# Developing Program and Practice Standards for Intensive In-Home Behavioral Health Treatment (IIBHT)

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# Why is this important?

Intensive In-Home Behavioral Health Treatment is utilized widely for youth with serious behavioral health needs and their families, yet the field has functioned for decades without accepted quality standards.

# Overall Goal for the Project

**Review, compile, and synthesize existing literature and information in order to define evidence-based standards for Intensive In-Home Behavioral Health Treatment (IIBHT) at practitioner, organizational, and system levels.**

- ***Produce materials*** **(e.g., informational briefs, quality frameworks, recommended standards and indicators) to guide the field**
- ***Inform future quality improvement efforts*** **(e.g., learning or quality collaboratives, state/MCO contracting, workforce development models, national interest or trade groups)**
- ***Support future research*** **on IIBHT implementation and outcomes**

# Brainstorm Activity—Think of Standards

**Take 5 minutes for people to pair-up and write down some of the most important quality elements you can think of with respect to:**

- **<u>IIBHT PROGRAMS</u>: "To achieve the most positive outcomes possible for youth with serious emotional and behavioral needs and their families, an effective IIBHT *Program* must…"**

- **<u>IIBHT PRACTICE</u>: "To achieve the most positive outcomes possible for youth and families, an effective IIBHT *Practitioner* (or team) must…"**

# Phase 1A: Literature Review and Expert Interviews

- Relevant manualized EBPs and promising practices
  - 10 models
- Peer reviewed literature
  - 24 articles and 18 book chapters/monographs/manuals
- Program and practice elements (Lee et al., 2014)
  - 14 Program elements; 27 Practice elements
- Two IIBHT models
  - OH IHBT; and Connecticut IICAPS
- State guidance
  - AZ, CA, CO, CT, DC, FL, GA, HI, IL, LA, ME, MA, MD, MI, MO, MT, NE, NC, NM, NJ, NY, OH, PA, VA, WI

# Phase 1B: Standard Development, Expert Task-Force

- Synthesized knowledge and developed initial draft quality standards for review:
  - 30 Draft Program Standards
  - 49 Draft Practice Standards

# Example From Program Standards

**Intensive In-Home Behavioral Health Treatment (IIIBHT)**
**Program Standards**

| Clinical Program Categories | Description |
| --- | --- |
| ***To achieve the most positive outcomes possible for youth with serious emotional and behavioral needs and their families, an effective IIBHT Program must:*** | |
| **1) Competent staff** | **1.1** *Role clarity:* Regardless of composition of teams (i.e., solo practitioners; two or three-person teams), there are clear roles and responsibilities for the IIBHT practitioners, including detailed job descriptions for each role [e.g., therapists, other qualified mental health professionals (QMHPs), peer support workers, supervisors].<br>**1.2** *Practitioner credentials:* All members of IIBHT teams (i.e., therapists, QMHPs, peer support workers, supervisors) have a clear set of credentials (i.e., relevant degree and training) appropriate to their role. Moreover, regardless of composition of teams (i.e., solo practitioners; two or three-person teams), IIBHT teams as a whole have credentials that allow them to provide the complete array of services included in IIBHT (i.e., if the program utilizes a single practitioner model, staff need to have the necessary credentials to provide the full continuum of IIBHT services).<br>**1.3** *Qualified personnel:* Practitioners have prior experience and training working with youth with intensive needs and their families, demonstrate the ability to engage and build relationships with youth and families, and demonstrate skills appropriate to their role (e.g., therapists, QMHPs, peer support workers, supervisors).<br>**1.4** *Stable workforce:* Turnover among staff is maintained at a level that does not detrimentally affect the performance of the IIBHT program (e.g., below 25% per year) and average tenure of practitioners is at a level that ensures effective provision of IIBHT by the program or organization (e.g., greater than two years).<br>**1.5** *Rigorous hiring processes:* The IIBHT provider organization has written interviewing and hiring protocols for each of the relevant positions. Interview and selection protocols are rigorous, and include, for example, behavioral questions, direct observation of skills, and/or written exercises (e.g., progress notes, treatment plan).<br>**1.6** *Effective training:* IIBHT staff and supervisors are required to participate in initial and booster trainings relevant to their roles and responsibilities. There are written training protocols that include behavioral rehearsal and direct observation of skills-based practice as well as knowledge tests. |

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# Example From Practice Standards

**Intensive In-Home Behavioral Health Treatment (IIBHT)**
**Practice Standards**

| Clinical Practice Categories | Description |
|---|---|
| **Engagement**<br>***To achieve the most positive outcomes possible for youth and families, an effective IIBHT Practitioner (or team) must:*** | |
| **1) Engagement** | **1.1** Describes the process of IIBHT treatment for youth and families, detailing roles, boundaries, and limitations, particularly as they differ from other treatment settings and modalities.<br>**1.2** Explains confidentiality (and limitations of confidentiality) specific to the IIBHT model, including how and why information may be shared with individuals within the team and outside the team (e.g., for supervision).<br>**1.3** Engages the youth/family utilizing evidence-based techniques. These include:<br>A. Promotes youth/family voice and choice in decision-making.<br>B. Identifies potential future barriers to attending treatment and actively brainstorms solutions.<br>C. Reframes or clarifies youth/family perspectives in a way that avoids criticism or judgement.<br>D. Utilizes strengths-based language.<br>**1.4** Implements motivational interviewing strategies based on the youth and family's change readiness. |
| **2) Cultural competence** | **2.1** Actively seeks to understand and demonstrate respect for the unique and diverse roles, values, beliefs, race, ethnicity, culture and gender of the youth, family, and their community.<br>**2.2** Avoids using expert or medically-based jargon |
| **Risk Identification, Safety Planning, & Crises Response**<br>***To achieve the most positive outcomes possible for youth and families, an effective IIBHT Practitioner (or team) must:*** | |
| **3) Risk identification** | **3.1** Identifies risk and safety concerns and situations across life domains that may lead to dangerous or potentially harmful consequences. |
| **4) Safety planning** | **4.1** Completes a safety plan, when clinically indicated, that includes identification of safety concerns, potential crises, triggers, actionable stabilization steps, means reduction steps, de-escalation and coping strategies, and family identified supports.<br>**4.2** Regularly monitors and updates safety plan as needed. |
| **5) Crisis response and stabilization** | **5.1** Serves as the lead crisis responder, responds to calls immediately, and is available for on-site stabilization as necessary.<br>**5.2** Uses crisis de-escalation skills and demonstrates ability to effectively stabilize crisis situations. |

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# Phase 2:
# IIBHT Decision Delphi Learning Community

- Learning Community (LC) engaged experts and stakeholders in *Delphi Process* to reach consensus on quality standards:
  - Structured technique which relies on a panel of experts
  - Experts respond to structured questions in two or more rounds
  - After each round, the standards (and their wording) are revised based on ratings and feedback and then new versions of the standards are reviewed again by the group
  - The process stops when a predefined criteria is reached (i.e., mean ratings for inclusion and language reach a predetermined level – >75% approval)

# Who are the experts and stakeholders that were chosen to engage in the LC?

- Participants include:
  - Developers of evidence-based practice models
  - Major providers of IIBHT across the country
  - Parent and youth leaders with perspectives on / lived experience of IIBHT
  - NASMHPD State Children’s Directors
  - Purchasers of IIBHT (e.g. managed care, other child serving agencies)
  - Additional stakeholders with expertise or a stake in IIBHT
- In total, approximately 150 individuals were invited to the process

# Standards Decision Delphi LC: Qualtrics

- LC participants will be asked to rate each standard in two ways:
  - Indicate whether an activity like the one described is *essential, optional, or inadvisable* for IIBHT
  - Indicate whether, as written, the description of the activity is *acceptable*, *acceptable with minor revisions*, or *unacceptable*.
- LC participants also had the opportunity to:
  - Provide an explanation of their rating
  - Offer alternative language if they deem an item *acceptable with minor revisions* or *unacceptable* as written.

# Inclusion Rating Example

**The following activities fall within the domain of "1. Engagement."**

A skilled in-home behavioral health therapist (or team):

As written, please indicate whether you believe inclusion of this activity is:

| | Inadvisable | Optional | Essential |
|---|---|---|---|
| 1. Describes the process of IIBHT treatment for youth and families, detailing roles, boundaries, and limitations, particularly as they differ from other treatment settings and modalities. | ○ | ○ | ○ |

Explanation for rating (optional):

# Language Rating Example

As written, please indicate whether the description of the standard is:
(Note: if not "Acceptable" please provide suggestions for revised language in the box below)

| | Unacceptable | Acceptable with Minor Revisions | Acceptable |
|---|---|---|---|
| 1. Describes the process of IIBHT treatment for youth and families, detailing roles, boundaries, and limitations, particularly as they differ from other treatment settings and modalities. | ○ | ○ | ○ |

# Round 1 Data Analysis Decision Tree

Part 1: Inclusion

>75% rate as "Essential" or "Optional"

Yes → "Explanation of Rating": Disregard

No → Qualitative Coding of "Explanation for Rating" → Top two themes (presented to task force)

>75% rate as "Inadvisable" → Standard removed (Included Round 2 & Labeled "Removed")

Part 2: Language

>75% language as "Acceptable"

Yes → Standard accepted (Included Round 2 & labeled "Accepted")

No → Qualitative Coding of "Suggestions for revised language" (Organize/present to task force )

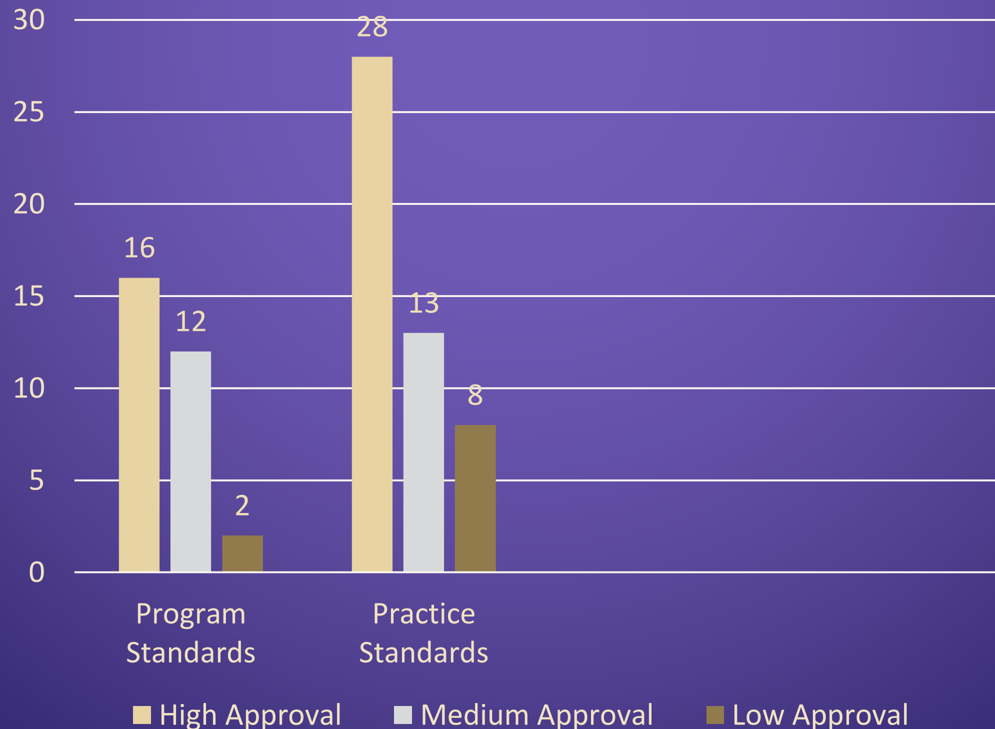
- Grammar
- Word Choice
- Sentence Structure

# Results Summary From LC Round 1

- A total of 157 people were included, 12 opted out.
  - A total of 58 people fully completed program standards (39% response rate).
  - A total of 74 people fully completed practice standards (48% response rate).
- Program standards: 16 out of 30 standards approved outright (> 75% rated inclusion as “Essential” and language “Acceptable”)
- Practice Standards: 28 out of 49 standards approved outright (> 75% rated inclusion as “Essential” and language “Acceptable”)

# Results Summary From LC Round 1

| High Approval | Medium Approval | Low Approval |
|---|---|---|
| Inclusion: >75% “Essential” | Inclusion: >75% “Essential” | Inclusion: <75% “Essential” |
| Language: > 75% “Acceptable” | Language: <75% “Acceptable” | Language: <75% “Acceptable” |



# LC Results Round 1 Program Standards High Approval

15. Commitment to flexibility and accessibility: IIBHT sessions are delivered at times and in places that are flexible, accessible, and convenient to the ~~family~~ youth and caregivers, including evening and weekend appointment times, and sessions at the location of the youth~~'s/family's~~ and caregivers' choice.

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments) |
|---|---|---|---|---|
| 0.100<br><br>Inadvisable: 0%<br>Optional: 0%<br>Essential: 100% | 0.91<br><br>Unacceptable: 0%<br>Minor Revisions: 9%<br>Acceptable: 91% | None | | |

Revised Standard:

15. Commitment to flexibility and accessibility: IIBHT sessions are delivered at times and in places that are flexible, accessible, and convenient to the youth and caregivers, including evening and weekend appointment times, and sessions at the location of the youth and caregivers' choice.

# LC Results Round 1 Program Standards Medium Approval

25. Review of ~~care~~ treatment plans: Each youth ~~/family's~~ and caregiver's initial treatment plan ~~of care~~ is reviewed by an expert (i.e., supervisor or EBP consultant) in the IIBHT practice model ~~(ideally external to the supervisor or coach)~~. Updated plans of care should also be regularly reviewed ~~no less than bi-monthly~~.

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments) |
|---|---|---|---|---|
| 0.78<br><br>Inadvisable: 0%<br>Optional: 22%<br>Essential: 78% | 0.51<br><br>Unacceptable: 13%<br>Minor Revisions: 24%<br>Acceptable: 64% | Impractical:<br>(7 comments)<br>-Undue burden<br>-May not have access to someone who can do this and may not be funds available | Supervisor should fill this role:<br>(6 comments)<br>-They are the ones that review plans already | Define bi-monthly:<br>(4 comments)<br>-Twice a month or every two months? |

Revised standard:

25. Review of care plans: Each youth and caregiver's initial plan of care is reviewed by an expert in the IIBHT practice model. Updated plans of care should also be regularly reviewed.

# LC Results Round 1 Program Standards Low Approval

4. Stable workforce: The organization or team will make every effort to ensure that turnover among staff is maintained at a level that does not detrimentally affect the performance of the IIBHT program (ideally, <25%) ~~and average tenure of practitioners is at a level that ensures effective provision of IIBHT by the program or organization (e.g., greater than two years)~~.

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments) |
|---|---|---|---|---|
| 0.57<br><br>Inadvisable: 3%<br>Optional: 36%<br>Essential: 60% | 0.55<br><br>Unacceptable: 9%<br>Minor Revisions: 27%<br>Acceptable: 64% | Not practical or enforceable due to high turnover rates (12 comments) | Turnover rates are not under the program's control (6 comments) | Remove timeframe: (3 comments) |

Revised standard:

4. Stable workforce: The organization or team will make every effort to ensure that turnover among staff is maintained at a level that does not detrimentally affect the performance of the IIBHT program (ideally, <25%).

# LC Results Round 1 Practice Standards High Approval

2. Explains confidentiality (and its limitations ~~of confidentiality~~) specific to the IIBHT model, including how and why information may be shared with individuals within the team (e.g. caregivers) and outside the team (e.g., for supervision).

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments) |
|---|---|---|---|---|
| 0.99<br><br>Inadvisable: 0%<br>Optional: 1%<br>Essential: 99% | 0.88<br><br>Unacceptable: 0%<br>Minor Revisions: 12%<br>Acceptable: 88% | Mention confidentiality with respect to youth and caregivers (2 comments) | | |

Revised standard:
2. Explains confidentiality (and its limitations) specific to the IIBHT model, including how and why information may be shared with individuals within the team (e.g., caregivers) and outside the team (e.g., for supervision).

# LC Results Round 1 Practice Standards Medium Approval

8. Works with the youth and caregivers to complete~~s~~ an individualized safety plan (if not completed by another provider, such as a care coordinator). ~~, when clinically indicated, that~~ Safety plans should include~~s~~ the identification of safety concerns, potential crises, triggers, ~~actionable stabilization steps, means reduction steps~~, de-escalation and coping strategies, actionable stabilization steps, prevention measures, and ~~family~~ youth- and caregiver-identified supports.

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments) |
|---|---|---|---|---|
| 0.96<br><br>Inadvisable: 0%<br>Optional: 4%<br>Essential: 96% | 0.50<br><br>Unacceptable: 1%<br>Minor Revisions: 47%<br>Acceptable: 52% | Safety plans should not be optional<br>(9 comments)<br>-Remove "when clinically indicated" | Family empowerment:<br>(5 comments)<br>-Families should be involved in this process | Jargon:<br>Means-reduction steps?<br>(2 comments) |

Revised standard:

8. Works with the youth and caregivers to complete an individualized safety plan (if not completed by another provider, such as a care coordinator). Safety plans should include the identification of safety concerns, potential crises, triggers, de-escalation and coping strategies, actionable stabilization steps, prevention measures, and youth- and caregiver-identified supports.

# LC Results Round 1 Practice Standards Low Approval

6. ~~Avoids using expert or medically-based jargon.~~ Uses language that is accessible to the youth and caregivers and, where necessary, translates clinical terminology (e.g., diagnoses and acronyms) used by professionals into content that is understandable.

| Inclusion Mean Score | Language Mean Score | Theme 1 (# comments) | Theme 2 (# comments) | Theme 3 (# comments) |
|---|---|---|---|---|
| 0.55<br><br>Inadvisable: 8%<br>Optional: 28%<br>Essential: 64% | 0.53<br><br>Unacceptable: 10%<br>Minor Revisions: 28%<br>Acceptable: 62% | Sometimes, medical jargon is necessary (10 Comments)<br>-Does not need to be avoided as long as explained. | Give examples of what you mean by jargon<br>(3 comments) | |

Revised standard:

6. Uses language that is accessible to the youth and caregivers and, where necessary, translates clinical terminology (e.g., diagnoses and acronyms) used by professionals into content that is understandable.

# LC Results Round 1 Program Standards

- Standards Added:
  - 4
- Standards combined:
  - 0
- Standards removed:
  - 0

# LC Results Round 1 Program Standards

New standards added:

5B. Reflective hiring process: When possible, the hiring process should reflect the racial, cultural, and linguistic diversity of the population(s) being served.

10B. On call Support: Programs arrange for 24/7 on-call support for their staff.

13B. Lead clinical role: In a situation where there are other overlapping programs or providers, IIBHT assumes a lead clinical role among all systems, programs, and providers involved with the youth and caregivers.

21B. Ensures that there is a procedure for checking in with the youth and family periodically after transition from formal IIBHT.

# LC Results Round 1 Practice Standards

- Standards added:
  - None
- Standards combined:
  - 3 sets
- Standards removed:
  - 2 (1 redundant and 1 moved to program standards)

# LC Results Round 1 Practice Standards

Removed standards:

18. Confers with the youth and family to use information collected in the assessment and clinical conceptualization process to develop a co-constructed definition of the main needs or goals for treatment.

    Reason: redundant with 19

49. Leads team in creating a procedure for checking in with the youth and family periodically after transition from formal IIBHT.

    Reason: removed and moved to program standards.

# Next Steps…

- Delphi Process, Round 2
  - Sent out March 1st
- Phase 3: Select Task Force
  - Seek specific feedback from categories of experts that were under represented in the Learning Community

    In-home EBP experts, IIBHT supervisors/managers
- Phase 4: polling and consensus process conducted via a Web-based interactive discussion platform
  - Inclusive of all participants from every stage/round of the process.

# We hope that the IIBHT standards will be utilized by:

- States, jurisdictions, and managed care entities
  - to inform contracting, financing strategies, investments in workforce development, and accountability efforts
- Provider organizations
  - to inform training, coaching, supervision, and continuous quality improvement (including fidelity) efforts
- Practitioners
  - to inform their work with youth and families, enhance practice, and aid in matching protocols and practices appropriately to youth and families' needs and populations that may benefit from receipt of IIBHT.

# Questions and Discussion

- Are there additional/different steps in this process you would recommend to get to the best set of IIBHT standards?
- How do we balance concerns about what is realistic in our current child-serving systems and organizations against what might be a “gold standard” for effective IIBHT?
- How would you recommend we disseminate and support use of these standards going forward?

# THANK YOU!

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