Risk – Benefit Analysis Form for Interrupting/Pausing Face-to-Face Services During COVID-19

As we provide in-home health care using Applied Behavior Analysis Services, (although the Denver area does not currently have a "shelter-in-place order") in concordance with the "shelter-in-place orders" in other U.S. cities, we are taking actions that will follow the guidelines and restrictions proposed in those cities for purposes of public health and safety measures, while continuing to provide the necessary level of care and support to our clients that is commensurate with the individual and unique needs of each of our clients. Current "shelter-in-place" orders include the following guidelines and restrictions that specifically relate to our services:

Essential Businesses stay open

- Home-based care for seniors, adults and children
- Healthcare operations

Essential Activities are allowed

- To do things essential to the health and safety of the household, including pets, like getting medical supplies, visiting a clinic or hospital, or obtaining supplies to work from home.
- To continue working for a healthcare operation, like a hospital, clinic, dentist's office, pharmacy, pharmaceutical and biotech company, a healthcare facility, healthcare supplier, home healthcare service, mental health provider, veterinary office or other related services.

Current CDC Guideline Checklist:

Client Name: ____________________ **Client Supervisor :** ____________________________________

Check "yes," if you agree that the following can and will occur while continuing to provide in-home ABA services. All **required** items must be checked "yes," in order for ABA services to be able occur in-home.

Required: □ **YES** □ **NO**	Less than 10 people gathering in one place in home location only (could be difficult with larger families and multiple providers present).
Required: □ **YES** □ **NO**	□ Social distancing: maintaining at least 6 feet between individuals without provider(s) wearing surgical mask. (See: Open Door & Greeting Protocol*) OR □ While working with client, if close contact is necessary (within 6 feet) and could include instances where there is direct contact with infectious secretions (respiratory droplets), provider(s) must wear disposable surgical mask or reusable clear face shield/mask at all times in protection of the client, as "The Centers for Disease Control and Prevention (CDC) identify an increased risk of COIV-19 infection --- and more acute conditions if infected – for individuals with intellectual disabilities and developmental delays regardless of age."
Optional: □ **YES** □ **NO**	For their own protection, provider(s) may also choose to wear PPE (e.g. respirator mask) under their surgical mask or under their clear face mask

	in order to further prevent their own exposure to infectious secretions of others (respiratory droplets) while working with a client. Once AWBP is able to order/receive N95 masks, this will become a required item.
Required: **□ YES □ NO**	● Provider(s) will wash hands with soap and water for at least 20 seconds immediately upon arriving at a client's home.
Required: **□ YES □ NO**	○ When soap and running water are unavailable, provider will use an alcohol-based hand rub with at least 60% alcohol.
Required: **□ YES □ NO**	○ Provider(s) will always wash hands that are visibly soiled as immediately as possible.
Required: **□ YES □ NO**	○ Provider(s) will use disinfectant wipes (provided by AWBP) to wipe down any items and/or surfaces before using (beginning of session).
Required: **□ YES □ NO**	○ Provider(s) will use disinfectant wipes (provided by AWBP) to wipe down any items and/or surfaces when done using (end of session).
Required: **□ YES □ NO**	● Provider(s) will avoid shaking hands or giving high fives to parents/clients- if contact occurs, wash hands as described.
Required: **□ YES □ NO**	● Provider(s) will use elbow to cover coughs/sneezes.
Required: **□ YES □ NO**	● Provider(s) will avoid touching eyes, nose, or mouth- if inadvertent contact occurs, wash hands as described.
Required: **□ YES □ NO**	● Provider(s) will avoid close contact with people who are sick, and will contact their healthcare provider immediately upon known exposure and/or upon displaying concerning symptoms and follow recommended steps.

Risk vs. Benefit Analysis:

Wellness Check: Clinician to call and/or text client prior to entry, to confirm the following:

- **Have you been in contact with anyone with a confirmed or suspected diagnosis of COVID-19?**
- **We need to assure your home is a safe place for staff to enter: is client or members in the household currently exhibiting any symptoms identified by the CDC as well as any of the more developed versions. Fever, cough, shortness of breath.**

1.	**Parent/Caregiver/Guardian has confirmed desire to continue in-person services from BT/RBT's and/or**	□ **YES**	□ **NO**

	Supervisor(s) (and/or has not cancelled in person sessions):	If yes, skip to #3.	
2.	Parent/caregiver, guardian has requested and/or confirmed desire to receive telehealth only services.	□ YES	□ NO
3.	Client has a funding source that allows for telehealth for supervisor level (Supervision, Assessment, Parent Training, etc.) (select “no” for tricare)	□ YES	□ NO
4.	Funding source also temporarily allows for telephone and live chat (e.g. text messaging) to be billed for under the codes listed above. (select “yes” for Medicaid, Cigna)	□ YES	□ NO
5.	Funding source allows for BT/RBT direct services to be delivered via telehealth if appropriate for client. (all but tricare)	□ YES	□ NO
6.	Client sessions could reasonably and effectively be delivered via telehealth, with a minimal or moderate amount of support or involvement required by the parent/caregiver that the parent/caregiver is/has stated they are willing to do.	□ YES If Yes, skip to #15?	□ NO
7.	If direct RBT/BT sessions cannot be delivered in person due to inability to guarantee “yes” to all ***required*** CDC items listed in the first section of this document AND/OR If direct RBT/BT sessions cannot be delivered via telehealth due to a “no” answer to #6: Are there potentially injurious, dangerous, fatal, extremely concerning outcomes that could occur as a result of not having direct BT/RBT sessions over the next 1-12 weeks?	□ YES	□ NO If no, skip to #15.
8.	In the client’s history, have there been any emergency medical/psychiatric visits (for the client and/or other individuals) requiring acute medical, behavioral health, and/or mental health care specifically due to the client’s behavior(s)?	□ YES	□ NO
9.	In the client’s history, have there been any behavior(s) that have resulted in arrest, jail time, and/or legal trouble (e.g. lawsuit) ?	□ YES	□ NO
10.	In the client’s history, have there been any behavior(s) and/or skill deficits that have led to manipulation, coercion, neglect, abuse, homelessness, loss of job, and/or loss of income ?	□ YES	□ NO
11.	Is significant regression of challenging behavior(s) a particular concern (with documented evidence of regression) when having gone a significant amount of time without direct ABA services and/or school attendance?	□ YES	□ NO

12.	**If so, are there skills that have been gained and maintained in replacement of problem behavior(s) that previous deficits had led to any of the consequences or outcomes listed in items 7-9?**	**□ YES**	**□ NO**
13.	**Is significant regression of skill acquisition behavior(s) a particular concern (with documented evidence of regression) when having gone a significant amount of time without direct ABA services and/or school attendance?**	**□ YES**	**□ NO**
14.	**If so, is the regression particularly relevant to losing what could be considered life altering progress (e.g. regression of medically necessary skills that required one or more years of 10 or more hours per week to acquire, indicating higher than "average" number of trials to criteria for a non-neurotypical learner to acquire essential skills using errorless and fading progressions that include progressions across minimal and/or subtle stimulus/response shaping).**	**□ YES**	**□ NO**
15.	**Are there any other risks to family members if there were to be an interruption/pause for in-person services? (e.g. parent/caregiver stress, parent/caregiver mental health needs, do parents have access to mental health care, is there any barrier to accessing medical care for family members that is not the same barrier for the client?)**	**□ YES**	**□ NO**
16.	**Are there any other physical disabilities or unique attributes/differences that would be important to consider when determining whether any in-person visits should be provided as an essential service for this client?**	**□ YES**	**□ NO**
	If so, please describe:		

Based on the item responses above, the recommendation by the supervisor is to:

□ continue providing in-person services by BT/RBT with an emphasis on supervision overlaps being done primarily via telehealth whenever feasible simply to decrease the number of individuals contacted per week for both client and staff protection.

□ provide telehealth sessions by BT/RBT as well as supervisor ONLY on either the same schedule or a slightly modified schedule to be worked out between staff, scheduling & client.

□ stop/pause all services altogether until variables change that may allow for either in person or telehealth to be provided.

If in-home ABA therapy services are desired, please fill out below:

“I ______(BT/RBT) have chosen to provide in-home ABA therapy for _______________(client name). I acknowledge and understand all risks of providing in-home ABA therapy as outlined by the CDC and state government guidelines. I hereby agree that the benefits of continuing in home face-to-face services outweighs the residual risks presented. I understand the actions required of myself and of the family that will be taken to mitigate such risks.”

RBT/BT Signature: ____

“ I _________________________(parent name) have chosen to permit in-home ABA therapy for _______________(client’s name). I acknowledge and understand all risks of providing in-home ABA therapy as outlined by the CDC and state government guidelines. I hereby agree that the benefits of continuing in home face-to-face services outweighs the residual risks presented. I understand the actions required of myself and of the therapist that will be taken to mitigate such risks.”

Parent/Guardian Signature: _______________________________________ *Date:* ___________

Supervisor Signature: ____

If in-home ABA services are voluntarily paused by the client’s family/guardian:

“I, ________________________ (parent/guardian name) have thoroughly assessed the risks and benefits of having in-home ABA therapy services and have decided to pause all in-home ABA therapy services for ___________________________ (client name) effective immediately until further written notice.

I, _________________________ (parent/guardian name) understand that I may resume in-home ABA services at any time as long as all precautionary measures (as outlined by the CDC and state government) are taken by myself and the therapist. I also understand that services will resume as quickly as possible given staff availability.”

Parent/Guardian Signature: _______________________________________ *Date:* ___________

Supervisor Signature: ____