SESSION 46:

STATEWIDE IMPLEMENTATION OF INTENSIVE IN-HOME TREATMENT: PERSPECTIVES FROM THREE STATES

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DISCUSSANT: RICHARD SHEPLER, PH.D., PCC-S
OHIO’S IMPLEMENTATION OF INTENSIVE HOME-BASED TREATMENT

BOBBI BEALE, PH.D.
RICK SHEPLER, PH.D., PCC-S
CENTER FOR INNOVATIVE PRACTICES
BEGIN CENTER FOR VIOLENCE PREVENTION
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.
RATIONALE FOR IHBT

- Comprehensive treatment modality
- IHBT actively assesses and manages safety issues
- Least restrictive, most normative
- Alternative to custody relinquishment
- Service of access and availability - delivered in the home and community
- Treatment is focused on whole family
- Avoids negative consequences and costs related to placement
- Targets high users of services & resources
YOUTH AND FAMILIES SERVED

- Youth at-risk of placement or returning home from placement
- Significant risk and safety concerns
- Multiple system involvement
- Multiple risk factors; Few protective factors
- High stress (multi-stressed)- Low resource families
- Underdeveloped emotional and behavioral skill sets
- Youth need significant supports and accommodations for success
- Families who have difficulty with service access
- System has not engaged youth & family effectively - system trust issues
- Less intensive services were unsuccessful in stabilizing current concerns
HISTORY AND CONTEXT

• Nationally: HOMEBUILDERS: 1974; Kaleidoscope, 1973
• Ohio: IHBT initially began in 1986 as a response to the state’s policy on deinstitutionalization and increase in community-based mental health services
• Ohio providers trained in HOMEBUILDERS model and added family therapy
• Ohio Association for Family-Based Services – 1989
CREATION OF IHBT STANDARD

- 2000-2005 Ohio Department of Mental Health convened a workgroup of state experts to develop mental health rule for IHBT
- Identified IHBT supervisors whose programs conformed to a home-based service delivery model and who demonstrated strong outcomes
- In addition, the workgroup included state partners, the Ohio Federation for Families, and provider trade organizations.
- Used expert consensus building process to identify the core standards
- Standards were incorporated into rule and passed through state process
<table>
<thead>
<tr>
<th><strong>Intensive Home-Based Service Delivery Model</strong></th>
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<tbody>
<tr>
<td><strong>Location of Service</strong></td>
</tr>
<tr>
<td><strong>Intensity</strong></td>
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<tr>
<td><strong>Crisis response &amp; availability</strong></td>
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<td><strong>Active safety planning &amp; monitoring</strong></td>
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<td><strong>Small caseloads</strong></td>
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<td><strong>Flexible scheduling</strong></td>
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<tr>
<td><strong>Treatment duration</strong></td>
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<tr>
<td><strong>Systemic engagement and community teaming</strong></td>
</tr>
<tr>
<td><strong>Active clinical supervision &amp; oversight</strong></td>
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<td><strong>Provider credentials</strong></td>
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<tr>
<td><strong>Comprehensive service array: integrated and seamless; single point of clinical responsibility</strong></td>
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</tbody>
</table>
PROGRAM STRUCTURE AND CREDENTIALS

- 2 to 8 FTE licensed clinical staff LSW, LPC, LMFT, LPCC, LISW, LIMFT, Psychologist
- Independently licensed and experienced supervisor
- 24 hour supervisory availability
- Intensive clinical support and field supervision as needed
- Supervisor holds fidelity to the model
- Weekly individual supervision/consultation
- Weekly team meeting
- Core training and quarterly ongoing trainings
IHBT FIDELITY TOOL: MATCHED TO IHBT RULE STANDARDS

- Intensity of service
- Location of service
- Caseload
- Crisis response and availability
- Safety Planning
- Treatment Partnerships and Youth and Family Engagement
- Comprehensive and integrated behavioral health treatment approach
- Accessible and Flexible Services and Scheduling
- Strength-based assessment & tx planning

- Comprehensive system collaboration & service coordination
- Treatment duration & continuing care planning
- Supervisory support and availability
- Cultural responsiveness
- Team composition
- Professional training and development
- Outcomes monitoring and quality improvement
- Fidelity monitoring
CURRICULUM DEVELOPMENT

• Ohio Association for Family-Based Services (OAFBS) created Ohio’s first home-based curriculum (1991):

• Ohio Department of Mental Health funded the University of Akron to develop a home-based intervention interdisciplinary certificate program and curriculum (1987-2008)

• 2003 to present: CIP has developed and refined IHBT training modules that reflect the competencies in the IHBT rule
CORE COMPETENCY AREAS

- Family systems
- Risk assessment and crisis stabilization
- Behavior management for children/adolescents with SED
- Cultural & linguistic competence
- Cross-system collaboration and coordination
- Trauma-informed care
- Resiliency-oriented, developmentally focused
- Skill building
- Educational and vocational functioning
- Youth and family engagement and partnering
- Strength-based assessment and treatment planning
- Co-Occurring Disorders
- Ethics in IHBT
- IHBT Supervision
ROLE OF CENTER OF EXCELLENCE

- Center for Innovative Practices created 2000
- Statewide dissemination and implementation support
- Clinical support: coaching and consultation
- Ongoing training
- Facilitation of IHBT Supervisor Collaborative
- State level policy advocacy
- Practice tool development
IHBT TARGET OUTCOMES

- Prevent/reduce more restrictive placements of child and adolescents with serious emotional disturbance (SED) when safe and possible
- Reunify child and adolescents with SED from more restrictive placements
- Stabilize behavioral health safety concerns
- Reduce behavioral health symptomatology
- Stabilize and improve functioning in key life domains
  - School
  - Family
  - Community
  - Peers
- Increased resiliency: adaptive coping, positive connections, activities, and supports
FUNDING: 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

• Ohio Department of Medicaid (ODM) and OMHAS rules promote high quality IHBT service provision.
• 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 required
• Must have behavioral health license (LSW, LPC, LMFT and above)
• CANS is required to determine service eligibility
• Fidelity review of IHBT team with passing scores required to bill Medicaid
• Service limitations
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
LESSONS LEARNED: IHBT IMPLEMENTATION ISSUES

• Technical assistance is often needed during initial implementation period
• Multiple partners and multiple systems are needed to support implementation
• High level training and ongoing coaching and monitoring of fidelity
• Strong clinical supervision is foundational
• Collect and disseminate outcomes. Stakeholders/funders increasingly relying on data to make financial decisions
FUNDING FOR SUSTAINABILITY

• 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)
FOR MORE INFORMATION ON IHBT

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Development of the MA In-Home Therapy Practice Profile

30th Annual Research & Policy Conference on Child, Adolescent, & Young Adult Behavioral Health
Tampa, FL
March 6, 2017
Background & context - IHT

- Intensive in-home therapeutic service
  - Average 14 – 16 hours per month of service per youth
- Delivered by a team of 2
  - MA level clinician
  - BA level therapeutic training & support staff
- Implemented in 2009 as part of federal class action lawsuit – Rosie D.
- MassHealth (Medicaid) funded via managed care
- 17,538 youth served in FY 2016
- 70 providers with 160 sites across the Commonwealth
Background & context - IHT

- Serves youth and families with complex behavioral health needs
- Workforce relatively young and new to the field
- High staff turn-over – 18-24 months
- Each provider responsible for onboarding and training of staff – no “state provided” training
- Results of qualitative reviews of care found:
  - Considerable variation in quality of service delivery across the state
  - Variable understanding by practitioners of their role and responsibilities
The Nike Approach to the “What”

Just do it!

Credit: Dr. Michael Hoge, Yale Program on Supervision
Defining the “what” in IHT

Description of the program
- Philosophy
  - values
  - principles
- Clear participant inclusion and exclusion criteria

Essential functions that define the program
- Defined features that must be present to say the program exists
- Core components

Operational definitions of the essential functions
- Clear description of each core component at the level of “saying and doing.”
- Promotes consistency across practitioners at the level of service delivery

Practical performance assessment
- Measures fidelity to the program/model or practice
- Used to improve practitioner competency & refine supervision and training

“Teachable, learnable, doable”

Credit: National Implementation Research Network (NIRN)
http://nirn.fpg.unc.edu/
## Features of a Practice Profile

<table>
<thead>
<tr>
<th>IDEAL PRACTICE</th>
<th>DEVELOPMENTAL PRACTICE</th>
<th>UNACCEPTABLE PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>First meetings and initial assessment</td>
<td>Addresses safety with some family members but not all.</td>
<td>Makes plan without family input.</td>
</tr>
<tr>
<td>• In first meetings, as part of initial assessment, observes family member</td>
<td>• Asks about known safety issues without observing or probing for other potential risks.</td>
<td>• Composes plan in clinical jargon.</td>
</tr>
<tr>
<td>interactions and invites each family member (as appropriate to situation)</td>
<td>• Minimizes level of risk.</td>
<td>• Uses generic template for plan.</td>
</tr>
<tr>
<td>to describe any immediate safety concerns of identified youth, risk to other</td>
<td>• Considers safety only in primary household but not household(s) of other primary</td>
<td>• Fails to assess risk, discuss safety issues, or make plan.</td>
</tr>
<tr>
<td>family members in the home (including homes of separated caregivers), or</td>
<td>caregivers.</td>
<td></td>
</tr>
<tr>
<td>risk of property damage.</td>
<td>• Considers only risks related to youth self-harm without broader context of risks in</td>
<td></td>
</tr>
<tr>
<td>• Explores concerns regarding both self-harm and harm to others.</td>
<td>family.</td>
<td></td>
</tr>
<tr>
<td>• Observes conditions in home and assesses for risk and safety (child-proofing,</td>
<td>• Identifies risks without evaluating importance of each.</td>
<td></td>
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<tr>
<td>weapons, pets, fire hazards).</td>
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</tr>
</tbody>
</table>

**Features of a Practice Profile**

- **Ideal Practice**: Practitioners in this category are able to apply required skills and abilities to a wide range of settings and contexts. They use these skills consistently and independently, and sustain them over time while continuing to grow and improve their position. Words used to describe ideal activities may include "all the time", "in a broad range of contexts.

- **Developmental Practice**: Practitioners in this category are able to apply required skills and abilities, but in a more limited range of settings and contexts. Words used to describe developmental activities may include "some of the time", "somewhat inconsistently", and "in a limited range of contexts".

- **Unacceptable Practice**: Practitioners in this category are not able to implement required skills or abilities in any context. Unacceptable practice activity may include more than the absence or opposite of expected practice; it may indicate deficiencies in the implementation on a larger scale. Words used to describe unacceptable activities may include "none of the time" or "inconsistently."
Benefits of Practice Profiles

- Facilitate development of effective training protocols, coaching and supervision strategies, and fidelity assessments
- Promote continuous improvement strategies and data-driven decision making
- Increase the ability of the program or practice model to be replicated in new settings, with new staff, and in new contexts
- Refine organizational and systems supports that facilitate consistent, effective practice
- Ensure outcomes can be accurately interpreted

Credit: National Implementation Research Network (NIRN) [http://nirn.fpg.unc.edu/](http://nirn.fpg.unc.edu/)
Our Development Process

**September 2015**
- Reviewed MassHealth docs
- Identified Initial Core Components

**November 2015**
- Launching Meeting
- Refined Core Components
  
  **Jan – April 2016**
  - Created Full Practice Profile

**April - May 2016**
- Reviewed relevant research articles
  
  **June - August 2016**
  - Final review by Workgroup participants
  - Webinar
  - Focus groups with supervisors and clinicians /TTS staff, hosted by Workgroup participants
November 2015 Kick-Off Meeting

Dr. Allison Metz,
National Implementation Research Network

Participants: IHT program directors and supervisors, MCOs, Court Monitor, ABH

Purpose:
- Introduce the Practice Profile Approach
- Share the Initial Draft of Core Components
- Work in Small Groups to Revise the Initial Core Components
November 2015: Results & Insights

Initial Core Elements

1. Initial Engagement
2. Practicing Cultural Relevance
3. Creating a Team
4. Assessing Needs & Strengths
5. Care Planning
6. Care Coordination
7. Implementing a Care Plan
8. Engaging Natural Supports & Community Resources
9. Transition Planning

Revised Core Elements

1. Practicing Cultural Relevance
2. Engagement
3. Assessment & Clinical Understanding
4. Risk Assessment & Safety Planning
5. Collaborative Intervention Planning
6. Intensive Therapeutic Intervention
7. Care Coordination & Collaboration
8. Engaging Natural Supports & Community Resources
9. Preparing to Exit

- Too much focus on Care Coordination process, not enough attention to Treatment
- Need to draw a clearer distinction between IHT and ICC.
IHT Core Elements Workgroups

- 10 workgroup meetings from January -- April
- Stakeholders included providers, managed care reps, and court monitor
- 42 Participants attended at least one session
- Each session had 10 to 17 participants
- Drew upon practice experience of seasoned supervisors
Iterative Versions

**IDEAL PRACTICE**

- Fully informs family of the assessment process and purpose.
- Elicits each individual family member's impression of core concerns, including risk and safety, in their own words.
- Uses family member language in subsequent descriptions of needs and strengths.
- Attends to pace and timing of information-gathering when families feel overwhelmed.
- Within 24 hours, clinician completes a brief initial assessment with family input regarding needs and strengths, youth/family vision for their future, what helps, what gets in the way, and next steps to guide first stages of IHT intervention prior to comprehensive assessment.

**DEVELOPMENTAL PRACTICE**

- Discusses with some but not all key family members.
- Uses only clinical language without family-friendly language.
- Late or incomplete initial assessment.
- Leaves out family concerns, strengths, or expressed vision for future.
- Slanted toward provider view of what family "should" work on.

**UNACCEPTABLE PRACTICE**

- No youth voice and no attempt to initiate contact or discussion.
- Ignores family's concerns in favor of provider bias.
- No initial assessment.
- Relies solely on another provider's assessment.
- Ignores or weeds out important concerns due to lack of expertise of IHT team.

**Exploring needs, vision, history of help, and strengths**

- In gathering further information for comprehensive assessment, explores family members' perspectives on identified needs — what causes them, what keeps them going, what stressors make them worse.
- Invites family members to describe times in the past when needs were less acute and what was different.
- Invites discussion of why choose IHT at this time (why now?).

- Explores needs but not family perspective on context.
- Discusses with only a subset of family members or discusses only as a group.
- No follow-up to clarify how family thinks about needs; too superficial.
- Too narrow a scope for what might cause problems or distress.
- Looks at only limited range of possible stressors.
- Looks only at general or external stressors but not intergenerational issues.

- Lacks curiosity about family.
- Biased toward provider view of what causes problems; does not balance with family view.
- Exaggerates or minimizes challenges that family is experiencing.
- Assumes knowledge of stressors.
- Discusses stressors without acknowledging coping strategies.

- Invites family members to envision and describe a time in the future when their family is able to manage these challenges more effectively.
- Discusses this future-oriented vision as a way to

- Talks about discharge from IHT without linking to family vision.
- Alters vision to make it more "realistic" or "achievable."

- No discussion of future or discharge.
- Expresses pessimism, hopelessness about change.
- Generates vision without family endorsement.
Results & Insights

- High level of consensus about what constitutes quality IHT. Discussions often focused on how to describe it.

- The process benefitted from very knowledgeable and skilled practice leaders who have years of experience delivering and managing IHT services.

- Many themes repeat across the Practice Profile components and are inter-related.
Literature Review

- **Purpose:** To ensure Practice Profile is informed both by the practice-based evidence from the field and by evidence-based practice from academic research and best practice literature.

- **General Findings:**
  - Significant alignment between the literature and the practice-based evidence from the workgroup.
  - Literature did push us in a few places.
  - Literature still scant about some aspects of IHT.

- **Results:** Several additions made to the “rows”.

- **Product:** A summary report is available on CBH KC website.
Completing the Practice Profile

Final Review

• By all Workgroup participants
• Full Practice Profile including changes resulting from Literature Review
• Completed June 16
• Substantially endorsed by participants, with a few changes suggested

Focus Groups

• Focus Groups with Clinicians, Therapeutic Training & Support Practitioners, and Supervisors
• Each focus group will review and provide feedback on one core component
• Onsite focus groups at 16 provider sites (14 unique providers)
Moving from the WHAT to the HOW

Individual Competency Drivers
- On-line, on-demand training modules
- Practicing Cultural Relevance Self-Assessment
- Practical tools re: genograms, eco maps, meeting facilitation, safety checklist

Organizational Alignment & Support Drivers
- Cross-walk to billable activities and provide guidance
- Cross-walk with managed care review tools
- Review training requirements in program specifications

Leadership Drivers
- Ongoing stakeholder engagement
- Program-level change management

Credit: National Implementation Research Network (NIRN) http://nirn.fpg.unc.edu/
Next Steps

✓ IHT Practice Profile available on CBH KC website: http://www.cbhknowledge.center/ihtpp/

✓ Development of practical performance assessments for use by supervisors

✓ Work with area graduate schools to use the practice profile as a basis for pre-service training
Website

- Download the full version and/or each matrix individually
- Webinar recording and slides
- More to come….
  - One page dedicated to each core element
  - Supporting tools and resources

In-Home Therapy Practice Profile

In the fall of 2015, the Knowledge Center, in collaboration with MassHealth, began an extensive effort to develop a practice profile for In-Home Therapy (IHT). A practice profile as defined by the National Implementation Research Network (NIRN), is a tool for operationalizing the core elements of a program or practice. It breaks down large concepts such as “engagement” into discreet skills and activities that can be taught, learned, and observed. IHT is a critically important service used by many thousands of youth and families throughout the Commonwealth. Yet case reviews with the Massachusetts Practice Review (MPR) have indicated extensive opportunity for improvement in IHT. MassHealth and the Knowledge Center believe that IHT services could be improved if guided by a well specified, fully operationalized practice profile.

In November 2015, the CBH Knowledge Center convened a kick-off meeting with a group of stakeholders from across the state to orient them to the work of developing a practice profile. A series of ten additional
For More Information

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Intensive, In-home Child & Adolescent Psychiatric Service (IICAPS)

Joseph L. Woolston, M.D.
Albert J. Solnit Professor, Child Psychiatry and Pediatrics
Conflicts of Interest/Disclosures

• Woolston:
IICAPS Partnership

IICAPS Providers:
20 sites, statewide in CT

CT State agencies:
- DCF
- DSS

Families and Children

IICAPS Services:
- training
- credentialing
- quality assurance
- data evaluation

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What’s the clinical problem?

• Children, 4-18, who have serious, persistent, multi-domain, behavioral & emotional disturbances

• Who display behaviors that are dangerous to self & others causing high risk for requiring institutional based care

• Who have frequent & multiple “co-morbidities”: Axes I, II, III
But these children aren’t in isolation
They live in microsystems that have compromised functioning at multiple levels
So the clinical problem also consists of the entire microsystem
Parental stress

Out of Control behavior

Child emotional & behavioral problems

Institutional service use

Traumatization

Mal-treatment

Problematic social environ.

Problematic school environ.

Ineffective parenting

Parental coping problems

Parental Hx Child Maltx

ICE

Main Problem

Ohio Scales

SUQ

Ohio Scales
IICAPS

- Intensive, in-home, relationship based, ecologically & family focused
- 2 person clinical team treats 8 families
- 3-4 teams in weekly Rounds co-led by CAP & senior mental health clinician
- Weekly team supervision: 15 min/case
- Manualized: Tools, Domains, Phases
- Funding: Medicaid, fee-for-service
IICAPS Service Provision

• Team provides each family approximately 5 hours/week of direct and indirect services
• Average max. LOS= ~6 months
• Services are provided wherever indicated to maximize engagement & improvement in microsystem functioning
• Documentation structures are Medicaid compliant
Growth of the IICAPS Network

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Closed Cases</th>
<th># IICAPS Teams</th>
<th># IICAPS Sites</th>
</tr>
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<tbody>
<tr>
<td>2007</td>
<td>372</td>
<td>14</td>
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<td>579</td>
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<td>2015</td>
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<td>127</td>
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</tbody>
</table>
IICAPS Interventions

- Child Emotional & Behavioral Problems
- Out of Control Behavior
- Institutional Service Use
- Parental Stress
- Parenting skills & practices
- Environmental Stressors
- Psychiatric Evaluation & Treatment
- Mobile Crisis Intervention
- Intensive Care Management
- Problem Solving Training
- Parenting Skill Building
- Problem Solving Training

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IICAPS Network: Outcomes

Cases Closed between July 1, 2009-June 30, 2015 (FYs 09/10, 10/11, 11/12, 12/13, 13/14, 14/15)

N=13,709

Tx Completers (n=9,477; 69.1%)

Non-completers (n=4,232; 30.9%)
IICAPS Outcomes Measures

Ohio Scales: Problem Severity & Functioning Domains

Environmental Stressors

Main Problem Rating

Service Utilization Questionnaire (SUQ)

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Ohio Problem Severity:
Paired T-test, IICAPS Intake and Discharge
(Treatment Completers; N=9,477)

Proportional Decrease, Parent Report: 37.8% (p<.0001)
Proportional Decrease, Youth Report: 35.6% (p<.0001)
Proportional Decrease, Worker Report: 35.6% (p<.0001)
Ohio Child Functioning: Paired T-test, IICAPS Intake and Discharge (Treatment Completers; N=9,477)

Proportional Increase, Parent Report: 23.8% (p<.0001)
Proportional Increase, Youth Report: 11.4% (p<.0001)
Proportional Increase, Worker Report: 26.5% (p<.0001)
Main Problem Ratings & Scores

Defining Main Problem: co-construction of description of behavior that puts child at risk for requiring institutional treatment

Rating Main Problem: 10 point scale with behavioral anchor points ranging from:

1 - Imminent risk of injury to self or others/gravely disturbed

to:

10 - No disturbance
Main Problem Rating: Paired T-test Results Measured at IICAPS Intake and Discharge

Mean Difference, Treatment Completers: 3.5 pts. (p<.0001)
Mean Difference, Non-completers: 0.88 pts. (p<.0001)
Service Utilization Data

• Service Utilization Questionnaire (SUQ): created by the IICAPS developers

• Parent report; excellent validity when compared to claims payment data

• Administered at Intake to collect data on service utilization during the 6 months prior to IICAPS Intake

• Administered at Discharge to collect data on service utilization during the period of the IICAPS Intervention (time variable)
Service Utilization Data: Number of Patients with a Treatment Event

Proportional Decrease, Pts w/Psych Inpatient Admission: 40.7%
Proportional Decrease, Pts w/ED Visit: 29.1%
Service Utilization Data: Total Days of Psychiatric Inpatient Stay

Proportional Decrease, Days of Psychiatric Inpatient Stay: 67.2%

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Family Health & Development Project

- RCT required by State partners for continued Medicaid rehab. funding
- 1’ outcome required: stat. sig. ↓ in psych. hosp. utilization v. contrast condition
- To be completed within 5 years; no funding support
- Sig. resistance by referral providers led to selective withdrawals; slow enrollment
Methods

• Single site study conducted in New Haven from 2011 through 2015
• Children and families identified among referrals to Yale IICAPS program
• Children and families randomized to IICAPS (n=53) or to Home-based Child Treatment Coordination (HBCT) (n=56)
Measures

- Child and family demographic characteristics
- Child out of control behavior and behavioral health symptoms [*CBCL, TRF, R-MOAS, CASI/CSI/ASI*]
- Parent/Caregiver parenting practices, problem solving, parental perception [*APQ, Problem Solving subscale of FAD, PCS*]
- Parent/Caregiver behavioral health symptoms [*BSI*]
- Child mental health service use [*SUQ*]
- Child school attendance, including days missed due to suspensions and expulsions [*SUQ*]
Other Data Sources

- Medicaid claims data
- Hospital discharge summaries
- School data
- Teacher data
Methods

• Parent/caregiver interviewed in home:
  – baseline/enrollment,
  – end of study treatment (approx. 6 months post-baseline),
  – 12 months post-baseline

• Brief monthly phone interviews to:
  – Aid in keeping participants engaged
  – Collect some behavior and mental health services data
FHDP Findings

• Sig. decreases in hos. utilization
  – in BOTH treatment arms (IICAPS> HBCT)
  – but NO stat. sig. differential treatment effect

on TRF & school suspensions during tx.
AND 6 mos. f/u

• 11 HBCTC (20%) sample lost to hospital utilization data collection 2’ withdrawal
IICAPS Summary: 7 years of experience

- Stat. & clin. significant **improvements** in:
  - Ohio Symptom Severity
  - Ohio Functioning
  - Main Problem rating

- Stat. & clin. significant **decreases** in:
  - Psychiatric hospitalization admissions and days
  - ED visits for psychiatric reasons

- RCT: sig. reduction in externalizing behaviors but no tx effect re. hospitalization