

Intensive In-home Services for Children's Mental Health in Virginia: Time to Focus on Quality

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Introduction

As part of a move away from institutional care, policy makers in Virginia have emphasized intensive in-home services (IIHS) for children with serious mental and behavioral health care needs. Intensive in-home services are viewed as more humane, more cost effective, and more developmentally appropriate than institutional care. Children served with intensive in-home services include:

- children at risk of foster care placement due to mental health or behavioral issues;
- foster children at risk of not being able to stay in their foster homes due to mental health or behavioral issues;
- children who risk not being able to stay in their homes due to mental health or behavioral issues, and
- children with court involvement due to behavior issues.

Intensive in-home services can take a variety of forms but are described in a general way within Virginia state government as time-limited interventions by a qualified provider that take place in a child's home to prevent an imminent out of home placement¹.

Experts in mental health treatment, however, emphasize more specific aspects of intensive in-home services including the importance of using evidence or research-based intervention programs.² Other important factors include:

- clear goals (or outcomes) for the intervention based on assessment of the child's presenting problems, the child's diagnosis and history, the family's dynamics, strengths and vulnerabilities;
- treatment plans developed in full partnership with the family that address the specific challenges placing the child at risk for out of home placement;
- an intervention team of experienced, educated, and highly skilled staff that can develop rapport with youth and members of family, sustain the hope of the family;
- small case-loads (2-4 children per worker);
- 24-hour availability of staff to work with the child and their family or guardian in the child's home; and

¹ Department of Medical Assistance Services web site, May 2010 training power point presentation on Intensive In-Home Services.

² Interview with Dr. Richard Barth, School of Social Work, University of Maryland, November 21, 2011 and personal correspondence with Dr. Bethany Lee, and Friday, January 20, 2012

- quick assessment and service initiation for the child and his or her family.

Experts also presume a robust system of community services and supports (a continuum of services) accessible to the youth and his or her family during and after the service.

For a five-year period, intensive in-home services were fairly easy to access for Medicaid eligible youth, particularly compared to other mental health services such as outpatient therapy, which can often have long waiting lists. Minimal licensing regulations and rather porous authorization procedures resulted in a rapid proliferation of providers (particularly for-profit providers). Families desperate for some kind of help for their child found the state and local system difficult if not impossible to navigate. Entrepreneurial providers walked families through the bureaucratic maze and were able to provide services; in effect, they ushered families through doors that the families did not know existed. These developments increased access but did not ensure quality service provision, resulting in a rapid increase in public dollars spent on services of uneven quality.

Although intensive in-home service availability expanded (along with the attendant increase in expenditures), it was not accompanied by robust provider reimbursement.³ In fact, the hourly rate was cut in 2010 from \$70/unit to \$60/unit, causing a number of highly regarded intensive in-home service providers to shift away from the service because the rate no longer covered expenses. Intensive in-home services are expensive services to staff when using experienced and effective personnel (24 hour, 365 days a year availability). In addition, state Medicaid policies were more restrictive than other funding sources about what constituted reimbursable IHHS services. For example, State Medicaid coverage did not include family therapy designed to improve family dynamics that might impact the child's wellbeing or any type of mentoring services for the child.

While Virginia's effort to devote more resources to intensive in-home services is laudable, increased attention to the **quality** of services being provided is essential. Simultaneously, the state must also develop a more robust **array of community-based services** to meet the needs of children with mental health disorders -- IHHS is not the only community-based service children need, and a lack of effective alternatives has led to an overreliance on this one type of intervention. Funds saved from reductions in IHHS and other high-intensity and costly services should be reinvested to develop a more complete service array. In addition, it is important to develop needed administrative and managerial infrastructure informed by **outcome measures**

³ IHHS is not the only service confronted with the reimbursement rate issue; Medicaid providers of most service types have had their reimbursement rates reduced due to the state budget crisis.

on the wellbeing of youth (and their families) served. Finally, Virginia must **balance** cost containment and quality improvement efforts.

Case Study

The following is one example of a child who benefitted from intensive in-home services, taken from the 2011 Annual Report of the Virginia Association of Community Services Boards.

Patty was 17 years old when she was referred to Henrico Area Mental Health and Developmental Services (HAMHDS). At the time, she was on probation with what seemed like little hope of turning things around. Patty was habitually truant from school and failing and she frequently ran away. She was also suicidal, which resulted in four psychiatric hospital stays. Issues with illegal drugs culminated in arrest and probation.

Patty received outpatient services on a weekly basis; however, her out-of-control behaviors continued, and she was at significant risk of an out-of-home placement. In November of 2010, Patty began receiving intensive in-home services for several hours a week. She developed a strong relationship with her therapist and her medications were monitored. She ceased to make attempts on her life and developed a brighter outlook. Patty started going to school on a regular basis and completing her work, which raised her grades and gained recognition for her efforts from her teachers. Many of those same teachers have written letters to Patty's parole officer and judge on her behalf.

Her parole officer also advocates for her, citing her compliance with rules and willingness to accept responsibility. Today, Patty is a much happier young woman and plans to finish high school. She has friends her own age who encourage positive activities as opposed to negative activities. Patty has since stepped down from intensive in-home services and is currently receiving outpatient therapy from HAMHDS.

Best Practices for Intensive In-Home Services

What does a good IHHS look like? There are a number of models used in various parts of the country with proven records of success. Homebuilders, Functional Family Therapy, Milwaukee Wrap-Around, and IICAPS are among these evidence or research-based models.⁴ For the most part, these models have been developed as a result of academic research, often are proprietary, and are designed to be delivered according to specific protocols. Typically, clinicians will attend an initial training offered as continuing education credits and then a specific region or jurisdiction will decide to put in place the model and its attendant administrative and managerial supports to ensure fidelity to the model. The commitment to a particular model involves on-going training of staff and adoption of required administrative and

⁴ See for example, SAMHSA's National Registry of Evidence-Based Programs and Practices (<http://www.nrepp.samhsa.gov>).

managerial supports to ensure fidelity to the model. Adopting such a model is a substantial commitment in terms of time, cost, and organizational culture.

Family Engagement and Advocacy

In addition to evaluation research looking at the effectiveness of specific IHS models, research currently being conducted suggests common elements among these programs that are the keys to their success.⁵ The presence or absence of these components and factors would be a starting point for evaluating if a program was likely to be effective. One component that the research is showing is the importance of fully engaging parent support and increasing parent skills. This includes teaching parents skills such as how to monitor their child's medications and communicate effectively with the child's psychiatrist regarding medication impact, how to advocate for their child with school personnel, and how to voice their concerns when the IHS is not meeting the expected outcomes.

Qualified Staff

While some IHS providers staff their service with entry level personnel and contract out supervision to an off-site licensed or license-eligible supervisor, effective IHS are staffed by a team of experienced, educated, and highly skilled staff. Entry level staff typically lack the requisite skills or judgment to work independently with youths (or their families) in crisis. Their on-going supervision by highly qualified master's level in-house supervisors is essential. As mentioned earlier, successful IHS consist of an intervention team of experienced and educated staff who can bring to the youth and his or her family in crisis:

- case-management skills;
- an understanding of family systems and how to develop interactions that foster the health of the child;
- therapeutic techniques needed by the youth and his or her family and in teaching the family skills they need to help their child;
- clinical skills in medication monitoring; and
- knowledge of community resources and support networks.

Members of the team need to have documented, demonstrated competencies in treatments specific to the needs of the child being served and skill in educating parents/guardians in the specific ways to help their child. For example, youth with emotional regulation problems need IHS providers who know how to teach strategies such as collaborative problem solving. Youth with substance abuse problems need providers with skills in motivational interviewing; children

⁵ Interview with Dr. Richard Barth, School of Social Work, University of Maryland, November 21, 2011 and personal correspondence with Dr. Bethany Lee, and Friday, January 20, 2012

who have witnessed violence need providers who know how to treat post-traumatic stress disorder. In addition, IIHS staff need clinical familiarity with medication issues that may be impacting the child.

Finally, successful IIHS clinicians are knowledgeable about the communities where the youth they are serving live. They coordinate with other systems impacting the child and his or her family and can show the family how to use these available supports and services.

Three Phases of Treatment

The IICAPS Program is one commonly cited research-based model. It was developed at Yale University and centers on three phases of treatment: (i) the engagement and assessment phase, which ends with development of a treatment plan, (ii) the work and action phase, which ends with accomplishment of the goals of the treatment plan, and (iii) the ending and wrap-up phase, which develops discharge recommendations. In assessing the child, four domains of strengths and vulnerabilities are examined: the child himself, the family, the school, and the physical environment. Treatment is carried out in a team approach, termed the “treatment alliance.” Treatment is refined using tools including the inventory of strengths and weaknesses, an eco-domain map, the treatment plan, and treatment progress updates. This is not a one-time refinement; it is an ongoing process.⁶

The engagement phase is important to ensure that the therapist working with the child and family are a good match, keeping in mind that family engagement is a critical piece of IIHS. Discharge plans are also important, because children need on-going supports due to the episodic nature of their illness. Often, the first and last phases of the service are given short-shrift, reducing the effectiveness of treatment.

Different research-based models may work better for different populations of children served under Virginia’s broad definition of IIHS, illustrating the need in Virginia for a clearer understanding of specific types of services and providers. A child who has experienced abuse and neglect would have needs quite different from a child in a more supportive home setting. The IICAPS Program, for example, cautions that the program may not be appropriate for children with serious psychiatric conditions.

Regardless of a child’s situation, intensive in-home services are only part of the treatment equation. The child is likely to need other types of mental health services (e.g. medication management by a trained child psychiatrist), many of which are not readily obtainable within

⁶ Joseph Woolston, “Strategies for Fidelity to IICAPS Model: Approaches at Multiple System Levels,” presented at 17th Annual RTC Conference, Tampa FL, 2/29-3/3, 2004.

Virginia's current mental health system. Thus, the lack of availability of an array of available mental health services impacts the overall effectiveness of IIHS.

Trends Leading to IIHS Expansion

Fewer Public Hospital Beds

Like many states, Virginia has been engaged in a decades-long effort to reduce its dependence on institutions for treating people of all ages with mental health conditions. That said, the state has always had fewer institutions for children than for adults. The only remaining state run psychiatric hospital for children is the 48-bed Commonwealth Center for Children and Adolescents in Staunton. The adolescent unit of Southwestern Virginia Mental Health Institute in Marion was closed for budget reasons during the Kaine administration, which had also unsuccessfully proposed closing the Commonwealth Center.

Focus on Community-Based Care

With regard to children's mental health, the passage of the Comprehensive Services Act (CSA) a generation ago was a watershed in efforts to both reduce dependence on institutional care and to combine disparate streams of funding to meet the needs of at-risk children. CSA was an early recognition of the decades of research showing that leaving children with their families and in their communities improves their outcomes and reduces stigmatization. From its passage, CSA became a major funding source for children's mental health and other services; however, the rapid growth of both state and local expenditures for CSA has prompted repeated efforts at cost containment. Over time, as state institutions downsized children were increasingly sent to private providers of residential services.

The cost (\$100,000 a year plus) of some of these providers prompted interest in alternative treatments. One recent effort to reduce the use of residential treatment has been the Children's Services Transformation during the Kaine administration, which focused on reducing Virginia's high rates of congregate care, particularly for foster children. Intensive in-home services were identified as a more cost effective and more humane alternative.

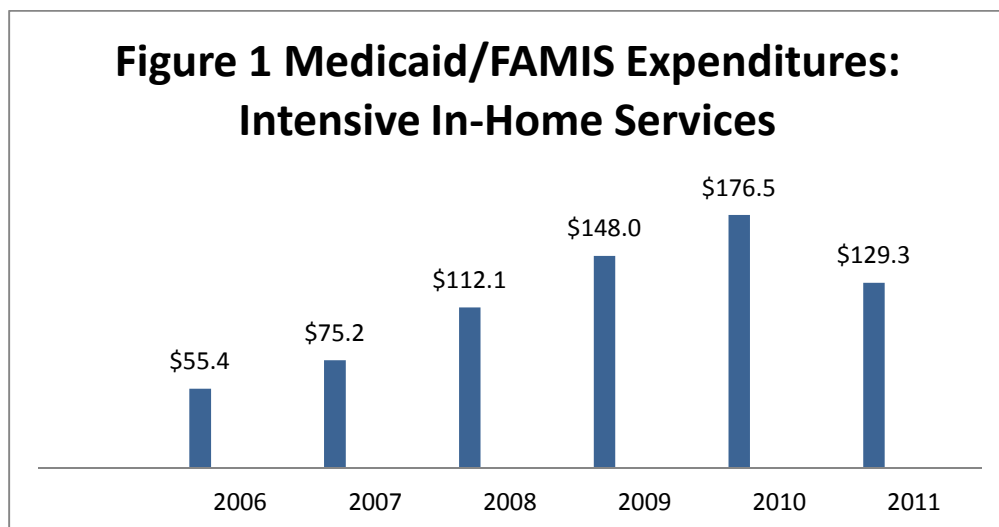
CSA has a ready-made infrastructure for examining the needs of individual children and the effectiveness of the services that they received: the local family assessment and planning teams (FAPT) that serve as case managers under CSA. CSA offers flexibility in services and a structure for case management, but its resources are heavily weighted towards mandated children, including those in foster care and certain children in special education. Non-mandated children faced a much more difficult time accessing any CSA services at all. As CSA expenditures

created growing budget pressure on state and local governments, the program's services were increasingly limited to mandated children.

Expanded Use of Medicaid

At the same time CSA investments in children's mental health were growing, so too were Medicaid expenditures for children. Medicaid became more involved for three primary reasons. The first was the passage of the State Children's Health Insurance Program (SCHIP) in 1996 and the corresponding state legislation creating the Virginia Families Access to Medical Health Insurance Security (FAMIS). This legislation brought access to state-funded health insurance for children up to 200 percent of the federal poverty level. Second, during the early 2000's, the state began to aggressively seek out Medicaid or SCHIP-eligible children who were not enrolled through extensive outreach and simplified application procedures (Virginia recently was awarded a \$26 million performance bonus for its strong efforts in enrolling eligible children). Third, during the recent budget crisis prompted by the weak economy, the state redoubled its efforts to shift costs wherever possible to Medicaid (where the federal government pays approximately half the cost) and away from the state general fund, which together with a local government match, funds CSA.

Virginia Medicaid expenditures on IHS increased from \$55.4 million in FY 2006 to \$176.5 million in 2010, an increase of 219 percent during a period in which the state was undergoing significant budget pressure (Figure 1). Expenditures moderated to \$129.3 million in FY 2011, but these are still more than double the FY 2005 expenditures.



Source: Department of Medical Assistance Services email dated 1/24/12.

Recent Attempts to Control IHS Expenditures

As Medicaid expenditures for children's mental health care increased significantly, there was a growing perception (borne out in interviews Voices recently conducted with key stakeholders) that the services were of uneven quality. Several interviewees used stronger terminology, expressing concerns about poor quality of some providers. This perception is validated by a news article several months ago about the indictment of a former in-home provider in Richmond, charged with defrauding Medicaid of \$1.5 million by billing for services provided by unqualified workers and to children who did not have mental health problems.⁷

Virginia Independent Clinical Assessment Program

As directed by the 2011 General Assembly, in the summer of 2011 Virginia Medicaid took its first step to screen for the appropriateness of intensive in-home services. The Virginia Independent Clinical Assessment Program (VICAP) was established to provide, as its name implies, independent clinical assessments for Medicaid-funded Intensive in-home services.⁸ Prior to this program, vendors themselves – whether public or private – were tasked with assessing all children and adolescents prior to providing them with the services offered by the vendor. This obviously created an inherent conflict of interest in conducting the screening.

Under VICAP, assessments are conducted by a licensed mental health provider or a license-eligible clinician either employed by or contracted by the community services board. Components of the assessment include: determination of the presenting problem, prior mental health treatment, family composition, developmental history, educational status, living situation, legal issues, substance abuse concerns, resources available, and strengths of the family. The assessment is completed with the guardian and child in a face-to-face interview. The clinician may recommend any of the following: no service, case management, intensive in-home services, mental health support services, psychiatric services, therapeutic day treatment, outpatient therapy, or other community services as needed.

Early results from the VICAP program suggest that approximately 20 percent of cases screened do not require intensive in-home services (though less intensive services may be appropriate). It should be emphasized that VICAP is not meant to deny services altogether, simply to determine if the more extensive (and therefore more expensive) services are needed. Opponents of the new assessment system argue that VICAP is a barrier to services.

⁷ *Richmond Times-Dispatch*, "Former Richmond pastor indicted in Medicaid fraud," March 21, 2012.

⁸ VICAPs are also necessary when other Medicaid-funded services such as Therapeutic Day Treatment Services, Mental Health Support Services (MCSS) are being considered.

Coordinated Care for Medicaid Behavioral Health Services

The 2011 General Assembly also directed DMAS to develop a coordinated care system for all services and populations currently managed through the fee-for-service system by July 2012. The procurement process is currently stalled, but this directive means that community-based behavioral health services for children and adults—including IHS and the VICAP process—will be under a managed care system soon. At a recent board meeting DMAS noted that “because of many recent changes in the administration of Medicaid community mental health services and the uncertainty of their affect (sic) on utilization, among other concerns, DMAS is currently developing an RFP for an Administrative Services Organization (ASO) to coordinate these services.” The ASO model will be used for the first three years of the contract; it is then believed the state will move to a full-risk model of care coordination to generate additional savings. The RFP was released December 2011 and was expected to be implemented by the start of the next state fiscal year on July 1, 2012. DMAS is projecting general fund savings of \$16.9 million per year from this care coordination approach by 2014, and a total Medicaid savings of nearly \$34 million for Medicaid behavioral health care generally (not just children) when the federal match is considered.

How care will be coordinated for children with mental health disorders and how their needs will be assessed remains to be seen. A key concern for children’s mental health advocates is that efforts to control the use of intensive in-home services and other community supports not primarily be driven by the desire to save money. As noted earlier, saving money should be the by-product, not the primary objective, of a well-run system of care that helps match the needs of each eligible child to appropriate, quality services, and effective services. These savings could then be re-invested in other parts of the under-funded children’s mental health system in Virginia. For example, there are critical shortages of acute care beds, trained providers, and case management services for families, as well as shortages of less intensive community resources generally.

Several states, including Kansas, Michigan, and New York have developed home and community based waiver programs for children with emotional disturbances (the umbrella term used in federal special education law for children with behavioral health care needs). A waiver may be a means for the state to refocus existing levels of funding towards a more comprehensive array of services for at-risk children, rather than putting disproportionate resources in one type of services.

Recommendations

1. Improve Consistency and Quality of In-Home Services

- **Develop Virginia’s Practice Models**

One of the most lacking aspects of quality mental health services in Virginia up to this point has been the lack of practice models, or templates, for the required qualifications and expected elements of various treatment modalities. Medicaid regulations have tended to provide the de facto model, but should really be seen as the minimum requirements rather than the ideal model. While there are no one size fits all approaches to intensive in-home services, a coalition of providers produced recommendations in 2011 regarding recommended changes in intensive in-home services (as well as therapeutic day treatment).⁹ These recommendations emphasized the need for:

- appropriate rates;
- models that are more clinically stringent;
- a phased approach to implement the recommended practice models; and
- development of a new hybrid “wrap-around” service model that meet the needs of the least clinically compromised children as part of a continuum of care that includes less intensive services than those currently offered.

- **Replicate existing models of excellence.**

Virginia already has models in place that are worthy of duplication. The current approach taken in Lynchburg is one example:

In Lynchburg, the local community services board (Central Virginia Community Services) has incorporated outcome measures into its intensive in-home services. Lynchburg’s program also works to closely match the needs and background of the child receiving services to the services that are provided. Staff is trained in multiple evidenced based modalities and use as appropriate. To illustrate, a child that has experienced a traumatic incident (such as witnessing domestic violence) is paired with a provider who has expertise in trauma-focused care. Similarly, a child in a home with a substance abuse issue will be paired with a provider who has experience in coping with substance abuse. Lynchburg provides close supervision to ensure that services delivered are related to therapeutic goals, uses supervisors who are licensed clinical supervision providers,

⁹ Beth Rafferty, et. al., “Recommended Practice Models for IIH & TDT,” unpublished draft, Fall 2011, prepared for a coalition consisting of the Virginia Association of Community Services Boards, the Association of Community Based Providers, the Virginia Coalition of Private Provider Associations, and the Virginia Network of Private Providers.

incorporates providers into multi-disciplinary treatment teams, and (at least informally) screens providers to ensure that they are of high quality. Additionally, there is a solid base of community supports which can be utilized. Strong relationships have been built with each of the several school districts served by CVCS so that a child receiving intensive in-home services gets the support they need from school when they have issues there. Moreover, work with the parents/guardian of the child includes education in effective ways of communicating and disciplining their child. It includes advocacy for their child, for example within the school disciplinary process or IEP. In addition, parents/guardians are invited to join in regularly meeting parents groups. Finally, resources from local non-profits and faith-based organizations are identified to meet the needs deemed vital to the well-being of the child.

2. Develop a more robust array of services to reduce over-reliance on IIHS

- Development of a more robust array should be in the context of a more coherent service delivery model that reduces fragmentation at the local level.
- Ensure that consumer care is based upon a comprehensive clinical assessment and an appropriate array of services for the population to be served, including making sure that treatment interventions are research based, delivered by well-trained providers, and appropriate to the needs of the child.
- Increase emphasis on key building blocks of a quality system: case management, building on strengths of families and the needs of the child, and a treatment team approach.
- Re-invest savings from appropriate utilization of intensive in-home services to other critical priorities for children's mental health, including developing a full array of services and training additional providers.
- Consider a Medicaid waiver for children with emotional disturbances that would provide for a more comprehensive set of services for children currently eligible for intensive in-home services. This could conceivably be accomplished within the current level of expenditures by more appropriately matching the services to the needs of the child.

3. Develop administrative structure informed by outcome measures on well-being of youth served.

- Collect necessary outcome data to ensure that these critical intensive in-home services are delivered by a clinically competent organization with appropriate medical oversight and the ability to help the child and their family access a robust array of appropriate, culturally sensitive services.

4. Ensure access to services through transition to care coordination.

- Support the Department of Medical Assistance Services close collaboration with children's mental health stakeholders as they roll out the Administrative Services Organization to ensure that access to appropriate services is not compromised by efforts to reduce expenditures.

Sources and Persons Interviewed

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Dr. Les Saltzberg, Department of Behavioral Health and Developmental Services

Bob Allin, Program Manager Child-Adolescent Services Team (CAST) and Doug Biliski, CAST Clinical Supervisor, Chesterfield Community Services Board

Mary Ann Bergeron, Executive Director, Virginia Association of Community Services Boards

Laura Easter, PHD, Director of Community Services, Elk Hill

Sandy Bryant, Director, Central Virginia Community Services, Lynchburg

Anne Holton, Annie E. Casey Foundation, Child Welfare Strategy Group Consultant

Beth Rafferty, Director, Mental Health Services, Richmond Behavioral Health Authority

Greg Peters, Executive Director United Methodist Family Services

The Reverend Melissa Hays-Smith, LCSW, Family Services of Roanoke Valley

Dr. Richard Barth, Director of the School of Social Work, University of Maryland.

Steve Harms, retired Deputy Chief of Staff for Governor Kaine, former Deputy Secretary of Health and Human Resources for Governor Warner, former Senate Finance Committee staffer for Health and Human Services

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