IHBT IMPLEMENTATION: CHALLENGES AND OPPORTUNITIES

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BEGIN CENTER FOR VIOLENCE PREVENTION
LEARNING OBJECTIVES

• Participants will be able to list key strategies that contribute to the successful implementation of IHBT programs.

• Participants will be able to list key challenges in implementing IHBT programs

• Participants will learn how the new ODM Medicaid rules apply and impact IHBT service provision.
SHARE THE BURDEN
SHARE THE RISK

• **Reality:** More at-risk youth living in the community

• **Behavioral Health Needs:** Adds to complexity of youth being served, complicating the risk profile

• **Community Need:**
  • Ability to effectively and safely manage risk in the community
  • Shared decision-making process for identifying youth and family needs, strengths, and safety issues, and matching services and supports to meet those needs
  • Intensive services and supports that address multiple functional aspects of youth’s life (family, school, peers, community)
Families with Complex Needs and Challenges

- Youth & Family Safety
- Family Stressors
- Trauma History
- Family & Neighborhood Risk Factors
- Basic Needs (financial, transportation, housing)
- Family Dynamics (Relationships, Boundaries, Hierarchy, Communication, Structure)
- Family Unit
  - SU Disorders
  - MH Disorders
- Health, Sleep, Nutrition, Exercise, Medication Compliance
- Acculturation; Language Barriers
- Neighborhood, School, Community Connections
- Family Skills
- Family Supports & Resources

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MULTIPLE RISKS REQUIRE MULTIPLE INTERVENTIONS
(SAMEROFF, GUTMAN, AND PECK, 2003)

• The number of risk factors was a better predictor of child outcomes than any specific single risk factor or characteristic of the child. (Sameroff & Rosenblum)
• Most youth experience risks across multiple social contexts
• Most interventions in single domains have not produced major reductions in problem behaviors

• Interventions need to be as complex as the multiplicity of risk factors and contexts and address all the social contexts in which the risks occur
Risk and Protective Factors in Context

School (+) (-)

Peers (+) (-)

Family (+) (-) (+) (-)

Informal Supports (+) (-)

Community (+) (-)

Work (+) (-)

+ = Protective Factors
- = Risk Factors

Center for Innovative Practices, 2007
RATIONALE FOR IHBT

- IHBT addresses risk and protective factors in context using comprehensive treatment modalities
- IHBT actively assesses and manages safety issues
- Least restrictive, most normative
- Alternative to custody relinquishment
- IHBT expands behavioral health continuum of care
- Access and Availability
- Treatment is focused on whole family
- Benefits other child-serving systems
- Avoids negative consequences and costs related to placement
- Targets high users of services & resources
INTENSIVE HOME-BASED TREATMENT

• IHBT is an intensive, time-limited behavioral health treatment for children and adolescents with significant behavioral health challenges and related functional impairments in key life domains.

• IHBT incorporates a comprehensive set of behavioral health services which are delivered in the home, school and community, with the purpose of stabilizing behavioral health and safety concerns, for youth who are at-risk of placement due to his or her behavioral health challenges, being reunified from placement, or require a high intensity of behavioral health interventions to safely remain in the home.
<table>
<thead>
<tr>
<th><strong>Intensive Home-Based Service Delivery Model</strong></th>
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<td><strong>Location of Service</strong></td>
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| **Intensity**                                 | Frequency: 2 to 5 sessions per week  
Duration: 4 to 8 hours per week |
| **Crisis response & availability; active safety planning and monitoring** | 24/7 |
| **Active safety planning & monitoring**       | Ongoing |
| **Small caseloads**                           | 4 to 6 families per FTE; 8 to 12 for team of two; **no mixed caseloads** (e.g. Outpatient and IHBT) |
| **Flexible scheduling**                       | Convenient to family |
| **Treatment duration**                        | 3 to 6 months |
| **Systemic engagement and community teaming** | Child and family teaming; skillful advocacy; family partnering; culturally mindful engagement |
| **Active clinical supervision & oversight**   | 24/7 availability; field support; individual & group |
| **Program structure and credentials**        | **Licensed Behavioral Health Professional: MA level preferred.** Program size: 2 to 8; .5 to 1 FTE IHBT Supervisor; Individual provider versus teaming approach |
| **Comprehensive service array:**              | Crisis stabilization, safety planning, skill building, trauma-focused, family-focused; resiliency & support-building interventions; cognitive interventions |
| **Integrated and seamless; single point of clinical responsibility** | |
PROGRAM STRUCTURE AND CREDENTIALS

- 2 to 4 FTE licensed clinical staff LSW, LPC, LMFT, LPCC, LISW, LIMFT, Psychologist
- Core training and quarterly ongoing trainings
- IHBT certified agency
- 24 hour availability of supervisors for each therapist
- Individual provider versus teaming approach
- Independently licensed and experienced supervisor
- Intensive clinical support and field supervision as needed
- Supervisor holds fidelity to the model
- Weekly individual and group supervision/consultation
IHBT ELIGIBILITY CRITERIA

• Youth with significant behavioral health impairment that impacts functioning in major life domains
• At risk for out-of-home placement; or
• Returning from out of home placement; or
• Requires a high level of mental health and substance use interventions to stabilize potential safety concerns
• Is under the age of 18; or
• Youth age 18 through 21 who are still living at home and attending high school or under the jurisdiction of another child serving system
YOUTH AND FAMILIES SERVED

• Less intensive services were unsuccessful
• Multiple system involvement
• Multiple risk factors; Few protective factors; safety concerns
• Youth need significant supports and accommodations for success
• System has not engaged youth and family effectively
• Families who have difficulty with service access (work, transportation, poverty)
• High stress (multi-stressed)- Low resource.
• Trust issues with the “system”
IHBT MODEL COMPONENTS

System of Care Principles

- Home-Based Service Delivery Modality
- Systemic Engagement and Change
- Multidimensional Assessment and Conceptualization
- Comprehensive Treatment Array Matched to Needs and Strengths

Resiliency-Oriented Developmental Perspective
IHBT TARGET OUTCOMES

• Reduced symptomatology
• Increased safety and decreased risk
• Reduced/No hospitalizations
• Improved family functioning
• Living at home
• Increased school functioning
• Reduced involvement in the JJ system
• Increased resources and natural supports
Reduced out of home placements
• 86% in 15 site evaluation (total youth served)
• 100% of youth ages 4 to 6 remained in their homes safely

Impact on Juvenile Justice Involvement
• At the conclusion of IHBT, there was a 50% drop in:
  • youth arrested (44% to 21%);
  • youth on probation (27.5 to 13%),
  • youth detained (13.5% to 7.1%).

Impact on School Success
• The percent of youth getting passing grades during IHBT treatment increased from 65 to 77%;
• The percent of youth with disciplinary problems in school decreased greatly from 68 to 49%
AGGREGATE OHIO SCALES SCORES AT ADMISSION AND DISCHARGE—PARENT RATINGS

Based on 309 cases
All findings p < .0001
IHBT AND BEHAVIORAL HEALTH REDESIGN

- OhioMHAS and ODM have included Intensive Home Based Treatment (IHBT) in the Medicaid Behavioral Health State Plan Services as one of the specialized services.
- Scheduled to begin on July 1, 2017.
- Bh.Medicaid.Ohio.Gov
KEY AIMS

• Increased adequacy of funding for IHBT
• Increased access and availability of intensive home and community-based treatments statewide
• Treatment delivered per model fidelity not per agency productivity standard
• Practice improvement with a focus on training and supervision
• Emphasis on fidelity and outcomes
ODM RULES FOR IHBT

• New rate for Intensive Home-Based Treatment
• Prior authorization
• Must have behavioral health license (LSW, LPC, LMFT and above)
• CANS ratings required to determine service eligibility
• Fidelity review of IHBT team with passing scores required to bill Medicaid
• Phone calls not billable
• Treatment provided while traveling in car is not billable
• Service limitations
POTENTIAL IMPACTS AND ADJUSTMENTS

• Influx of IHBT programming
• Attention to fidelity
• Minimizing service delays due to prior authorization process
• Supervisory time needed for managing authorization submissions and denials etc.
• Supervisor time needed for tracking IHBT Fidelity items
• Choosing between programs
## Deciding on the Right Service for the Right Youth

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<tr>
<td><strong>Population of Focus</strong></td>
<td>Mental Health (5 – 21)</td>
<td>Mental Health (5 – 21)</td>
<td>Co-occurring SU/MH (11 – 21)</td>
<td>Juvenile Justice (12- 17.5)</td>
<td>Juvenile Justice (11- 18)</td>
</tr>
<tr>
<td><strong>Level of Research Support</strong></td>
<td>Evidence-Informed</td>
<td>Research supported</td>
<td>Research supported</td>
<td>EBP</td>
<td>EBP</td>
</tr>
<tr>
<td><strong>On-Call</strong></td>
<td>24/7 crisis response</td>
<td>No</td>
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<td>No</td>
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<tr>
<td><strong>Intensity</strong></td>
<td>Multiple weekly sessions 4 to 6 hours per week per family</td>
<td>Variable</td>
<td>Multiple weekly sessions 4 to 6 hours per week per family</td>
<td>Minimum of two sessions per week</td>
<td>Average 12 to 14 sessions over 3 to 6 months</td>
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<tr>
<td><strong>Location</strong></td>
<td>Home &amp; Community</td>
<td>Home; Office</td>
<td>Home &amp; Community</td>
<td>Home &amp; Community</td>
<td>Office; Home</td>
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IHBT: Intensive Home-Based Treatment  
I-FAST: Integrated Co-Occurring Treatment  
ICT: Integrated Co-Occurring Treatment  
MST: Multisystemic Therapy  
FFT: Functional Family Therapy  
I-FAST: Integrated Family and Systems Treatment
# Difference between High Fidelity Wraparound and IHBT

<table>
<thead>
<tr>
<th>HFWA</th>
<th>IHBT</th>
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<tr>
<td>• Planning process</td>
<td>• Treatment intervention</td>
</tr>
<tr>
<td>• Primary function: Care Coordination &amp; Supports</td>
<td>• Primary function: Comprehensive &amp; intensive clinical stabilization</td>
</tr>
<tr>
<td>• No licensure required</td>
<td>• Licensed BH Professional</td>
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<tr>
<td>• Caseloads: 12-15</td>
<td>• Caseloads: 4 to 6</td>
</tr>
<tr>
<td>• LOS: 12 to 18 months</td>
<td>• LOS: 3 to 6 months</td>
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REFERRAL DECISION CRITERIA

- Safety planning needed?
- 24/7 crisis response needed?
- Internalizing/externalizing disorder?
- Age (11 and under; over 18)?
- Level of research support?
- Family therapy needed?
- Service coordination and planning
- Individual therapy/skill building for youth needed?
- Juvenile Justice involvement?
- Substance use issues?
- Co-occurring substance use and mental health disorder?
- Treatment dosage
- Supports and resource needs
HUMAN RESOURCE CHALLENGES
BUILDING THE WORKFORCE

Existing
- Find trained professionals with dual skills sets

Pre-service
- Survey current graduate level coursework
- Develop new curriculum
- Integrate co-occurring content into current curriculum

Post-service
- Train and build the skills in the field
RECRUITMENT AND RETENTION

Recruitment
How we PAY impacts WHO we attract

Retention
How we SUPPORT them impacts how LONG they stay

Retention
PAPERWORK and PRODUCTIVITY drive burnout and intention to leave
Recruitment, Training and Retention

- Manageable Workload & Expectations
- Salaries, Incentives, & Opportunities for Advancement
- Training, Coaching, & Clinical Supports

Recruitment, Training and Retention
POLICIES THAT SUPPORT IHBT STAFF

- Reasonable productivity requirements
- Sufficient pay
- Flexible work hours
- Rotating coverage for on-call
- Cell phones
- Laptops
- Safety policies for workers
- Supervisor support and availability
CHARACTERISTICS OF EFFECTIVE IHBT STAFF

- Comfortable in high-risk situations
- Able to think on their feet
- Strong boundaries
- Calm in a crisis
- Comfortable with 24/7 on-call
- Available and accessible to families
- Strength-based and respectful of families
- Strong case conceptualization skills
- Knowledgeable of community resources
- Strong collaborative relationships in the community
- Knowledgeable of youth and family rights
TRAINING: IHBT COMPETENCIES

- Family systems
- Risk assessment and crisis stabilization
- Behavior management for children/adolescents with SED
- Cultural competency
- Intersystem collaboration and coordination
- Trauma-informed care
- Educational and vocational functioning
- Strength-based assessment and treatment planning
- Co-Occurring Disorders
- Behavioral Health and Juvenile Justice
- Ethics in IHBT
- IHBT Supervision
IHBT COMMON CONCERNS

• Being on-call
• Staffing a dedicated supervisor
• Managing high risk caseload

• Worker safety
• Travel
• Finding qualified staff
• Salaries
CHARACTERISTICS OF EFFECTIVE IHBT SUPERVISORS

- Comfortable in high-risk situations - able to respond in calm manner to crises
- 24/7 availability, accessibility, and support
- Encourages strength-based and respectful relationships
- Able to spot ethical and boundary issues

- Strong case conceptualization skills
- Knowledgeable of community resources
- Strong collaborative relationships in the community
- Knowledgeable of youth and family rights
- Conveys philosophy of extreme persistence
SUPERVISION ISSUES UNIQUE TO HOME AND COMMUNITY-BASED WORK

- Ethical issues are more complex and frequent
- Clinical complexity of family situations
- Management of high risk and safety issues
- Maintaining staff morale and retention
- Staff work independently in unstructured, unpredictable and clinically complex situations
- Supervising staff with the least experience to do the most complex work
LESSONS LEARNED: IHBT IMPLEMENTATION ISSUES

• Technical Assistance is needed to maximize effectiveness of IHBT

• A uniform data collection system is necessary in order to provide timely clinical feedback and track quality improvement

• Stakeholders/funders increasingly relying on data to make financial decisions

• Multiple partners and multiple systems are needed to support implementation

• High level training and ongoing coaching and monitoring of fidelity

• Agency/program level funding requires more than Medicaid
PROGRAM SUSTAINABILITY

• Cultivate referral source relationships
• Medicaid is necessary but not sufficient for implementation and ongoing sustainability.
  • Agency startup expenses;
  • Costs related to turnover;
  • Training costs;
  • Consultation costs; and
  • Coverage of youth who do not qualify for Medicaid benefits.
• Establish diverse funding sources prior to implementation
• Fund the fidelity (training, consultation, technical assistance)
CONTACT INFORMATION

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