Comprehensive Autism Care Demonstration

Social Responsiveness Scale-2 (SRS-2)

Under TRICARE's Autism Care Demonstration (ACD), applied behavior analysis (ABA) providers are required to use the Social Responsiveness Scale-2, (SRS-2) scores at baseline and annually thereafter, as one measure of the assessment and analysis of treatment effectiveness for beneficiaries between the ages of 2.5 to 99 years. Health Net Federal Services, LLC (HNFS) offers the following information to inform and clarify those requirements, and assist ABA supervisors with using the SRS-2 in their treatment and discharge planning.

What is the SRS-2?

The SRS-2 is a respondent-based measure of the severity of social deficits and symptoms related to autism spectrum disorder. The SRS-2 scores are standardized by comparing characteristics of a large sample population of people diagnosed with ASD, grouped by age and gender. The test asks parents and caregivers to rate the presence of symptoms they have noticed over time and in various environments.

Why is the SRS-2 used?

Standardized assessments give families and provider teams clear, consistent measurements of progress. Changes in scores are compared over time and against treatment plan goal progress. TRICARE has selected the SRS-2 because it identifies social impairment associated with ASD and quantifies its severity. This allows assessors to understand the level of ASD symptomology compared to others of the same age with an ASD diagnosis and understand current and ongoing impacts.

What are SRS-2 submission requirements?

Age-appropriate SRS-2 forms (preschool, school-age male, school-age female, and adult) must be completed at the initial treatment and annually thereafter. The name of the respondent and relationship to the beneficiary is required on all forms. Providers must submit all scores produced by the publisher's scoring, including the SRS Total T-score, the SRS Social Communication and Interaction (SCI) T-score and SRS Restricted Interests and Repetitive Behavior (RRB) T-score as well as the T-scores for Awareness (AWR), Cognition (COG), Motivation (MOT), and Communication (COMM). Submission of all outcome measure results must include the full publisher print report or hand-scored protocol and summary score sheet(s). Imbedding scores within the treatment plan or other clinical documents does not meet submission requirements.

How is the SRS-2 scored?

The SRS-2 generates raw scores for five treatment domains, which are converted into T-scores. The raw scores of each domain are combined with their total converted into the SRS-2 Total T-score. The SCI score is calculated by combining raw scores from the AWR, COG, COMM and MOT and converting the total into the SCI T-score. T-scores for each domain are organized by gender and respondent age with each having varying but similar ranges of possible scores from 32–114. All T-scores have a mean of 50 with a standard deviation of 10 points.

How must ABA providers use the SRS-2 scores under the Autism Care Demonstration?

ABA supervisors must use the SRS-2 as part of a comprehensive analysis of beneficiary progress to guide related aspects of treatment, behavior intervention and discharge planning. This includes analyzing score progress, monitoring areas of stagnation and/or regression and informing treatment-planning decisions based on the expected and actual amount of change for each comparison period.

While another provider may complete the SRS-2, it is necessary for treating ABA providers to review and fully understand the scores. It is important respondents remain consistent in their responses. Treating ABA providers may need to engage with the family when large discrepancies in responses do not match assessed skills sets. As with any respondent-based measure, especially those only responded to annually, respondent bias to temporary perceptions should be considered.

When do SRS-2 scores indicate the need for a treatment plan modification?

A total T-score of 59 and below is considered low to no symptomology and generally not associated with ASD. A total composite score between 60 and 65 is associated with mild to moderate deficits in social interaction. Scores between 66 and 75 are considered to display a moderate deficit in social interaction, and a score greater than 76 is considered severe and strongly associated with the clinical diagnosis of ASD.

The following indicators at each 12-month comparison would suggest the need for additional analysis and treatment plan modifications; and should be clearly documented and addressed in treatment plan updates:

- Limited measurable improvement or stagnation in any required T-score over time
- T-scores increasing over successive review periods
- T-scores higher than 76 which indicate high symptomology and high need for specific treatment areas or globally high symptomology when found in the total score
- T-scores below 59 indicate low to no ASD symptomology especially when found in the total T-score and should be considered in discharge criteria and lessening of focus on areas found at or below this score

What is the relationship between SRS-2 scores and treatment plan changes?

ABA providers must use SRS-2 results to inform their treatment, behavior intervention and discharge planning for all beneficiaries. This means both identifying when treatment strategies are not effective or durable over time and when scores are near or within the ranges considered of low treatment need, both indicating possible discharge.

ABA providers must identify and document a direct relationship between score changes and treatment plan changes. Treatment plans must address lack of improvement or an increase in the SRS-2 score, and identify contributing factors and changes to treatment. For example, if there is a deficit between authorized, recommended therapy hours and delivered therapy hours, providers must analyze and document changes to SRS-2 scores possibly caused by this deficiency, as well as a plan to correct the deficit. This also includes treatment recommendations and summaries, focusing less on areas with scores representing low need. In the treatment plan, providers can address these changes by documenting adjustments to treatment amounts, goal areas, parent training and/or discharge timelines.

For additional information about TRICARE's ABA benefit, please visit **www.tricare-west.com/go/ACD-provider**.