some curricula were designated as part of an associate in arts degree and some were listed as core requirements to transfer to a four-year institution. See Figure 4.

Figure 4
Alabama Two-Year Colleges
Courses in Education, Child Care, ASD and/or Behavior Analysis/Management

College/ University	Description	Type of Instruction	Courses Offered	Contact Information
Alabama Southern	Early Childhood Elementary Ed Secondary Ed Special Ed (AA)	Classroom, Web-enhanced classroom, Web courses online	See Catalog: http://www.ascc.edu/Default.asp?PN=DocumentUploads&L=2&DivisionID=2365&DepartmentID=2960&LMID=118669&ToggleSideNav=ShowAll *utilizes STARS Program	Jana Horton Registrar 251-575-8252
Bevill State	Early Childhood Elementary Ed. Secondary Ed. Child Development (AA) Psychology (AS)	Classroom, Online	ECE and Elementary: http://www.bscc.edu/programs/catalog_academics.pdf#page=4 Secondary Education: http://www.bscc.edu/programs/catalog_academics.pdf#page=7 Child Development:	Toll Free Main Line: 1-800-643-3271

			http://www.bscc.edu/programs/catalog_careertech.pdf#page=7 Psychology: http://www.bscc.edu/programs/catalog_academics.pdf#page=7 *utilizes STARS Program	
Bishop State	Early Childhood Education (AA) Psychology (AS)	Classroom	ECE See Brochure: http://www.bscc.cc.al.us/PDFs/brochures/EarlyChildhoodEducationBroch.pdf *Psychology: http://www.bishop.edu/psy/index.html *utilizes STARS program	ECE: Jessie Eleby 251-405-7251 eleby@bishop.edu Psychology: Malvereen Harris 251-405-7138 mharris@bishop.edu
Calhoun Community College	Child Development Program Assoc of Science, or Assoc. of Applied Science, Or CDA Credentials/Cert.	Classroom, Online, Hybrid classes	Child Development: http://www.calhoun.edu/Social_Science_Div/ChildDevelopment/courses.html ** **page contains links for each degree program	Judy Johnson 256-306-2751
Central Alabama Community College	Core requirements for transfer to 4-year institution, Child Development Certificate	Classroom, Online, Hybrid classes	No Specific Areas identified for core requirements * Child Care Certificate: http://www.cacc.edu/clientuploads/catalog/2010_Catalog.pdf (Page 115) *utilizes STARS program	Sherry Ingram (main switchboard) 256-215-4240 singram@cacc.edu
Chattahoochee Valley Community College	Core requirements for transfer to 4-year institution, Child Care and Development Certificate, Child Care and Development Administrator Cert., Child Care Paraprofessional Cert.	Classroom	No Specific Areas Identified for core requirements* Child Care and Development: http://www.cv.edu/component/option,com_wrapper/Itemid,132/ (pages 133-134) *utilizes STARS program	Admissions: 334-291-4929 Child Care and Development: Sonia Hollett Health Sciences Coordinator 334-291-4925
J.F. Drake State Technical College	Associate of technology degree/certificate program for immediate workforce entry.	Classroom/ work site	No Specific Areas Identified	Toll Free: 1-888-413-7253
Enterprise State Community College	Core requirements for transfer to 4-year institution, Child Development Assoc. in Applied Science or	Classroom, Online	No Specific Areas Identified for core requirements* Child Development: http://www.escc.edu/divisions/soc_di	Admissions: 334-347-2623 ext 2234 Child Development: Cynthia Covington

	Certificate		v/courses.htm#ChildDEVELOPMENT *utilizes STARS program	ccovington@escc.edu
Faulkner State	Early childhood education and Elementary education (A.S) Training Certificate in Child Development	Classroom	Education: http://www.faulknerstate.edu/wp-content/uploads/2010/01/catalog.11.12.website-85.pdf Training Certification in Child Development: http://www.faulknerstate.edu/wp-content/uploads/2010/01/catalog.11.12.website-136.pdf *utilizes STARS program	Main Line Toll Free: 1-800-231-3752
Gadsden State	Child Development (A.A.S) Early Childhood Education (A.S) Elementary Education (A.S) Psychology (A.A) Human Services (A.A.S)	Classroom, eLearning	Child Development: http://www.gadsdenstate.edu/academics/history/pdf/childdevelopment.pdf Early Childhood/Elementary Ed: http://www.gadsdenstate.edu/academics/history/pdf/earlychildhood.pdf Psychology: http://www.gadsdenstate.edu/academics/history/pdf/psychology.pdf Human Services: http://www.gadsdenstate.edu/academics/history/pdf/humanservices.pdf *utilizes STARS programs	Regina Evans Department Clerk revans@gadsdenstate.edu 256-549-8330
Ingram State Technical College	No opportunities identified Education for Incarcerated Adults	Classroom	No Specific Areas Identified	Main Line: 334-285-5177
Jefferson Davis Community College	Core requirements for transfer to 4-year institution	Classroom, Online	No Specific Areas Identified for core requirements* *utilizes STARS program	Admissions: 251-809-1594
Jefferson State Community College	Core requirements for transfer to 4-year institution Child Development Certificate	Classroom, Distance Learning	No Specific Areas Identified for core requirements* Child Development Certificate: http://www.jeffstateonline.com/CHD/index.aspx *utilizes STARS program	Enrollment Services: 1-800-239-5900 x7704 Child Development: Kathi Wales kwales@jeffstateonline.com 205-856-6047
Lawson State Community College	Core requirements for transfer to 4-year institution Child Development/ Early Childhood Education (AAS)	Classroom	No specific areas identified for core requirements* Child Development/ECE: http://www.lawsonstate.edu/catalogs/LSCC%202007-2009--Electronic%20Student%20Catalog%20&	Main Line: 205-925-2515 Child Development/ECE: Sadie Harris

			%20Handbook.pdf (page 96 of handbook)	Dept. Chairperson 205-929-6387
Lurleen B. Wallace Community College	Core requirements for transfer to 4-year institution Education (Early childhood, Special Ed k-6; A.A) Child Development (A.A.S)	Classroom, Online, Hybrid classes, Telecourse, CD/DVD	Education: http://www.lbwcc.edu/academics/aa_and_as_degrees.aspx http://www.lbwcc.edu/Uploads/files/Downloads/Student%20Services/COLLEGE%20CATALOG%20.pdf (see page 57) Child Development: http://www.lbwcc.edu/Uploads/files/Downloads/Student%20Services/COLLEGE%20CATALOG%20.pdf (see pages 48-49 *utilizes STARS program	Main Line: 334-222-6591
Northeast Alabama Community College	Child Development (Certificate or A.A.S) Elementary/Early childhood Ed (A.S) Middle/High School Ed (A.S) Special Education (A.S)	Classroom, Online	Child Development: A.A.S: http://www.nacc.edu/assessment/program_requirements/AAS1112.pdf Certificate: http://www.nacc.edu/assessment/program_requirements/CER_STC1112.pdf Education (All): http://www.nacc.edu/assessment/program_requirements/AS1112_A.pdf (note area name at top of each form) *Utilizes STARS program	Child Development: Debra O'Neal onealdd@nacc.edu 256-228-6001*2295 Admissions: 256-228-6001*2222 or *2322
Northwest-Shoals Community College	Core requirements for transfer to 4-year institution Teacher Education (A.A) Child Development (A.S)	Classroom, Online	Teacher Education: http://nwscc.cc.al.us/Catalog1112/AS_PreElemEd.pdf Child Development: (A.A.S) http://nwscc.cc.al.us/Catalog1112/AS_PreHumanEnvironSci.pdf Certificate: http://nwscc.edu/Catalog1112/STCert_CHD.pdf	Main Line: 256-331-5200 Child Development: D. Durdunji 256-331-5450 durdunji@nwscc.edu
Reid State Technical College	Early Child Care Education (Assoc. in Applied Technology)	Classroom, Online	Early Child Care Education: http://www.rstc.edu/childcareinfo.html	Coretta Boykin 251-578-1313 cboykin@rstc.edu
Shelton State Community College	Core requirements for transfer to 4-year institution Child Development (A.A.)	Classroom, Online	No specific areas identified for core requirements* Child Development: http://www.sheltonstate.edu/Uploads/files/instruction/Catalog%20only%2009-10.pdf#page=109 *Utilizes STARS program	Admissions: admissions@sheltonstate.edu 205-391-2214 Child Development: Kevin Burns 205-391-3934 kburns@sheltonstate.edu

Snead State Community College	Core requirements for transfer to 4-year institution Child Development (Certificate or A.A.S)	Classroom, Online	No specific areas identified for core requirements* Child Development: http://www.snead.edu/Details.aspx?id=837 *Utilizes STARS program	Main line: 256-593-5120 Child Development: Karen Watts kwatts@snead.edu
Southern Union State Community College	Core requirements for transfer to 4-year institution Child Development (Certificate or A.A.S)	Classroom, Online	General Core Classes: http://www.suscc.edu/DivisionHomePage.aspx#Associate * Child Development: http://www.suscc.edu/Child_Development_HomePage.aspx *Utilizes STARS program	General Education: Dr. Mary Jean White 334-745-6437 ext 5402 mjwhite@suscc.edu Child Development: Cindy Calhoun 334-745-6437 ext 5330 ccalhoun@suscc.edu
H. Council Trenholm State Technical College	Early Care and Education (Certificate or AA)	Classroom	Early Care and Education: http://www.trenholmtech.cc.al.us/index.php?id=earlycare	Main Line: 1-866-753-4544
Wallace Community College	Core requirements for transfer to 4-year institution Elementary or Early Childhood Education (A.A. or A.S) Special Education (A.A. or A.S) Child Development (Certificate)	Classroom, Distance Education	General Core Classes: http://www.wallace.edu/programs/catalog.pdf#AA * Elementary or Early Childhood: http://www.wallace.edu/programs/catalog.pdf#AA (see page 66) Special Education: http://www.wallace.edu/programs/catalog.pdf#AA (see page 85) Child Development: http://www.wallace.edu/programs/catalog.pdf#AA (see page 96) *Utilizes STARS Program	Main Line: 1-800-543-2426
Wallace State Community College	Core requirements for transfer to 4-year institution Child Development (Certificate, A.S. or A.A.S)	Classroom, Online	General Core Classes: http://www.wallacestate.edu/programs/academic.html * Child Development: http://www.wallacestate.edu/fileadmin/user_upload/WallaceState/documents/CHD/CHD_Catalog_Info_01.pdf *Utilizes STARS Program	Main line: 256-352-8238 Child Development: Dee-Retha Preuitt 256-352-8383 dpreuitt@wallacestate.edu
Wallace Community College Selma	Core requirements for transfer to 4-year institution	Classroom, E-learning	No specific areas identified for core requirements* *Utilizes STARS Program	Academic Advising: 334-876-9295

*STARS Program: Statewide Transfer and Articulation Reporting System http://stars.troy.edu/.

Paraprofessional Training- currently paraprofessionals are required by No Child Left Behind of 2001 (section 1119) to have completed at least two years of study at an institution of higher learning, obtain an associates (or higher) degree, and demonstrate a rigorous standard of quality through a state or local academic assessment.

Existing Standards

Minimum Standards

- Alabama Quality Teaching Standards (http://alex.state.al.us/leadership/alqts_full.pdf)
- Council for Exceptional Children Teaching Standards (http://www.cec.sped.org/content/navigationmenu/professionaldevelopment/professionalstandards/well-prepared-final.pdf and http://www.cec.sped.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=1637&CAT=none)
- Interstate New Teacher Assessment and Support Consortium (INTASC) (http://www.ccsso.org/Documents/2011/InTASC_Model_Core_Teaching_Standards_2011.pdf)
- National Council for Accreditation of Teacher Education (NCATE) (http://www.ncate.org/linkclick.aspx?fileticket=nX43fwKc4Ak%3D&tabid=669)
- No Child Left Behind (NCLB) Standards for Teachers and Professionals (http://www2.ed.gov/policy/elsec/leg/esea02/pg2.html#sec1119, see Sec. 1119)

Best Practices/Model Standards

- Council for Exceptional Children Standards for Developmental Disabilities/Autism (http://www.cec.sped.org/Content/NavigationMenu/ProfessionalDevelopment/ProfessionalStandards/What_Every_Special_Educator_Should_Know_6th_Ed_revised_2009.pdf, see pages 113-121)
- Advanced Knowledge and Skill Set: Developmental Disabilities/Autism Specialist (http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CE0QFjAA&url=http%3A%2F%2Fwww.cec.sped.org%2FContent%2FNavigationMenu%2FProfessionalDevelopment%2FProfessionalStandards%2FDD%26A_Specialist.doc&ei=5KaNT6LmH-fl0QGBs5G1Dw&usg=AFQjCNEsDAFqEvsLGIA1zG4VWeJGQTPKzA)
- National Autism Center's National Standards Report (http://www.nationalautismcenter.org/pdf/NAC%20Standards%20Report.pdf)
- Behavior Analyst Certification Board Task List for ASD (http://www.bacb.com/Downloadfiles/AutismTaskList/708AutismTaskListF.pdf)
- ASD Competencies as Developed by Other States
- Commission on Accreditation of Rehabilitation Facilities (CARF) (www.carf.org)

Recommendations (to date) for Standards of Professional Service

Minimum Standards

Minimum Standards for special educators pursuing a Class B, A, or AA certification are geared toward the collaborative degree. There are several routes to pursuing this certification. Sixteen universities offer some form of collaborative degree at the Bachelor's level (Early Childhood or Collaborative Special Education – K-6, 6-12), and

ten at the Master's level. The standards for collaborative teachers are outlined in the Minimum Standards listed above.

Of concern to some members of this group is the "collapsing" of the collaborative programs into inclusive programs for Pre-K – 6. The University of West Alabama, Jacksonville State University, and the University of South Alabama are examples. The "collapsed" degree rolls Early Childhood, Special Education (K-12) and Elementary Education together. The teacher then graduates with a certification in all three areas are dual certification in elementary/special education. It is the opinion of several members of this work group that collapsing programs waters the curriculum even further and results in a lack of much needed content coverage. Others feel it is a positive trend. The group agrees, however, that training for pre-service teachers of students with autism require more specialized training than the collaborative degree gives them at the current time. While dual certification may help the inclusion teacher, which is a positive outcome, it has the potential to minimize the specialized knowledge required of teachers working with students with more severe DD/ASD.

For individuals in a dual certification program, it must be ensured that best practices/model standards (see Best Practices list above) are followed in the teacher certification program. As an alternative, it is suggested that a Developmental Disability/Autism certification (endorsement) be required for those teaching this unique population.

Best Practices/Model Standards

Best practices for all educators serving students with DD/ASD are those outlined by the Council for Exceptional Children (CEC) standards for teaching students with DD/ASD (2010). These should be the standard for special educators working with students with DD/ASD. This group recommends that pre-service teachers meet these CEC standards for DD/ASD and should have an undergraduate class in behavior management as well as practicum experience with students with Developmental Disabilities to include Autism. Courses in transition and the Alabama Alternate Assessment (AAA) are also recommended.

Best practices for preparing the pre-service teacher to serve students with DD/ASD include mentoring, observation, practicum and internship opportunities in model classrooms where highly qualified special education teachers already teach students with ASD. Unfortunately, since there is no requirement in the state of Alabama to ensure that teachers who serve this population understand the disorder, as well as the evidence-based practices required to teach them, many teachers may not have been trained in methods that work.

Teachers of students with ASD need to use evidence-based practices as outlined by the National Research Council (2001) and the National Autism Center's National Standards Project (2009), which were designed to benefit parents, caregivers, educators, and service providers since these individuals make the complicated decisions regarding the education and interventions used for our students with ASD.

Evidence shows these best practices include early and intense instruction specifically tailored to the individual student and include antecedent and behavior packages, joint attention intervention, modeling, naturalistic teaching strategies, peer training, schedules, self-management, and story-based interventions.

Programs using existing minimum standards are not likely to cover these best practices. Teachers also need to be aware of treatments that lack empirical evidence (such as facilitated communication, gluten and casein free diet, and sensory integration) (National Standards Project, 2009; CDC Standards for Advanced Knowledge, 2010; National Research Council, 2001).

Other best practices include collaboration among stakeholders (and among departments), strategies that promote successful transitions, facilitate maintenance and generalization of skills learned, and integration into various settings with levels of support that change to meet individual need. The use of proactive strategies and positive behavioral supports, specialized instruction to foster communication, maintaining a safe environment, social skills training, and promoting autonomy for individuals as well as involvement in the transition process are also very important.

Best practices for training teachers (in and out of college) include modeling the promotion of FAPE and LRE, setting high expectations for self, staff, and exceptional learners. Mentoring teacher candidates, newly certified teachers and colleagues, as well as providing structure, ongoing training and support to families, professionals and paraprofessionals, should be incorporated into programs with a focus on service to students with significant disabilities (National Standards Report, 2009; National Research Council, 2001).

Professional Development/In-Service Training

No requirement at the state level to list professional development opportunities for teachers. LEAs approve Continuing Education Units at that level. Autism specific training and conferences are not specifically listed at the state level.

Opportunities for Change and Vision of this Workgroup: Where We Need to Go and How We Get There…

Current Direction and Recommendations

With knowledge of existing programs, certifications, and current continuing education requirements, this workgroup makes the following recommendations:

- Include paraprofessionals in professional development recording in the STIPD. This will facilitate "professionalization" of this much-needed support position and provide a training record for individuals seeking to move toward teacher certification as well.
- Promote collaboration between teacher education programs and psychology programs regarding course-sequencing leading to state certification and national BCABA licensure. To see a sample recommendation for a potential program for Auburn University, see Figure 5.

Figure 5.1
Auburn University Department of Special Education, Rehabilitation and Counseling
Alternative 5th Year Master's – UG other than Education, >60 hours (current ASD emphasis)

Course		**Potential Areas of ABA Emphasis**
RSED 7400	Curric and Teaching for Students with ASD and ED	Special Topics in Applied Behavior Analysis
RSED 7410	Program Implementation Secondary	
RSED 7230	Advanced Behavior Management	Concepts and Principles of Applied Behavior Analysis
RSED 7420	Research in Specialization for Students with ASD and ED	Advanced Topics in Behavior Analysis
RSED 7430	Research into Practice for Students with ASD and ED	Behavior Assessment and Program Evaluation
RSED 7460	Positive Behavioral Supports	Behavior Change Procedures and Ethical Considerations
RSED 7410	Program Implementation for Students with ASD and ED	
RSED 7120	Adv Assessment	
RSED 7410	Program Implementation Secondary	
RSED 7910	Practicum – Collab	
RSED 7410	Program Implementation for Students with ASD and ED	
RSED 7220	Adv Teaching Methods	
RSED 7910	Practicum – Collab	

RSED 7910	Practicum – Collab	
EDMD 7210	Integ Techn into Curric	
RSED 6120	Curric Elementary Sp Ed	
RSED 6160	Collaboration	
RSED 6060	Severe Disabilities	
RSED 6070	Mild Disabilities	
RSED 7910	Practicum	
CTRD 6700	Developmental Reading	
RSED 6170	Transition School Community	
RSED 6180	Instructional Classroom Manag	
RSED 7910	Practicum	
RSED 7910	Practicum	
RSED 7410a	Program Implementation Secondary	
RSED 6140	Curric Severe Disabilities	
RSED 7430	Research into Practice	
RSED 9710	Practicum	
RSED 7920	Internship	

Figure 5.2
Auburn University Department of Special Education, Rehabilitation and Counseling
Master's Program 30 Hours Traditional Master's (current ASD emphasis)

Current Courses		**Potential Areas of ABA Emphasis**
RSED 7400	Curric and Training for Students with ASD and ED	Special Topics in Behavior Analysis
RSED 7410	Program Implementation Secondary	
RSED 7230	Advanced Behavior Management	Concepts and Principles of Applied Behavior Analysis
RSED 7420	Research in Specialization for Students with ASD and ED	Advanced Topics in Behavior Analysis
RSED 7430	Research into Practice for Students with ASD and ED	Behavior Assessment and Program Evaluation
RSED 7460	Positive Behavioral Supports	Behavior Change Procedures and Ethical Considerations
RSED 7410	Program Implementation for Students with ASD and ED	
RSED 7120	Adv Assessment	
RSED 7410	Program Implementation Secondary	
RSED 7910	Practicum – Collab	
RSED 7410	Program Implementation for Students with ASD and ED	
RSED 7220	Adv Teaching Methods	
RSED 7910	Practicum – Collab	
RSED 7910	Practicum – Collab	
EDMD 7210	Integ Techn into Curric	

- ALSDE include professional development opportunities that focus on ASD and developmental disabilities (e.g., the Autism and ALABA conferences) on the Autism Alabama link at the ALSDE website. This link should include guidelines for submitting opportunities to be posted for Continuing Education units.
- An Alabama autism professional development lattice for educators should be adopted for implementation in order to classify the qualifications of those providing services for individuals with DD/ASD. Professional development levels benefit both Local Education Agencies/school districts, as we as those working with students with DD/ASD. LEAs/school districts will know the background and experience of a potential employee and the employees will know how to progress in professional development and education. See Figure 6.

- An autism endorsement for those teachers (Level 6 or above on the lattice) or who:
    - Have 50% of students on their caseload or in their class who are eligible for services under IDEA for autism (required).
    - Who have at least one student on their caseload or in their class who is eligible for services under IDEA for autism (recommended).
    - Have completed fifteen semester hours that include ASD characteristics, assistive technology for students with disabilities, behavior management, environmental arrangements, evidence-based practices for students with ASD, positive behavior supports, assessment and diagnosis, and/or field based experience (practicum). Up to six semester hours can be based on two years of classroom experience with students with ASD. In addition, hours may be from different universities, in class or on-line, if they satisfy different curriculum requirements, are from collaborating programs, and the student has a home university for transcript purposes. The endorsement is to be issued by ALSDE, not the individual universities. We also recommend summer class offerings to accommodate teacher availability. See Figure 5.

Figure 6
Alabama Autism Professionals Development Lattice for Educators

	Most Likely to Use Training	**Training and Education Resources**	***Considerations**
Level 1 Orientation	• Administrators • GENED Teachers • Paraprofessionals • Support Staff • Bus Drivers, cafeteria, and office staff	• Yearly before first day of school • Local SWPBS staff training • 1-2 hour state orientation for DD/ASD (can be webcast)	• DSM-V Severity of ASD • Level 1 Support • Requiring Support
Level 2 Basic Support Strategies	• Administrators • GENED Teachers • Art, music, PE teachers • Paraprofessionals • Support Staff	• Yearly (within sixty days prior to start of school) • Autism specific strategies for inclusion and behavior management • 1-2 hour state training (can be webcast)	• DSM-V Severity of ASD • Level 1 Support • Requiring Support
Level 3 Intermediate Support Strategies	• Administrators • GENED Teachers • Specific course teachers (e.g., music, art, PE) • Paraprofessionals • Support Staff	• 3-14 hours CEU in DD/ASD related material (behavior analysis, behavior management) • 3-14 semester hours coursework in DD/ASD • PD modules ALSDE website • Alabama CC or 4 year college system course	• DSM-V Severity of ASD • Level 2 Support • Requiring Substantial Support
Level 4 Educational Interventions for DD/ASD to support classroom teachers	• Paraprofessional with Specialization	• No Child Left Behind (2001) • Alabama State Department of Education • 15 hours CEU in DD/ASD related material l(behavior analysis, behavior management) • 15 semester hours coursework in DD/ASD or behavior management	• DSM-V Severity of ASD • Level 3 Support • Requiring Very Substantial Support • Axis III medical or neurological problems that may be relevant to the individual's current or past psychiatric problems

Level 5 Certified Special Education Teacher	• Certified Collaborative Special Education Teacher • Certified early Childhood Special Education Teacher	• Bachelor's degree in Special Education • Passed praxis/general knowledge exam • Certified in field	• DSM-V Severity of ASD • All Levels • All Axes of DSM-V
Level 6 Special Education Teacher with ASD/DD Specialization	• Practicing teacher with Level 5 degree and 15 hours ASD/DD specific (college credit or approved experience)	• Autism/DD Endorsement • Meeting state requirements for 15 graduate hours specific to DD/ASD	• DSM-V Severity of ASD • All Levels • All Axes of DSM-V
Level 7 Master Teacher with DD/ASD Specialization	• Practicing teacher with Master's degree in Special Education	• No Child Left Behind (2001) • Alabama State Department of Education • Equivalent to ALT-A • Master's degree with focus in DD/ASD and/or BCABA credential	• DSM-V Severity of ASD • All Levels • All Axes of DSM-
Level 8 PhD Level with DD/ASD Specialization	• Doctor of Philosophy in Special Education or Doctor of Education with 15 graduate hours in DD/ASD related credits		• DSM-V Severity of ASD • All Levels • All Axes of DSM-
*To see proposed DSM-V criteria, visit http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=94.			

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