



In-Home Behavioral Services (IHBS)

Practice Guidelines

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Purpose of In-Home Behavioral Services Practice Guidelines

These guidelines outline best practices for the provision of In-Home Behavioral Services (IHBS), which all IHBS providers should strive to implement. The guidelines describe what IHBS should look like in practice: They are intended to provide guidance for IHBS providers and providers of other behavioral health services and for families. The guidelines describe how IHBS works according to youth- and family-centered practices, beliefs, and quality services consistent with the CBHI mission, values, vision, and strategic priorities.

The guidelines describe how services **should** be delivered in order to be most effective. In addition, IHBS is governed by documents that govern what IHBS **must** do: performance specifications, medical necessity criteria, and provider contracts with MassHealth's Managed-Care Entities (MCE). Many documents referenced throughout the manual are found in the *Appendices* of this manual and are available as a resource to providers in the CBHI section of the Massachusetts Behavioral Health Partnership (MBHP) website at www.masspartnership.com.

Additional CBHI resources such as links to training materials can also be found in the *Appendices*.

IHBS is part of an array of MassHealth behavioral health services, which include CBHI home- and community-based services. A brief description of CBHI services can be found in [Appendix A](#).

The Children's Behavioral Health Initiative (CBHI)

Mission

CBHI is an interagency initiative of the Commonwealth of Massachusetts Executive Office of Health and Human Services, whose mission is to strengthen, expand, and integrate state services into a comprehensive, evidenced-based, community-based system of care to ensure that families and children with significant behavioral, emotional, and mental health needs obtain the services necessary for success in home, school, community, and throughout life.

Values (System of Care Philosophy)

- **Child-Centered and Family-Driven:** Services are driven by the needs and preferences of the child and family, developed in partnership with families, and accountable to families.
- **Strengths-Based:** Services are built on the strengths of the family and their community.

- Culturally Responsive: Services are responsive to the family’s values, beliefs, and norms, and to the socioeconomic and cultural context.
- Collaborative and Integrated: Services are integrated across child-serving agencies and programs.
- Continuously Improving: Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence-based practices, and best practice.

Vision

CBHI places the family and child at the center of our service-delivery system and builds an integrated system of behavioral health services that meets the individual needs of the child and family. Policies, financing, management, and delivery of publicly funded behavioral health services will be integrated to make it easier for families to find and access appropriate services and to ensure that families feel welcomed and respected, and receive services that meet their needs, as defined by the family.

Strategic Priorities

- Increase timely access to appropriate services.
- Expand array of community-based services.
- Reduce health disparities.
- Promote best clinical evidenced-based practice and innovation.
- Establish an integrated behavioral health system across state agencies.
- Strengthen, expand, and diversify workforce.
- Strive for mutual accountability, transparency, and continuous quality improvement using data-based decision making.

Overview of In-Home Behavioral Services

In-Home Behavioral Services (IHBS) are part of the array of CBHI services that families can access through a CBHI “hub.” The hubs are Outpatient Treatment, In-Home Therapy, and Intensive Care Coordination.¹

Eligibility

Any Medicaid-eligible youth who meets established medical necessity criteria can receive IHBS.² There is no requirement that youth have a “serious emotional disturbance” in order to receive this service, nor is the service reserved for youth whose behavioral challenges arise solely from developmental disabilities. Rather, IHBS has been designed with the clinical flexibility to offer highly individualized behavioral support services to youth with a broad array of emotional and developmental conditions, including those with co-morbid diagnoses.

IHBS is appropriate when specialty skills or additional clinical expertise are needed in applying behavioral principles, or when less specialized services and strategies have not been effective. Sometimes it is difficult, for example, to determine the cues that set off a problem behavior or the re-enforcers that keep it going. Sometimes the obvious interventions are unacceptable, such as ignoring a problem behavior when it is seriously disruptive or dangerous. Sometimes it is hard to know which of many behaviors to address first, or how to measure the behavior in a way that allows a provider to track progress. Sometimes the ongoing treatment team has so many other family needs to address that it makes sense to include a behavioral specialist to work with caregivers around behavior support. These are just a few examples of situations where IHBS may meet the child’s medical need, making a referral to IHBS appropriate.

Note that IHBS need not supplant or replace other forms of treatment. Rather, the IHBS team’s clinical expertise and data collection should enhance the quality and effectiveness of ongoing treatment while serving as a valued consultant to the hub provider or Individual Care Planning Team (CPT).

¹ As noted below, there are times when IHBS can occur without one of the hubs listed here. These instances require a “hub waiver” from the member’s managed-care entity (MCE).

² These medical necessity criteria can be found online at <http://www.mass.gov/eohhs/docs/masshealth/cbhi/mnc-in-home-behavioral-services.pdf> and as [Appendix E](#) to these guidelines.

Components of Service Delivery

IHBS is usually delivered by two staff members working together as a team. The Behavior Therapist (BT) is responsible for the following tasks.³

- Overseeing the initial assessment process and gathering pertinent background information, including the hub provider's comprehensive assessment
- Conducting the functional behavioral assessment and examining the nature, frequency, and precipitants of behavior across multiple settings
- Developing the initial Behavior Support Plan in conjunction with the youth and family
- Overseeing implementation of the plan, measuring the effectiveness of identified behavior change strategies, and proposing modifications as needed

The Behavior Support Monitor (BSM) is supervised by and works closely with the Behavior Therapist (BT). The monitor may play a number of important roles, including the following.

- Modeling behavior-support strategies
- Observing and supporting families as they employ these strategies
- Gathering data for use by the therapist and team
- Providing feedback on parental engagement and implementation of the behavioral plan

The Behavior Therapist has a master's or doctoral degree. The BST must be supervised by a licensed clinician. The Behavior Support Monitor (BSM) has a bachelor or associate's degree and appropriate training in implementation of behavior support strategies. (See "Performance Specifications" for details.)

The work of the IHBS team should be family-driven and youth-guided, strengths-based, culturally responsive, collaborative, and continuously improving. Individuals in both roles must understand the IHBS service and its foundations in Applied Behavioral Analysis (ABA) and Positive Behavior Support (PBS); demonstrate the ability to listen to and work with youth and family members; build collaborative relationships with other treatment providers; and modify practice in a way that reflects family culture. The science of behavioral change is centrally driven by the analysis and monitoring of data. Gathering baseline data at the point of assessment and throughout implementation of the Behavioral Support Plan is essential for the effective delivery of IHBS. Data-

³ While the performance specifications and medical necessity criteria refer to Behavior Management Therapist and Behavior Management Monitor, the IHBS guidelines reflect the Positive Behavior Support (PBS) approach that seeks to support the child, rather than simply manage the behavior. We encourage use of the newer terminology as found in these guidelines.

gathering activities, including the functional behavioral assessment, can also assist families, educators, and other treatment providers in understanding the factors that influence problem behaviors and in objectively measuring progress over time.

A central goal of IHBS is to identify and reduce the incidence of behaviors that negatively affect a youth's quality of life and his or her availability for learning. By working collaboratively with professionals in community and educational settings, IHBS can collect valuable data and promote the use of consistent treatment interventions. In so doing, IHBS assists youth in generalizing and applying new skills across environments. When an IHBS provider models how to track and analyze data, other providers on the team can sharpen their own skills for measuring and thinking about behavior.

Gathering and understanding data can be a challenge for family members, especially when they do not fully understand the reasons for these activities. Devising data-gathering strategies that match the needs and strengths of the family and that can be employed by other professional and natural supports is critical to providing behavior therapy within a CBHI framework.

Clinical Vignette: Sophie

Sophie, age 7, lives with her mother. She has no siblings and her father is not available. She has experienced many transitions and losses in her short life and has had multiple psychiatric diagnoses, including ADHD, bipolar disorder, and PTSD. Sophie is highly impulsive and active. When frustrated, she becomes physically aggressive with her mother and has daily tantrums that can last an hour. During these tantrums, she can "tear the room up," according to her mother. Sophie has a disturbed sleep schedule and often has late-night tantrums, so that both Sophie and her mother are chronically overtired. Sophie is unsafe in the car: she unfastens her seatbelt while her mother is driving and throws her toys into the front seat. Her mother worries that Sophie could open a door. Sophie's behaviors are so hard to manage that she and her mother rarely go out together, with the exception of transporting Sophie to school. While Sophie's behavior at school is not quite as explosive as at home, her impulsivity and inability to follow instructions or comply with requests results in her being sent repeatedly to the principal's office and sometimes sent home. She usually is not permitted to participate in school field trips due to her disruptive behavior. Mother and daughter spend long, uninterrupted stretches of time together in increasing isolation. Sophie's mother is feeling increasingly hopeless, angry, and negative about Sophie and about herself as a parent.

A bright spot for the family has been connecting with the local Community Service Agency (CSA) through a referral from Sophie's school. Sophie's Intensive Care Coordinator (ICC) and Family Partner create a very strong relationship with Sophie's mother and have been effective in developing a plan that addresses her need for emotional support around parenting. Nevertheless, interventions to modify Sophie's behavior—star charts and attempts at time-outs—have not been very successful. Although initially hesitant to engage with another provider, Sophie's mother eventually agrees to the suggestion of the ICC and Family Partner to refer Sophie to IHBS.

Sophie's new IHBS team, a psychologist behavior therapist, and a behavior support monitor, engage Sophie and her mother. They team gathers data about the nature and setting of Sophie's disruptive behaviors, as well as about those times that she is happy, able to focus, and able to

respond somewhat positively to limits and requests. During the functional behavioral assessment (FBA), Sophie's IHBS team identifies two main functions that drive her problematic behaviors: gaining and holding her mother's attention, and avoiding daily tasks that she does not like, such as meals, bedtime, and bath time. The team looks for competing pathways—other ways that Sophie can get her needs met—that can be the foundation of a behavior-support plan.

Developing the plan is not easy. The team has to work hard to develop a relationship with Sophie's mother that will allow her to trust the IHBS approach. It takes much iteration before the IHBS team and Sophie's mom land on a plan that she feels is doable and that reflects her values.

Because mother and daughter spend so much time together, and so much of the attention Sophie receives is in response to negative behaviors, it is important to shift their interactions. The team focuses on setting routines to increase predictability and to set clear expectations that give structure and shape to their long days together. With each routine, the IHBS team, Sophie, and her mother identify the concrete steps involved, the expectations for appropriate behavior, and the consequences for positive or negative behavior. The team photographs Sophie demonstrating the appropriate behavior for specific routines, such as sitting down for meals or getting ready for bed, and includes them on the charts and visual cues they create for her.

Safety in the car is a priority for Sophie's mother. Reinforcing positive behavior is particularly challenging while driving, but the team and Sophie's mother come up with a creative solution using an incentive that Sophie loves: Silly Bandz, rubber bracelets formed into different shapes like animals and letters (a wildly popular toy in 2010). On each car trip, Sophie's mother wears several bands on her wrist. Each time Sophie demonstrates that she can be safe in the car, such as staying buckled in her seat, her mother takes a toy band from her wrist and passes it back to Sophie. At the end of each car trip, Sophie and her mother have a concrete data point to measure her behavior as they count the bands she earned.

The behavior support plan provides a solid foundation for Sophie and her mother. Sophie responds well to the concrete step-by-step breakdown of routines and is starting to use these alternate pathways to get her needs met. Sophie enjoys demonstrating her mastery of routines, and her mother has become much invested in the data collection and even starting to gather data on Sophie's sleep to share with the pediatrician. The interactions between mother and daughter begin to feel calmer and more relaxed. At her mother's request, Sophie's team consults with her classroom teacher on reinforcing the behavior support plan in the school setting through a similar approach to school routines. As a result, Sophie is rarely sent to the principal's office and she is able to participate in field trips. Although the family has met its Wraparound goals, has graduated from ICC, and said goodbye to their Family Partner, IHBS is still necessary. The ICC and IHBS clinicians obtain a hub waiver from Sophie's Managed-Care Entity so that IHBS can continue without enrolling Sophie in a new hub service.

After nearly two years of hard work, Sophie graduates from IHBS. To help Sophie and her mother deal with ongoing challenges, particularly in Sophie's peer relations, the family engages in outpatient services, giving the outpatient therapist five months to get to know them and their IHBS team before the end of IHBS. While her challenging behaviors have not abated entirely, Sophie has learned alternative, positive ways to get her needs met. Sophie's mother has a much deeper understanding of her behavior and its underlying messages. She says she has the skills to cope with Sophie's behavior and develop new strategies to support positive behavior. Having had much time to plan for this transition, and understanding that they can always re-enter IHBS if needed in the future, Sophie and her mother graduate from IHBS.

What IHBS Is

- Designed to work closely with the youth and family to identify behaviors that are barriers to the youth remaining safely at home and to improve quality of life
- Based on a committed partnership between IHBS staff and the youth and family
- Delivered in collaboration with the existing team of providers
- Focused on increasing functional replacement behaviors and decreasing targeted problem behaviors, using behavioral interventions assessed through objective data
- Based on a behavioral, theoretical orientation
- Based on an approach that considers developmental, contextual, and cultural factors in the design of interventions
- Based on an approach that continually uses data to inform intervention development and to monitor progress
- Delivered by a highly specialized team that can assist the treatment providers and the hub provider team in selecting interventions; implementing those interventions as planned; monitoring progress using data; and using outcome data to modify those interventions, as needed
- Contingent on the child or youth meeting Medical Necessity Criteria

What IHBS Is Not

- Unstructured, although good IHBS clinicians are creative
- Indicated simply because other services are not working – there should be an identified need for behavioral support for IHBS to address
- Delivered without the active involvement, collaboration, and voice and choice of the parents
- Delivered in isolation from other service providers
- Designed to replace services provided under an IEP or as part of residential programming, although IHBS can provide an important complement to other school-based behavioral services

The IHBS Process

Below are the typical steps through which a family uses IHBS.

1. Referral
2. Initial IHBS contact with family

3. Assessment
4. Development of behavior plan
5. Ongoing cycle of plan implementation and collaboration
6. Preparation and transition out of IHBS

Referral

Referrals to IHBS will usually come from a “hub” service. IHBS providers should be familiar with the array of MassHealth behavioral health services and with the role of hub providers. The CBHI Clinical Pathways grid ([Appendix G](#)) provides a diagram of referral pathways. As noted within the grid, the responsibility for care coordination lies with the most intensive hub service (i.e., ICC is the most intensive; then IHT; and then Outpatient).

IHBS providers should implement a process for screening referrals to ensure that referrals are appropriate, meet the medical necessity criteria for IHBS, and have clearly defined treatment goals. As indicated in the IHBS Performance Specifications ([Appendix D](#)), “When the need for IHBS is identified in a youth’s outpatient or IHT treatment plan or ICP (for youth in ICC), the Outpatient, IHT, or ICC referring provider is responsible for communicating the reasons for referral and the identifying goals for IHBS to the IHBS provider.” The referring service should provide a copy of the child’s comprehensive assessment, treatment plan (or individualized care plan if in ICC), and most recent CANS.

If a caregiver self-refers, IHBS providers should first determine whether the child is already receiving hub services and contact that hub service provider. If no clinical hub provider is present, and the family expresses interest in ICC, IHT, or outpatient therapy, IHBS provider staff should assist the family in finding and enrolling in the appropriate or preferred level of care. IHBS should stay connected to the family throughout this process and be prepared to respond to any referral from the clinical hub. If the youth in question is not eligible for, or would not benefit from, a hub service, IHBS providers should apply for the IHBS hub waiver with the youth’s MCE (described below).

In instances where the IHBS provider is contacted by a professional referral source other than a hub provider (e.g., a pediatrician, the family, school personnel, MCI, etc.), the IHBS provider should educate the referral source about the designated pathways for referrals and assist them with contacting a hub provider (with consent of the family) in their geographic area. Mobile Crisis Intervention (MCI) clinicians and others knowledgeable about CBHI referral pathways may make recommendations for IHBS as clinically indicated, but they should not make direct referrals to IHBS. The determination of medical necessity for IHBS is the responsibility of the IHBS provider. During the initial referral process, IHBS staff should confer with the referral source and others knowledgeable about the youth’s treatment needs. In the event that a youth does

not meet medical necessity criteria for IHBS, provider staff must convey the rationale for this decision to the referring hub provider and family and, to the extent possible, assist in the identification of alternative treatment options.

Initial IHBS Contact with Family

Direct contact with the family typically takes the form of one or more phone calls within five days of referral, followed by an initial face-to-face meeting within 14 days of

Hub Waivers

The member's MCE may decide to waive the requirement that a youth be enrolled in a MassHealth hub in order to receive IHBS. MCEs make these determinations on a case-by-case basis. There are three possible grounds for a waiver. Decisions to waive the hub and CANS requirements are made by the MCEs on a case-by-case basis, although MCEs usually approve waivers when the criteria described below are met.

1. The MCE determines that the youth will not benefit from a clinical hub. The CBHI services were structured in such a way that requires the existence of a hub that makes referrals to, identifies the goals of, and provides oversight of any of the three hub-dependent services: Family Support and Training (FS&T), Therapeutic Mentoring (TM), and IHBS. There are certain situations where IHBS is clinically indicated without a hub's involvement. Criteria for considering an IHBS hub waiver include, but are not limited to, the following: youth who are nonverbal or those with no need for additional therapeutic services due to their functional level (they meet the exclusionary criteria for IHT, ICC, and/or OP); or youth whose family has no need for care coordination. A hub waiver should be considered for these youth. Youth with a primary diagnosis of autism or a pervasive developmental disorder are not excluded from receiving IHBS, provided they meet the medical necessity criteria and may not benefit sufficiently from outpatient or other hub services.
2. In some situations, youth have an existing non-Medicaid reimbursed outpatient therapist (paid for by private insurance, school, etc.) and do not require an additional outpatient therapist, IHT, or ICC.³ The youth is in outpatient services through a commercial insurance plan ("MassHealth secondary"). In this case, the outpatient provider should include a comprehensive assessment as part of the referral, but the CANS is not required and MassHealth cannot require the outpatient provider to perform other hub functions.

"If the member has MassHealth as a secondary insurance and is being referred to IHBS by an outpatient provider who is paid through the member's primary insurance, the IHBS provider must obtain from them or conduct a comprehensive behavioral health assessment. A CANS is not required." (See [Appendix E.](#))

contact with the family. Practically speaking, this means:

1. Telephone the parent/caregiver within five calendar days of referral, including self-referral, to offer a face-to-face interview with the family.
2. Fourteen days is the Medicaid standard for the timely provision for services established in accordance with 42 CFR 441.56(e). The 14-day standard begins from the time at which the family has been contacted.
3. Providers shall maintain a waitlist if unable to offer a face-to-face interview and initiate services within five calendar days of contact with the parent/caregiver.

The quality and responsiveness of this initial contact can have a significant effect on family engagement and the resulting treatment outcomes. For this reason, providers should use the initial phone contact and subsequent face-to-face meeting to build a rapport with the youth and family, while learning as much as possible about their treatment needs and goals for their child.

During these initial communications, it is also important to find out what the family has been told about IHBS and what they expect from the service. Providers should explain that caregivers and families are partners in the effective delivery of IHBS, working with the provider to learn new skills and to increase and sustain behaviors that are more positive. This model of IHBS may feel different from other therapeutic modalities that the family has experienced. Many caregivers will appreciate the structure that a behavioral approach provides and will be eager to learn new strategies to support their child. Others may be feeling overwhelmed or discouraged and look to IHBS providers to change the child's behavior directly. In either situation, it is crucial to explain that the service includes both direct interventions with the youth (assessment, observation, modeling use of proposed interventions, and the teaching of replacement behaviors) and developing the caregivers' capacity to offer ongoing behavioral supports once the service is no longer medically necessary. This capacity building may include training parents, caregivers, and others to identify and avoid situations that trigger challenging behaviors; to employ various behavior support and de-escalation strategies; and to cue the use of replacement behaviors.

Providers will have to adjust the amount of teaching done in the beginning stages of care, based on the complexity of the interventions proposed, the caregivers' ability to assimilate and apply the information, and the unique factors sustaining or reinforcing the youth's existing behaviors. The earlier that families come to understand how IHBS works, the more likely they are to be engaged as partners in creating and maintaining their child's new repertoire of behavior.

Assessment

Getting the Hub's Comprehensive Assessment

The referring hub service is responsible for providing an up-to-date, comprehensive assessment and treatment plan as background and context for the functional behavioral

assessment (FBA) conducted by the IHBS provider. (See below for an in-depth discussion of the FBA.) The comprehensive assessment should describe the youth's and the family's prior significant history; their strengths and needs; and any relevant psychiatric, developmental, medical, and cultural considerations. The plan of care articulates the youth's and family's vision and identified treatment goals, as well as the measurable objectives and interventions carried out by other team members.⁴

A good comprehensive assessment will address youth and family strengths as well as needs. *Actionable strengths* are often actually quite challenging to identify; families may be taken aback when asked about strengths. Actionable strengths are generally identified by consideration of what motivates family members (including what they like to do when they have spare time) and how they have coped successfully with various challenges in the past. These motives and skills, often overlooked, may be building blocks for a behavior-support plan. IBHS providers can make valuable contributions to the family and treatment team's understanding of strengths.

Assessment and the CANS

The comprehensive assessment from the hub provider should include the most recent Child and Adolescent Needs and Strengths (CANS) document. The CANS is a particularly useful tool to inform the IHBS team on the behavioral functioning of the identified youth, given that it assesses the youth across various domains. Hub providers are mandated to complete the CANS as part of the initial assessment, and then to update it at intervals of 90 days or less. If the hub provider does not send updates on a regular basis, the IHBS team should request them.

Even though IHBS providers do not complete the CANS, they should ensure that their staff understands the CANS domains and the rationale for ratings. Extensive information about the CANS may be found at the CBHI website at www.mass.gov/masshealth/cans.

In updating the CANS, the hub provider should incorporate information from the whole treatment team and collateral contacts. If the CANS completed by the hub provider does not reflect the strengths and needs of the youth as understood by the IHBS team, the IHBS team should discuss this with the family and the hub provider.

⁴ A clinical assessment may occasionally appear "thin" or otherwise insufficient for informing the FBA or resulting behavior-support plan. If this occurs, the IHBS provider should collaborate with the hub provider, the youth, and the family to identify and solicit missing information or to ensure that information is properly documented and incorporated into treatment planning. Should the youth's hub clinician be unable to respond to requests for clinical information or feedback, or if it becomes clear that the complexity of the youth's and family's service needs may require additional care coordination, IHBS staff have a responsibility to discuss other hub services with the youth and family and to facilitate appropriate referrals with the family's consent.

Different providers often have different perspectives on a youth and family. It is the responsibility of the hub provider to combine these facets into a holistic understanding.

Occasionally, families will exercise their right to limit the scope of information that the hub provider shares with others, including the IHBS provider. If the hub provider, in collaboration with the family, decides that the IHBS provider will not receive a print copy of the CANS, the IHBS provider is expected to document in the youth's medical record (i.e., progress notes) all communications with the hub provider that relates to the CANS and treatment planning for IHBS services.

The IHBS Functional Behavioral Assessment

When evaluating the target behaviors and developing appropriate interventions, a high-quality FBA will incorporate information from the comprehensive assessment and care plan developed by the hub provider, along with direct input from the youth and family. For instance, a family history of domestic violence may affect the therapist's analysis, findings, and recommendations, including how best to respond to a youth presenting with verbal or physical aggression. Similarly, youths' and families' skills and formal and informal supports may suggest specific strategies for structuring and implementing the Behavior Support Plan. Developing effective and sustainable behavior support plans begins with a focus on the youth's and family's strengths, and builds on existing competencies to develop new skills and replacement behaviors.

IHBS staff should prepare to conduct a functional behavioral assessment (FBA) as soon as the parent or guardian provides consent to treat. Although the FBA focuses on target behaviors identified by the referrer, the goal of the assessment is to develop a broader understanding of the context for these behaviors. In the context of IHBS, an FBA gathers information about the youth and family in service, including, but not limited to, pertinent history; clinical diagnoses; social and other developmental skills; the nature and quality of personal relationships; and the environments in which day-to-day activities occur. This information is often available from the hub service's comprehensive assessment.

The FBA provides the context for an assessment of target behaviors, the antecedents and consequences of those behaviors, and the range of potential behavior supports and interventions that may be used to replace distracting, disruptive, or destructive behaviors with appropriate responses.

The resulting FBA allows the IHBS provider to develop and implement a Behavior Support Plan that responds directly to the youth's and family's concerns and that can be effectively integrated into their overall plan of care.

Conducting a functional behavioral assessment is a core competency for any IHBS provider. There are many resources and templates to inform the FBA process in addition to the IHBS performance specifications. Functional behavior assessment (FBA) is defined as "a systematic set of strategies that is used to determine the underlying function or purpose of a behavior, so that an effective intervention plan can be

developed. FBA consists of describing the interfering or problem behavior, identifying antecedent or consequent events that control the behavior, developing a hypothesis of the behavior, and testing the hypothesis. Data collection is an important part of the FBA process.”⁵

The Functional Behavior Assessment will perform the following.

1. Operationally define the target behaviors as well as potential precursor behaviors. A target behavior needs to be described in a way that is concrete, so that everyone can agree when it occurs.
2. Observe the ABC (antecedents, behavior, and consequences) that identify where, when, and under what circumstances the behavior occurs, how much it occurs, and what consequences follow from the behavior.
3. Examine the environmental factors that correlate with incidents of the behavior, including scene and setting, situational influences, relevant persons, and stresses.
4. Frame a hypothesis regarding the motivations of the problem behavior (the consequences that it achieves), and possible *competing pathways* through which the youth can gain desired rewards using desired replacement behaviors.⁶ A common goal is to make the youth’s challenging behavior “irrelevant” because the youth acquires a better way to get the desired end.
5. The hypothesis and competing pathway will inform the Behavior Support Plan. The plan will serve as a test of the hypothesis—if the data show that implementation of the plan does not produce the expected outcomes, the IHBS team must engage in further assessment and revision of the plan.

A strong connection should exist between the outcome of the FBA and the resulting Behavior Support Plan, although this plan is expected to evolve over time as the IHBS clinician increases his or her knowledge of the youth and family, the various functions of a youth’s behaviors across settings, and the most effective strategies for promoting positive and sustainable change.

Gathering Data

Families will usually be accustomed to the idea that IHBS providers gather data from past and current assessments and treatments. They usually are willing to sign releases of information to other providers. When they are not, it is worth careful exploration of

⁵ National Professional Development Center on Autism Spectrum Disorders, *Evidence-Based Practice: Functional Behavior Assessment*, http://csesa.fpg.unc.edu/sites/csesa.fpg.unc.edu/files/ebpbriefs/FBA_Steps_0.pdf.

⁶ Competing pathways are alternate behavioral paths involving desired (or at least acceptable) behaviors, rather than unacceptable behaviors that a person can use to get to a desired end. They are the acceptable sequences of child behavior that we wish to cue, reinforce, and support through the plan.

their reasons for refusal. This can be an important source of information about potential barriers for this family in working with providers, which may need to be addressed with the family once or continuously in order to sustain an effective working relationship.

Data sources include an interview (often more than one) with the family and one or more conversations or interactions with the child or youth. IHBS providers also should review relevant educational and behavioral health records including recent IEPs and educational testing; past psychological, neuropsychological, neurological, and functional behavioral assessments; and current treatment plans. IHBS should request caregiver permission to communicate with these informants as well as other current providers, such as teachers or other CBHI service providers who work with the child at home and in the community.

IHBS staff may also want the youth, caregivers, or others to complete questionnaires or standardized rating scales for baseline assessment and ongoing data collection. Measures should be written out in the preferred language of the informant whenever possible. It is also important to be sensitive to the possibility that respondents have reading or writing difficulties that they may not initially acknowledge. The cognitive and emotional effort involved in responding to interviews and questionnaires must not be underestimated. If families understand why the data is needed, how it will be used, and can see the results over time, they may be more cooperative in gathering the information.

Finally, the FBA process typically requires multiple behavioral observations in whichever setting(s) the target behaviors occur. Data on antecedents, behavior, and consequences can be gathered from a variety of helpful second-hand sources, but a hallmark of behavioral intervention is independent observation of the phenomenon, when feasible. Ideally, the Behavior Therapist and the Behavior Support Monitor should have a chance to observe the child unobtrusively in the settings where the target behavior occurs. It also is revealing to observe the child in settings where the target behavior rarely or never occurs. Finally, observational activities can be used to train other participants (such as parents and teachers) to objectively report on behaviors. When conducting observations, providers should take care to explain the reason for the visit and the fact that the family has requested that the observation take place.

Development of the Behavior Support Plan

After the IHBS collects sufficient data, the IHBS team develops a highly specific Behavior Support Plan within 28 days of the first meeting with the family.

The plan should identify individualized, positive behavioral interventions based on the youth's assessed need(s). (See service specifications, [Appendix F](#).) The plan should specify goals, objectives, and interventions (e.g., skills training, reinforcement systems, removal of predictors or triggering stimuli, etc.), which are designed to teach and

promote the use of specific replacement behaviors, and to diminish or extinguish problem behaviors affecting the youth's quality of life.

The plan will include the following.

1. A statement of the youth's and family's goals for behavior change
2. A description of the specific behaviors to increase, decrease, eliminate, or replace
3. A statement regarding the environmental context, contributing factors, and potential function(s) of the problem behavior, and possible competing pathways that were developed in the FBA
4. A description of planned, positive interventions based on competing pathways
 - a. Interventions focused on antecedents or predictors
 - b. Skill-building interventions to increase the child's repertoire of appropriate behaviors
 - c. Consequential interventions (i.e., rewards or re-enforcers) to increase the functional replacement and desired behaviors and to reduce the problem behaviors
5. Established baselines for the incidents of the target behaviors and proposed benchmarks for measuring progress towards treatment goals
6. Strategies for collecting and using behavioral data
7. Procedures for training, supervising, and maintaining intervention integrity (i.e., consistently implementing the plan) with the caregivers, other significant individuals in the youth's life, and other treatment team members

Collaboration with Hub Provider/Care-Planning Team

The Behavior Support Plan is developed with the active participation of the youth, the caregiver(s), and the hub provider. Especially when a youth is receiving IHT or ICC, other team members may participate in the development of the Behavior Support Plan and the integration of its strategies into the larger plan of care. As a result, it is best practice for the IHBS team to present their FBA findings and analysis formally to the youth and family, the hub provider, and any other team members that the parent or caregiver has chosen to involve in the delivery of behavior supports. All participants should have an opportunity to discuss the information collected, to review the proposed goals and objectives of the plan, and to help identify strategies for ongoing implementation and monitoring of behavioral interventions.

After the plan is developed and reviewed, the family and other team members should be able to

- understand the language of the plan;
- clearly identify the target behaviors and how they are defined and counted; and

- understand their roles in the plan, including what data they will be asked to collect on the youth’s behaviors.

Once finalized, all participants should be asked to sign the Behavior Support Plan. The family should receive a copy of the plan in their preferred language to assist in their full engagement and understanding of the behavioral plan.

Family Voice and Choice in IHBS

CBHI is based on the premise that “family voice and choice” leads to strong engagement and best outcomes. Some clinicians express concern that a family-driven approach devalues clinical expertise. This view reflects a misunderstanding of family voice and choice. On one hand, the family is the expert on their own history and values, their quality of life, and their experience of their child. They are the ones who will have to implement much of the plan and to live with the consequences. On the other hand, the IHBS team holds expertise in behavioral science and can usually offer the family a variety of options for applying the principles of behavior change. A successful plan results when caregivers (and the youth, to the extent that his or her development permits) can fully understand the variety of options available, and can freely choose the options that make the most sense for them.⁷

In order to ensure consistent implementation, the Behavior Support Plan should be written in nontechnical language that is understandable to the youth and the family and to other collaborators. A plan that uses jargon will be hard for non-behaviorists to understand and implement. IHBS collaborates with the hub provider and other treatment team members to ensure the positive behavioral interventions are clearly defined and easy to carry out. IHBS also communicates regularly with the hub provider and the youth’s and family’s team to confirm that the components of the Behavior Support Plan are aligning with the overall treatment plan. The hub provider, in turn, should ensure that all treatment team members understand how ongoing communication and coordination with the IHBS provider will occur.

Some families may choose to share the final Behavior Support Plan with the youth’s school, or ask that school staff and the IHBS provider consult about ongoing behavior intervention strategies. This additional collaboration can be very helpful—promoting consistent responses to challenging behaviors, re-enforcing use of learned positive

⁷ “Family voice and choice” is sometimes mistakenly taken to mean that providers should always agree with caregivers. This simplistic approach, of course, would be both unproductive and in some cases unethical. However, a respectful clinical process will ensure that family voices are genuinely heard, not just during the assessment phase but also throughout the treatment process; that family members are truly informed about the options available to them; and that families are supported in choosing the options that they believe will work the best. If the family and the clinician disagree on which option is preferable, it is usually wise and effective to try the family’s preferred option first. If the evidence shows that this option does not work, this becomes useful information for further collaborative planning.

replacement behaviors, and collecting data on the youth's functioning within the demands of the school environment. IHBS staff also may find it useful to observe implementation of behavior support strategies in the school setting in order to evaluate which intervention and replacement behaviors are effective and generalizable across settings.

Using Data to Evaluate and Improve Service Effectiveness

While it is important to begin IHBS with an agreed-upon plan in place, everyone involved should recognize that identified goals, benchmarks, and intervention strategies will most likely evolve over time, in response to feedback from the youth and family; input from the hub provider or treatment team; and the IHBS provider's own assessment of the effectiveness of various behavior-change strategies. The IHBS provider is responsible for making modifications to the Behavior Support Plan, as needed, in collaboration with the caregiver or guardian.

Ongoing data collection is one factor that informs the IHBS team's evaluation of the Behavior Support Plan and its effectiveness over time. The use of data is a hallmark of behavioral change strategies, including ABA and PBIS. IHBS's data-driven approach to treatment also can inform the work of other home- and community-based service providers supporting the youth and family. For this reason, IHBS providers should consider how data collected under the plan can be presented to, and used by, other members of the care-planning team. For instance, the preparation of visual graphs and corresponding trend analysis can assist the hub provider and other team members in measuring the impact of their own clinical efforts. Presentations of objective behavioral data also can encourage family members to persist in difficult behavior-change strategies, especially where progress is gradual and may otherwise be hard to quantify.

When analyzing the effectiveness of Behavior Support Plans, IHBS providers are encouraged to measure multiple data points, including the frequency of challenging behaviors, the environmental factors that affect the behaviors, the time and location in which these behaviors occur, and which interventions increase the occurrence of positive, prosocial behaviors. When brought into the larger treatment-planning process, this information can help focus team members' attention on specific behavioral triggers or particularly challenging times of day. Data may suggest responsive strategies such as previewing difficult transitions, building in use of sensory tools, increasing structured activities, or adding positive incentives for use of replacement behaviors.

It is usually the role of the Behavior Support Monitor to carry out the data collection strategy through direct observation or collecting data from adults in the child's life. When a child is developmentally capable of self-monitoring and reporting, it is good practice to make him or her an active partner in this process as well.

Sometimes a Behavior Support Plan can be implemented without adjustment. More often, however, the team will need to make changes to the plan based on subsequent data collection. It is very important for the IHBS team to convey the empirical nature of this process to all participants—if the plan does not “work” right away, it is not a failure

but an opportunity to learn. When children have serious behavioral problems, the adults in their lives can become very discouraged, frustrated, and oriented toward blame. Focusing on IHBS as a learning process can help everyone regain both perspective and relief from the oppressive belief that someone should have all the answers.

Safety Plan

The IHBS provider is not required nor expected to provide urgent response to the youth and family when there is an emergency or crisis. The referring hub provider, in the event of a crisis or emergency, is responsible for ensuring urgent response to the youth and family, and that the youth is engaged with Mobile Crisis Intervention (MCI) as needed. When there is no hub provider, the IHBS provider should ensure an urgent response and engage MCI when appropriate. IHBS should follow any emergency protocols during and after business hours as established by their agencies.

While safety planning is not the responsibility of hub-dependent services such as IHBS, occasions exist when IHBS can provide valuable consultation to the hub provider and the family on specific behavioral interventions that will reduce risk for the youth and their family or that will assist in the stabilization of the youth when escalating or in crisis. These interventions may be incorporated into the safety plan written by the hub provider. IHBS may also assist in behavioral rehearsal with coaching to ensure that the family is, in fact, able to implement safety strategies as needed.

IHBS providers should be familiar with the principles and operations of Mobile Crisis Intervention. Service specifications and guidelines for MCI may be found on the CBHI website. Some youth have multiple contacts with MCI; in these cases, safety planning with the family should generally include the MCI team as well as the hub provider. IHBS may contribute to safety planning by reviewing recent crises from an ABC point of view, helping participants to identify intervention points in the path to behavioral escalation.⁸

Ongoing Cycle of Implementation and Collaboration

Many providers are familiar with a Plan-Do-Study-Act (PDSA) cycle used in health care quality management.⁹ IHBS, adhering to the CBHI value of Continuous Improvement, follows the same paradigm on an individual level and in a collaborative context.

⁸ For further information about crisis planning, see [Appendix I](#) for the CBHI crisis-planning tools, and a Companion Guide for Providers on the Crisis Planning Tools for Families. The Safety Plan form in [Appendix Q](#) is required for use by In-Home Therapy, Intensive Care Coordination, and Mobile Crisis Intervention providers, unless the family declines. The other tools are optional. Use of these tools helps promote consistency across levels of care.

⁹ Institute for Healthcare Improvement, www.ihc.org/resources/Pages/HowtoImprove.

- **Plan:** Initial assessment leads to a formulation (hypothesis), which leads to a test intervention (initial Behavior Support Plan).
- **Do:** The plan is implemented as a trial intervention.
- **Study:** Implementation and results of the trial intervention are evaluated in practice.
- **Act:** Either continue with the successful plan with continued monitoring, or revise the unsuccessful or partially successful plan and restart the cycle.

The cycle continues until the youth has met his or her behavioral goals or until he or she for some other reason no longer meets medical necessity for the service.

The IHBS team coaches the caregiver on how to implement strategies identified in the Behavior Support Plan while modeling new positive interventions directly with the youth. The team also coaches and encourages the youth, teaching positive replacement behaviors, promoting self-regulation strategies, and soliciting feedback on what kinds of goals and incentives he or she finds motivating. Typically, the caregivers will benefit from some education to help them understand better what motivates their child. Education will be most effective when it is offered in a culturally informed way and when it recognizes the caregivers' own expertise regarding their child.

The IHBS team also educates and consults with other treatment providers on ways to integrate behavioral support strategies into their work with the youth. One of the most powerful interventions can be simply to get everyone to respond to the youth in a consistent way.

Regular phone contact, face-to-face consultation, and coordination with other involved parties such as school personnel, other treatment providers, and significant people in the youth's life are also provided as part of the behavioral service. IHBS performance specifications require contact with the hub provider as follows: "For youth who receive ICC, In-Home Behavioral Services—as needed, but at least one per week with the youth's ICC care coordinator to provide updates on progress on the identified ICP goal(s). For youth not receiving ICC, the In-Home Behavioral Services staff has regular, frequent contact with the youth's referring provider to report updates on progress on the identified behavioral goal(s)." (See [Appendix C](#) for the IHBS Service Definition that outlines the billable components of the service.) However, weekly communication with the IHT or Outpatient hub is also recommended when youth present with complex behavioral needs, or when multiple providers are involved in implementation of the behavior plan. Weekly contact is also suggested at the outset of service delivery and whenever a need exists to substantially modify the Behavior Support Plan.

Many children in IHBS have (or should have) special education services to address their educational needs. Sometimes parents need support in understanding the IEP process and their rights. IHBS teams may be able to provide useful advice or referral to other supports, such as the Federation for Children with Special Needs or an educational advocate. The IHBS team should always collaborate with the hub provider on issues involving the school, as the hub provider has the primary responsibility for care

coordination. Collaborating with schools about behavior is often extremely important in developing a consistent approach to managing a child's behavior. In addition, school staff often have an excellent understanding of a child's strengths and needs, and frequently can share effective approaches that they have discovered from working with the child. Finally, what happens in school matters enormously to a child. Behavior can easily spill over from one context into another, from school to home or vice versa. In order to understand the child's behavior, it is important to know what is going on across settings.

Frequency, intensity, and duration of IHBS activities should be tailored to meet the individual needs of the youth. Service intensity may be highest during the initial phase of assessment and planning, and may be a bit lower while the family is practicing implementation of the plan. Additional service authorizations may be needed to be dealt with an emergent crisis or to formulate a major change to the plan. Similarly, the frequency and intensity of service may appropriately fade as the family approaches transition and is increasingly able to manage with less external help. IHBS should document the rationale for changes in service intensity, making sure that the hub provider and any other key partners understand and can plan for these changes to occur.

Clinical Vignette: José

José, age 16, is diagnosed with a pervasive development disorder. He refuses to take the bus almost daily, does not follow reasonable requests from his mother, and has frequent outbursts of anger both at home and in the community. School staff report that Jose has responded well to structure and routines at the school.

José's mother speaks only Spanish, and there are no Spanish-speaking teachers at the school. IHBS works closely with her, assigning a Spanish-speaking behavioral team to discuss José's behavior at home and to share information of José's success at school with his mother. José's mother and IHBS together develop a plan to set up a home schedule similar to the school schedule, developing a chart to document and reward José for taking the bus daily.

*As José's mother develops *confianza* (trust), she asks for assistance from IHBS to develop a morning and afternoon school routine, given that this is the time (antecedents) when José acts out with the highest frequency. IHBS works with her during the morning to develop a specific routine that consists of José waking up, eating breakfast, and then dressing himself. She and IHBS develop a transition routine so that José becomes more successful with taking the bus daily. The team also finds ways to reward José more immediately in response to desired behaviors on his part. José, his mother, and the behavioral team decide to sing a song as José's cue that the bus is arriving and that José should prepare himself for school. He responds very positively to the established routines and re-enforcers, and his mother reports improvements in José's ability to transition from home to school.*

This vignette illustrates the importance of linguistically appropriate service provision, and identifies how the IHBS team can assist a family to transfer best practices from school at home. Sometimes, the transfer of best practices needs to follow a different pattern, such as from home to school. It also is a reminder that IHBS always occurs in the context of relationships. As parents develop a trusting relationship with their provider team, they may feel more comfortable asking for help with new issues.

Preparation and Transition Out of IHBS

Transition (also called discharge, termination, or graduation) planning begins at the start of services. IHBS providers should engage the treatment team and the family in conversations early in the treatment process about how they will know if they have achieved their goals, and how best to ensure that those changes can be sustained after IHBS ends. The following are suggestions for engaging in a positive and supportive discussion of the transition process.

- Review what termination will look like at the beginning of the service.
- Continually discuss with the youth and family their achievements and the progress they have made toward their goals.
- Use a positive frame for ending: an accomplishment of goals reached through hard work and a cause for celebration.
- Identify which behaviors and supports will replace the IHBS service after termination.
- Use regular provider feedback, along with objective data, to help families measure the progress that has been made
- Remind families that they may be referred to the IHBS service in the future if new goals are identified. Some families think that if they graduate, they cannot return. It is important to dispel this misconception.

Indications for Ending IHBS

There is no prescribed length of stay for IHBS. The intensity and duration of service delivery is an individualized determination, based on the medical necessity criteria for the service ([Appendix E](#)). Even after initial treatment goals are met, youth may satisfy criteria for continuing care, if new behavior goals and objectives are identified or if continued behavioral support and training is needed in order to avoid regression.

Transition out of IHBS should occur when there is agreement among the family and current treatment team that the youth has met all of his or her IHBS goals and no longer needs or meets the criteria for continuing in IHBS services. Factors involved in determining a youth's and family's readiness for transition include documented progress over time, as evidenced by routine data collection, the successful integration and generalization of new replacement behaviors, and the achievement of identified goals and objectives.

The IHBS provider should be in regular discussions with the hub provider and the youth and family regarding the level of documented treatment progress and anticipated periods for the achievement of service goals. Any proposed timeframe for discharge from IHBS should be reviewed with the hub provider well in advance, and should involve thoughtful planning with the family and other team members in order to ensure a coordinated and seamless transition-planning process.

Transition Meeting and Plan

As the time for transition draws near, it is best practice to convene a face-to-face meeting with the youth and family, the hub provider, and any others team members who are centrally involved in the youth's plan, so that everyone hears the same details about the transition plan.

Sometimes transition out of IHBS will involve transition into a new service, or a transfer of the behavioral work to an ongoing provider. In the clinical vignette of Sophia, an outpatient therapist was able to continue the work with the youth and mother that IHBS had started. If the team envisions such a transfer, it is important to make sure that the new provider is in place and has had ample time to form relationships with the youth and family and begin to support the ongoing behavior plan before IHBS ends.

In other cases, it may be appropriate to initiate a new service in order to address other behavioral health needs. With appropriate consent, it is the hub provider's responsibility to ensure linkage and referral to any of these potential service providers.

As noted in the Performance Specifications, the IHBS provider, in collaboration with the family and youth's treatment team, develops a written discharge or transition plan that includes documentation of the reasons for discharge as well as ongoing strategies, supports, and resources to assist the youth and family in maintaining treatment gains.

While the specifications indicate that the discharge plan must be given to the family and, with consent, to the existing behavioral health providers within five business days of the last date of service, the details of the plan really should be discussed among the parties far in advance of this stage. The transition plan should be documented in the youth's IHBS record and distributed, with family consent, to everyone involved in the youth's plan. It is expected that the hub provider will update the youth's treatment plan or ICP to reflect that the youth has met his or her goals and no longer needs or meets the criteria for IHBS.

Early Termination

If the family withdraws from the IHBS service without notice, the IHBS provider should immediately notify the hub provider and attempt to learn the reason for the family's withdrawal from service. IHBS staff should make every effort to contact the caregiver (or the youth, in situations where the youth can consent to his or her own care) by phone and in person, and to either reengage them in services or provide assistance for appropriate follow-up plans (i.e., schedule another appointment, facilitate an appropriate service termination, or provide appropriate referrals). These outreach

activities, and any subsequent follow-up plans, should be documented in the youth's medical record.

Clinical Vignette: Carlos

Carlos, age five, arrived from Puerto Rico with his grandparents, who also were his guardians. Carlos at times has been prescribed more than five different psychotropic medications for frequent angry outbursts. He is enrolled in Intensive Care Coordination and Outpatient Therapy. Soon after the family arrived, Carlos had a crisis and exhibited self-harming and sexualized behavior, encopresis, and enuresis. He was hospitalized and the ICC made a referral for IHBS.

Now Carlos is discharged, with IHBS in place. His grandmother asks for help in managing Carlos's behavior. Carlos, his grandmother, and the IHBS team develop a set of routines. The IHBS team teaches his grandmother, his outpatient therapist, and his Family Partner how to use the game "red light, green light, yellow light" as a concrete and fun way to help Carlos with behavioral self-regulation. Carlos engages and develops a close relationship with both his IHBS behavior support therapist and monitor, who help reinforce Carlos's behavior. Carlos's preferred reinforcement is for his grandmother to make fried chicken and yellow rice for him on the Fridays when Carlos met with 80% or better on his weekly chart. Carlos's grandparents work closely with ICC, Family Partner, Outpatient Therapist, and IHBS. Carlos is able to graduate from IHBS due to his dramatic, measurable improvements. Carlos and his family will continue for some time in ICC and for much longer in Outpatient because he has many serious challenges.

In this vignette, an extensive provider system is involved with the family. Close coordination of the work of IHBS with other providers allows everyone to work on agreed-upon tasks without confusion or duplication. Although the behavioral work is done, at least for now, the providers who are continuing with the family understand the behavioral principles and interventions taught by IHBS, so they are able to support the family in maintaining the child's behavioral progress.

Documenting Progress

IHBS providers regularly communicate with the hub provider, the youth or the youth's family, and other providers to monitor progress toward the youth's goal(s). The IHBS provider documents progress using data collected at baseline and then at regular intervals per the Behavior Support Plan.

IHBS providers are expected to adhere to the MCE CBHI Health Record Documentation Standards, which outline the documents required in the youth's health record ([Appendix E](#)). IHBS providers are expected to have the following in the youth's medical record.

1. A copy of the comprehensive assessment completed by the hub provider along with applicable parts of the CANS, depending upon family consent, completed by the hub provider. If the member has MassHealth as secondary insurance and is being referred to services by a provider who is paid through the family's primary insurance, the IHBS provider should request a copy of the child's treatment plan. In these instances, a CANS is not required ([Appendix E](#)). Should

the hub provider be a non-Medicaid provider and not have a treatment plan or be unwilling to share it, a qualified clinician at the IHBS provider agency must conduct a comprehensive behavioral health assessment.

2. Documentation of all contact and communication that the IHBS provider has with the youth and family and all other relevant involved parties, including the hub provider and any other providers who are also involved with the family.
3. A copy of each update of the hub provider's treatment plan (or ICP for youth in ICC).
4. The IHBS Behavior Support Plan that references the goals or objectives for IHBS identified within the referring hub provider's treatment plan (or ICP for youth in ICC).
5. "Progress notes that document all contact and demonstrate clarity of medical necessity, i.e., (a) relevant to the action/treatment/care plan, (b) assess symptomatic and functional progress and risk, as applicable, and (c) identify what the provider did in the session" ([Appendix F](#)). Providers must ensure that IHBS staff adequately document medical necessity and should provide ample support for paraprofessional staff to do so.

There is no prescribed progress-note format that the IHBS provider must use. The IHBS provider organization is responsible for developing or selecting an appropriate format. IHBS providers may want to review the forms available at www.abhmass.org/msdp.html. IHBS providers should consult with their provider organization's leadership for additional guidance if needed.

It is the responsibility of the IHBS provider organization to determine its own policies and procedures about documentation requirements stated in the performance specifications, MCE Provider Manuals, and Commonwealth of Massachusetts regulations.

Working with Hubs and Other Services

CBHI providers are responsible for coordinating, collaborating and integrating care and service delivery to meet the youth's needs, as well as assisting the youth and caregiver to make informed decisions on care and service delivery. The IHBS provider does not have the care-coordination responsibilities of a hub provider; however, he or she has the following responsibilities as a hub-dependent provider.

- Ensuring that the youth is currently engaged in one of the hub services (ICC, IHT, or Outpatient), unless a waiver has been approved by the MCE
- Verifying that IHBS is needed in order to facilitate achievement of a goal or objective identified on the hub provider's treatment plan or ICP (for youth in ICC), unless a waiver has been approved by the MCE

- Verifying that a comprehensive assessment and CANS completed by the hub provider demonstrates medical necessity for the IHBS, unless a waiver has been approved by the MCE
- Systematically gathering data about intervention effectiveness
- Contacting the hub provider regularly (at least once a week if the hub is ICC) to provide updates on progress
- Ensuring that IHBS is aware of youth's safety plan, as needed and with appropriate consent
- Assisting the youth, caregiver, and hub provider to understand and use positive behavioral interventions to augment or diminish specific behaviors related to the youth's behavioral health condition.

In comparison, the hub provider has the following responsibilities, unless a waiver has been approved by the MCE.

- Completing a comprehensive assessment and CANS
- Assisting the family in exploring options and making informed decisions to meet the youth's needs
- Completing a treatment plan (or ICP for youth in ICC) and engaging the family in a safety-planning process
- Ensuring that the youth and family are linked with natural supports, hub-dependent services, other behavioral health services, and other community-based supports, as appropriate
- Ensuring communication and collaboration among providers. In ICC, this requires convening regular face-to-face team meetings; in IHT and Outpatient, face-to-face meetings are not required but are often best practice.

Youth Engaged in ICC

Youth enrolled with Intensive Care Coordination (ICC) have, or need, multiple services to be coordinated. While ICC provides a clinically informed intervention, it does not provide direct clinical treatment, as does IHBS.

For youth engaged in ICC, the IHBS provider participates as a member of the Care Planning Team (CPT) and attends all CPT meetings. The CPT, including the youth and his or her family, identify the treatment goals to be addressed by the IHBS provider, and the team continually assesses the youth's progress to determine if the treatment goals need to change. At these meetings, the IHBS provider shares data tracking the youth's progress on behavioral interventions related to the identified behavioral goals.

The IHBS provider develops and identifies to the CPT an anticipated schedule for meeting with the youth and a timeline for goal completion. The IHBS provider

determines the appropriate number of hours per week or month for IHBS based on the needs of the youth, as identified in the ICP. The IHBS Behavior Support Plan must reflect one or more goals on the ICP, and treatment planning and delivery must be synchronized with ICC. Providers coordinate their scheduled time with the family so that the family is not overwhelmed with appointments and visits.

Decisions about roles and responsibilities for each member of the CPT, including the IHBS provider, are negotiated within the CPT in a manner that best meets the needs of the youth and family and is in accordance with performance specifications. The IHBS provider supports the youth's participation in the CPT meeting and process.

The IHBS provider is responsible for communicating in advance to other CPT members when the youth is nearing completion of his or her goals and no longer needs or meets the criteria for IHBS.

Youth Engaged in IHT or Outpatient Therapy

For youth who are not receiving ICC, the IHBS provider must coordinate with the referring outpatient or IHT provider and, with family consent, attend any treatment team meetings in order to present the Behavioral Support plan and share data on the youth's progress. The IHBS provider develops and identifies to the referring outpatient or IHT provider a projected timeline for goal completion and an anticipated schedule for meeting with the youth that is agreeable to the family. The IHBS provider determines the appropriate number of hours per week or month for IHBS, based on the needs of the youth as identified in the behavior plan. Providers coordinate their scheduled time with the family so that the family is not overwhelmed with appointments and visits. The IHBS provider, when requested by the family, will accompany the family to meetings about the youth's behavioral needs in schools, day care, foster homes, and other community-based locations. All meetings are scheduled at a time and location that are convenient for the youth and family.

IHT is provided by a master's-level clinician, usually partnered with a bachelor's-level person (Therapeutic Training and Support staff). Both may play a role in care-coordination tasks, including locating resources, communicating with other providers and supports, and helping the family find solutions to concrete needs that affect the child's behavioral health (e.g., housing, transportation). Additionally, IHT provides direct clinical interventions, such as family therapy, at an intensity and duration commensurate with the youth's needs. Youth receiving IHT as their hub service typically need a moderate level of care coordination; if they need a higher level, a referral to ICC should be discussed.

An outpatient provider can also function as a hub. Usually children using outpatient as a hub have a modest need for care coordination but still require weekly check-in phone calls from the IHBS provider. (See [Appendix H](#), "Tip Sheet for Outpatient Clinicians.") If the child needs a higher level, a referral to ICC should be discussed. Additionally,

outpatient therapists provide direct clinical interventions, such as individual or family therapy.

Therapeutic Training and Support vs. Behavioral Support Monitoring

It is possible for a youth and family to be involved simultaneously with both a Therapeutic Training and Support (TT&S) staff member through In-Home Therapy (IHT) and with a Behavior Support Monitor (BSM) through IHBS, if it has determined that the youth meets the Medical Necessity Criteria for both services. In these situations, it is essential to clarify the rationale for each service. The roles of the TT&S and BSM, and their accompanying activities and schedules, should be specified and clear to everyone involved. More service providers in the home are not necessarily better.

When both roles are present, the BSM will focus specifically on helping the family to implement the Behavior Support Plan. The TT&S should understand and support the Behavior Support Plan, but should ordinarily focus with the family on other tasks in the IHT treatment plan. Please refer to the Performance Specifications for more details of each service.

A provider organization may have staff cross-trained to perform both TT&S and the BSM functions. In most situations, however, it would be confusing for the same staff person to provide both Behavior Support Monitoring and Therapeutic Training and Support to the same youth and family.

Youth Involved with State Agencies

When a youth is involved with state agencies, the hub provider is responsible for communicating and collaborating with them with the consent of the family. IHBS participates in that process of communication and collaboration as directed by the hub provider.¹⁰ In some circumstances, communications will be routed through the hub provider, while in other cases it will make more sense for the IHBS team to work directly with the agency or school. The fact that the other party is a state agency does not eliminate the need for family consent, except in specific instances spelled out in the law, such as 51B investigations or upon release of information by court order. A subpoena of records does not override a patient's right to privacy; the provider who receives a subpoena should consult with legal counsel.¹¹

¹⁰ State agencies include child-serving agencies within the Executive Office of Health and Human Services, as well as public school districts, the courts, and probation.

¹¹ By consent of the family, we mean consent of the caregiver or legal guardian, except in cases where the youth has the right to consent to his or her own care. Massachusetts does not have a formal process for emancipation of minors but does recognize circumstances where a person younger than 18 has the right to make certain decisions (such as medical) for herself or himself.

IHBS providers may on occasion receive referrals for youth in residential or group care through their hub service provider, in cases not requiring a hub waiver. **The timing of referral is critical:** IHBS cannot initiate services before the youth is “ready for discharge to a family home environment or community setting with community-based supports,” per the medical necessity criteria. However, it is best for the referral to occur early enough to allow the IHBS provider’s participation in the discharge-planning meeting from the residential or group care facility, when appropriate. A well-timed referral occurs as soon as the youth has a concrete and imminent plan for return to the family home environment with community-based supports. IHBS providers should be prepared to educate referrers about the ideal timing for referrals.

When the Hub Service Ends

Sometimes a youth who is receiving services from a hub provider (ICC, IHT, or Outpatient) is referred to a hub-dependent service such as IHBS, and then subsequently withdraws from treatment with the hub provider. In these situations, the IHBS provider should make every effort to contact the hub provider and the family to discuss any plan to re-enroll with the hub provider, or to enroll with another hub provider. The IHBS provider must explain to the family that IHBS cannot continue in the absence of a hub provider, unless circumstances permit a hub waiver. If the youth no longer has a hub provider, and the IHBS provider believes it is clinically appropriate to continue IHBS without the hub provider, the IHBS provider must discuss a hub waiver with the MCE.

A hub service provider should always consult with other services providers well in advance of the planned ending of the hub service. Transition planning when ending a hub-dependent service, such as IHBS, should include a discussion regarding the need for a referral to another hub service, or application for a waiver.

Augmenting the FBA to Serve as a Comprehensive Assessment

The Functional Behavioral Assessment (FBA) is considered an adequate substitution for the comprehensive assessment when the FBA is augmented with the typical elements of a comprehensive assessment, such as concerns about what the patient presents; developmental history; medical history; psychiatric history; substance-use history; allergies or adverse reactions; medications; mental-status exam; risk assessment; strengths; clinical formulation; and DSM-5 diagnosis.

Providing IHBS to Siblings

The siblings of a child enrolled in IHBS will often be part of the IHBS process, as informants to the assessment process and as participants in implementing a Behavior Support Plan. Since everyone in the home is part of a dynamic behavioral system, it is often important to include siblings in the intervention process for the enrolled youth.

An IHBS provider may also *enroll siblings* within the same family, when each sibling meets medical necessity for the service and each has a hub provider in place. Each sibling must have a treatment plan (or ICP if the youth is in ICC) with a behavioral goal that will be addressed in IHBS. Each sibling must have a separate medical record with full documentation, as required by IHBS performance specifications. If in doubt about enrolling siblings, the IHBS provider may call the MCE that is serving the youth to request consultation.

The same staff person may serve enrolled siblings. However, assignment of the IHBS staff person should be based on the best staff fit for the individual youth. The siblings may not be living within the same household.

Culturally Relevant Practice

Culturally relevant services include respectful recognition of differing values and culture of the youth, family, school, and other providers. This includes, but is not limited to, recognition of economic status, gender, sexual orientation, ethnicity, race, language, and the unique values and goals of each youth and family. It uses the strengths of all in order to provide comprehensive care to families. To ensure that effective care is provided, agency staff, supervisors, and administrators should seek consultation and additional services when necessary to overcome barriers that compromise the delivery of care. Providers should make every effort to recruit staff that represents the diversity of the youth and families served and to deliver services in the primary language of the youth and families served.

Culturally relevant practice is an ongoing, learning process. Even in the strongest provider organizations, there will always be room for growth. Culturally relevant practice accepts and respects differences; emphasizes the dynamics and challenges arising from cultural and linguistic differences in planning and delivering services to diverse populations; and is committed to acknowledging and incorporating the following.

- *Cultural awareness.* Culture plays an important role in how families view helping relationships and how they engage with providers.
- *Sensitivity to cultural diversity.* A variety of factors, including ethnicity, language, lifestyle, age, sexual orientation, and social status, contribute to cultural diversity.
- *Bridging linguistic differences in appropriate ways.* Families may be bilingual, but will typically prefer their first language during times of stress or crisis. Some types of content may be more effectively communicated in the preferred language. Providers should ask what language the family prefers to use.

- *Assessment of cross-cultural relations.* Which positive or negative experiences has the family had with their local school or community? How do their culture and experiences affect their perception of potential supports in the community?
- *Expansion of cultural knowledge.* How can providers help families to engage in their community and identify allies and supports for their family through understanding other cultures better?
- *Adaptation of services.* It is important to remember that not all members of a group share the same cultural values. Providers should ask questions that will help them to adapt services to be respectful of specific cultural needs of the family.
- *Access to nontraditional services.* Some cultures use and value nontraditional services, such as natural healing, spiritual guides, or identified leaders in their culture. Explore family beliefs about acceptable interventions and supports and recognize the value and strength of these nontraditional services.

The following text describes provider responsibilities in providing culturally competent services.

1. The program provides services that accommodate the youth; take into consideration the youth's family and community contexts; and build on their strengths to meet behavioral health, social, and physical needs of the youth.
2. The program staff will have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of the population served. To ensure that effective care is provided, program staff, supervisors, and administrators will seek consultation and additional services when necessary to overcome barriers obstructing the delivery of care.
3. The provider ensures access to qualified staff in order to meet the cultural and linguistic needs of all families served in their local community.
 - a. Providers ask the family's language of choice.
 - b. Because staff with linguistic capacity is preferable to translators, providers offer the youth a clinician who speaks his or her language of choice whenever possible, or refers him or her to a provider who can do so.
 - c. The provider has access to qualified interpreters and translation service providers who are experienced in behavioral health care appropriate to the needs of the local population served. The program must maintain a list of qualified interpreters for the cases when it must seek translation services outside of the agency.
 - d. Interpretation and translation services are provided at a level that enables a youth to participate fully in the IHBS program. Any written

documentation should be available in the family's primary language when requested, including discharge documents.

4. Programs will provide ongoing, in-service training that includes delivering culturally competent care relevant to the client populations.
5. Programs will include cultural competence in their ongoing quality assessment and improvement activities.

Staffing, Training, and Supervision Requirements

Supervision Requirements

The IHBS provider ensures that all licensed master's-level clinicians participate in weekly individual or group supervision with a senior clinician. Please refer to the performance specifications for the credentials required of supervisors.

Staff Training

Please see IHBS performance specifications for staff training requirements. It is up to each provider to implement training consistent with the specifications, and to document compliance with the requirements.

Cultural competence is a central value of CBHI and should be an aspect of all training.

Credentialing Requirements

Please refer to the IHBS performance specifications for credentialing requirements for the Behavior Support Therapist and the Behavior Support Monitor.

Credentialing Waiver Requests

On occasion, IHBS provider agencies may wish to consider candidates for the IHBS position who may not meet all of the credentialing requirements. For a list of approved degrees, please refer to [Appendix R](#). In these instances, providers may request a credentialing waiver when a candidate does not meet credentialing criteria and there is a need in the community for the following.

- Improving member access
- Meeting a member's linguistic or cultural needs
- Meeting a member's need for specialized care
- Other member- or system-driven need

[Appendix J](#) contains the CBHI Staff Credentialing Waiver Request Form that must be used in applying for a credentialing waiver. Instructions for the waiver process and supporting documentation are included in the form. The provider submits a single

request to all MCEs via an e-mail address on the form; each MCE subsequently makes its own decision on the waiver. The candidate is prohibited from performing IHBS services for a MassHealth member until the IHBS provider receives waiver approval from the member's MCE.

Use of Interns

MCEs provided guidance on this topic in August 2011, as follows below.¹²

Behavior Therapist – A person working toward his or her master's degree (i.e., in his or her second year of a master's program with a clinical track) *and* working in an intern capacity under the supervision of a licensed clinician may bill at the master's-level clinician rate. The provider may not bill for activities of interns in their first year of a master's program.

Behavior Support Monitor – For a person working toward his or her bachelor's or associate's degree and working in an intern capacity under the supervision of a licensed clinician, a credentialing waiver request (see above) may be submitted by the organization to the MCEs.

Staff Transitions

IHBS providers are expected to have a protocol in place for managing both planned and unplanned staff turnover. Families on the vacating staff person's caseload should be prioritized for reassignment to a new IHBS staff member. Placing the family on a waitlist should be avoided whenever possible.

In the event of an unplanned staff transition, it is important to reach out to the family immediately to inform them of the change. Typically, the supervisor should contact the family, offer to be available to them as needed, and offer to meet with them to strengthen the connection with the family, assess the impact for the family of losing their helper, and assess any immediate needs. It is not enough to have a Behavior Support Monitor serve as the contact if the Behavior Support Therapist leaves, even if the relationship between the family and the Support Monitor is strong.

When it is not possible to assign a family immediately to a new IHBS staff member, the provider must treat the family as waitlisted when updating MABHA per MCE requirements.

¹² Available at www.masspartnership.com/pdf/MCE%20Use%20of%20Interns%20for%20All%20CBHI%20Services%20

If the family is willing to consider transition to another organization, the provider should consult MABHA and contact other IHBS providers to check for availability of openings elsewhere.

Medical Necessity Criteria for Admission

The IHBS medical necessity criteria can be found in [Appendix E](#).

Any service provided to a youth and family must meet the medical necessity criteria for that service, be requested by the youth and family, and be tied to a goal in the hub provider's treatment plan (or ICP for youth in ICC). Upon receipt of a referral for IHBS, the provider is responsible for ensuring that the youth meets the IHBS medical-necessity criteria. IHBS is available to youth through age 20; youth become ineligible for IHBS on their twenty-first birthday.

Throughout the course of services and during treatment plan updates, the IHBS provider is responsible for ensuring that the youth is reassessed for medical necessity.

Access to Care

Guidelines for access to care and for contacting families may be found in the "Guidelines for Ensuring Timely Access to CBHI Services" and "Access to Care Protocol" (see [Appendices K](#) and [L](#), respectively). IHBS providers are expected to ensure that all relevant staff are trained on all aspects of this protocol, including expectations and guidelines on access to care-related definitions, response time to referrals, and waitlist follow-up expectations.

Timeframes and Documentation

The IHBS provider, upon receiving a referral from a hub provider or family, contacts the family within five calendar days of the date of referral to initiate services. The IHBS provider offers the family a face-to-face appointment to initiate services within five calendar days of the first phone contact with the caregiver, as described in the IHBS Performance Specifications ([Appendix D](#)).

All referrals to IHBS are recorded and tracked on an IHBS agency Referral Log/Waitlist. Providers may develop their own waitlist format; [Appendix M](#) provides an example of the minimum information that should they capture.

At the time of referral, the hub provider is responsible for sharing with the IHBS provider a copy of the comprehensive assessment, including the CANS, and the treatment plan (or ICP for youth in ICC). While there is no requirement related to the utilization of a standardized intake form, IHBS providers should gather health care information during the intake process that may affect overall treatment planning.

Documentation of relevant medical information (i.e., preexisting medical conditions, food allergies, asthma, prescribed medications, preferred medical providers, most recent physical) and a list of the necessary skills for IHBS to develop is recommended.

IHBS providers must ensure that they obtain consent from the youth's legal guardian. For example, if a youth is placed in the legal custody of the Department of Children and Families (DCF), the DCF case manager is responsible for signing the consent to services for the youth.

IHBS providers should not allow the absence of documentation from the hub provider to become a barrier to providing timely access to services. IHBS providers are encouraged to continue to request the CANS, comprehensive assessment and treatment plan or ICP upon receipt of referral. In the event that the hub provider fails to forward these documents in a timely fashion, the IHBS provider is encouraged to contact the hub provider's supervisor or program director to resolve this issue. If this is not effective, the IHBS provider should contact the youth's MCE. In the absence of these documents from the hub provider, the IHBS provider is encouraged to have a phone discussion with the hub provider, and to document both the medically necessary need and the domains and goals or skills for the IHBS provider to address. This verbal, clinical rationale from the hub allows the IHBS service to commence while awaiting the requested documentation from the hub provider.

Waitlist Activities

If the IHBS provider is unable to offer a face-to-face appointment and initiate services within five calendar days of contact with the family, the provider is expected to speak with the family. During this conversation, the provider should determine whether the family would like to receive services from another IHBS provider in their area, or whether they would prefer to wait for an available IHBS opening at the current IHBS provider. The IHBS provider documents the family's preference in the Referral Log/Waitlist. (See [Appendix M](#) for an example of the information that should be collected.)

Hub providers should solicit the family's preferences for the agency where they will receive IHBS. The fact that a hub provider works well with a certain hub-dependent provider is not a sufficient reason for influencing a family's choice to wait for a particular provider. If the family is willing to receive IHBS from another agency in the area, the IHBS provider that currently holds the referral must assist the hub provider in facilitating a referral to another agency. The IHBS provider should check availability on the MABHAccess website; call other agencies to confirm availability; and communicate,

as “permitted use” under HIPAA, the minimum necessary information to another agency to enable the family to receive services as soon as possible.¹³

Unless the IHBS provider is ready to engage a family in services, it is not acceptable to offer an initial appointment in order to remove a family from a waitlist. A provider may not offer an appointment or send out a staff person to meet the family without having the immediate capacity to assign a permanent staff person to work with the family.

In the event that the IHBS provider exhausts the list of local IHBS providers and there is no opening within a reasonable distance from the youth and family, the IHBS provider should contact the youth’s managed care entity (MCE) with a list of all IHBS providers that they have called. The MCE is responsible for ensuring access to the members within its network.

IHBS providers are expected to contact all waiting families on a weekly basis, unless the family directs otherwise. IHBS providers should not circumvent this requirement by offering to call less than weekly. Families should be asked to contact the IHBS provider and inform them if they accept an appointment with another provider. Contacting families on the referral log is a billable activity once the referred youth has been assigned to an IHBS staff person who has contacted the family to schedule the initial appointment.

As noted above, it is the responsibility of the IHBS provider to determine whether referred youth meet the IHBS medical necessity criteria. Ordinarily it will be possible to do this using the information provided by the hub provider, at the earliest possible stage. If there is a question about whether the youth meets medical necessity for IHBS, it is important to alert the family and clarify what additional information is needed to determine medical necessity. Information available at this stage may point to another behavioral health service as more appropriate, in which case IHBS staff should discuss this option with the referring hub provider and the family.

Reporting and Monitoring Access via MABHAccess

The Massachusetts Behavioral Health Access website (MABHAccess) captures IHBS data through a weekly and monthly reporting system. This provides a resource for families looking for care and for providers assisting them in this process. It also allows MCEs to track current network capacity.

IHBS providers are expected to record and track all referrals on an internal agency Referral Log/Waitlist. (See [Appendix M](#) for an example of the data to collect.) Providers use data from the log to update MABHAccess.

¹³ See the U.S. Department of Health and Human Services website at www.hhs.gov/ocr/privacy/hipaa/understanding/coveridentities/usesanddisclosuresfortpo.html for additional information and consult your legal counsel if necessary.

At least once per week, the IHBS provider must enter updated information into MABHAccess on the IHBS program's available capacity (the number of new referrals the program can accept). At the end of each month, the IHBS provider must also enter into MABHAccess information on their program's enrollment, referrals, and any youth waiting. This monthly data collection set includes the following.

1. The number of youth *waiting for the first available agency* and the dates of initial phone contact with these families
2. The number of youth *choosing to wait for your agency or staff* and the dates of initial phone contact with these families
3. Referral information comprising
 - a. referral date;
 - b. date of initial contact with the family; and
 - c. date of the first available appointment offered to the family.

If a youth is waiting to be assigned to new IHBS personnel following staff turnover, the IHBS provider should report that youth in both the waitlist section and the referral section of the MABHAccess data entry form. For "date of contact" and "date of referral," the last day that the vacating staff person worked should be entered.

The MCEs receive regular reports from MABHAccess. Each month, the MCEs conduct a follow-up process to monitor the status of each youth who is identified on MABHAccess as awaiting services. Additionally, MCEs monitor program capacity and waitlists on a monthly basis.

Access for Non-English-Speaking Youth

Children and families who do not speak English have the same right to MassHealth services as those who do speak English. Every provider is obligated to respect this right. All providers are expected to maintain a list of qualified interpreters, including interpreters for the deaf and hard-of-hearing populations, to provide services should the IHBS provider need to access translation services outside of their organization.¹⁴ Because using staff with linguistic capacity is preferable to using interpreters, providers are expected to offer the family or youth a staff person who speaks their language of choice whenever possible, or refer him or her to a provider who can do so. If there are no providers within a reasonable distance from the family's home with staff who speak the family's or youth's language of choice, the family's preferred provider is expected to use qualified interpreters, experienced in behavioral health care, appropriate to the

¹⁴ The Massachusetts Commission for the Deaf and Hard of Hearing provides information and training related to communication access for people who are deaf or hard of hearing. Visit the website at www.mass.gov/eohhs/gov/departments/mcdhh/.

needs of the family. Documents should be translated into the preferred language of the family.¹⁵

Billing

The IHBS Service Definition in [Appendix C](#) describes the various components of the service for which IHBS providers may bill. For example, as specified within the Service Definition as well as the IHBS Performance Specifications ([Appendix D](#)), collateral contacts (phone and face-to-face) are a billable function and the responsibility of the IHBS provider.

- Billing occurs in 15-minute units. There is no limit on billing for activities relating to service components.
- All services billed by the IHBS provider must be consistent with the IHBS Service Definition and documented to meet the Medical Necessity Criteria for the service ([Appendix E](#)).
- IHBS providers should review the various IHBS service components to ensure that their staff are billing appropriately.

The following functions are billable services.

- *Member transportation provided by staff.* Please note that staff travel time is built into the current rate structure for IHBS, and thus is not billable as separate units.
- *Telephone support for the youth.* Care coordination is a function and responsibility of the hub provider whose treatment plan (or ICP for youth in ICC) documents the goal(s) that the IHBS provider is addressing. The IHBS provider has no formal care coordination responsibility, but is expected to collaborate with the members of the youth's and family's treatment team (or CPT for youth in ICC) about care-planning activities.

As noted within the IHBS Service Definition, time spent in supervision and time spent preparing for sessions with youth are not separately billable activities, as they are included in the rate.

¹⁵ The Americans with Disabilities Act, 42 U.S.C. § 12101, et seq. (ADA) and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, prohibits discrimination against individuals with disabilities, including depriving them of the full and equal enjoyment of the goods, services, facilities, or accommodations of any place of public accommodation, including hospitals and other health care providers. To ensure an equal opportunity in using their services, hospitals and other health care facilities must provide "effective communication" to individuals who are deaf or hard of hearing by providing appropriate "auxiliary aids and services," including the provision of qualified American Sign Language interpreter services and assistive listening devices.

MCE Authorization Parameters and Billing Codes

The MCEs reimburse providers based on claims received for medically necessary services rendered to eligible youth. Each IHBS provider is responsible for monitoring eligibility and obtaining authorization from the MCE for the youth to whom they provide the IHBS. IHBS providers should check the MassHealth Eligibility Verification System (EVS) daily to check the status of the youth's managed-care eligibility.

The authorization parameters for IHBS are 240 units/60 days (eight weeks). All authorization parameters are floors (minimums), not ceilings (maximums); and additional units may be requested and will be approved based on meeting the medical necessity criteria for the service ([Appendix E](#)). If a provider anticipates that she or he will exhaust the total number of units authorized before the end date of the authorization, the provider may contact the MCE to request additional units. As stated above, in the event that the hub service is discontinued, the IHBS provider should follow the applicable MCE protocol on authorization.

[Appendix N](#) contains the MCE Common IHBS Clinical Review Questions that may be part of the MCE authorization process. IHBS providers are expected to be prepared to provide answers to these questions, upon request, to the MCE currently serving the youth.

The following codes should be used by IHBS providers when submitting claims to the appropriate MCE for reimbursement for IHBS.¹⁶

One (1) unit = 15 minutes

H2014-HN = Behavior-support monitoring provided by a bachelor's-level clinician

H2014-HO = Behavior support therapy provided by a master's-level clinician

The IHBS provider's responsibility is to ensure that claims are appropriately submitted, e.g., using appropriate codes; ensuring that MCE-specific claim-submission requirements are met; ensuring that IHBS services provided to a youth meet the IHBS medical necessity criteria and are documented in the youth's medical record, etc.

If siblings within the same family each are receiving IHBS from the same IHBS provider, the provider is responsible for ensuring that each sibling meets the IHBS medical necessity criteria, including the requirement of a hub provider, and that each sibling has his or her own medical record in which all services to that sibling are documented.

Please refer to [Appendix O](#) for the authorization processes of each of the MCEs.

¹⁶ Available at www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-352.pdf.

Appendices

Appendix A: Availability of CBHI Services to Members in Various Benefit Plans

Eligibility

The implementation of the Children’s Behavioral Health Initiative (CBHI) signaled a major expansion of behavioral health services for children and youth who are younger than 21 and have MassHealth. MassHealth now provides health insurance for a large percentage of the Commonwealth’s children.

Even if a family earns too much money to be income-eligible for MassHealth, a child in that family with a disability may be eligible for MassHealth benefits, including one with a mental or behavioral health diagnosis. This type of MassHealth coverage, called CommonHealth, is available regardless of family income, with a sliding fee scale for premiums.

Children and youths younger than age 21* who are enrolled in either MassHealth Standard or MassHealth CommonHealth may access medically necessary MassHealth behavioral health services. Approximately 85% of MassHealth-enrolled children and youth have either Standard or CommonHealth coverage. Children and youth younger than 21 enrolled in MassHealth Family Assistance – a smaller program developed to expand health care to more individuals – may be able to access certain behavioral health services, if the service is medically necessary.

Below is a summary of MassHealth behavioral health services** for children and youth younger than 21. Next to the service are the types of MassHealth coverage available for them. Note: This list of services covered by MassHealth provides only general information. Parents and youth should call their MassHealth health plan for the most up-to-date, accurate information.

Behavioral Health Service	MassHealth Coverage Types
Outpatient Therapy	Standard, CommonHealth, Family Assistance*
Mobile Crisis Intervention	Standard, CommonHealth, Family Assistance*
Structured Outpatient Addiction Program	Standard, CommonHealth, Family Assistance*
In-Home Therapy	Standard, CommonHealth, Family Assistance*
Intensive Care Coordination	Standard, CommonHealth
Family Support and Training (Family Partners)	Standard, CommonHealth
In-Home Behavioral Services	Standard, CommonHealth
Therapeutic Mentors	Standard, CommonHealth

* Note: Some members younger than age 19 who are eligible for Family Assistance receive premium assistance as their only MassHealth benefit. For these members, MassHealth pays the premium for commercial insurance but does not reimburse

providers directly for services. These members are not eligible for MassHealth behavioral health services.

Additionally, some families with Family Assistance also have commercial health insurance coverage. As a result, their children are not eligible for enrollment in any of MassHealth's managed-care programs, nor are they eligible for community-based MassHealth behavioral health services (with the exception of Mobile Crisis Intervention). Families may call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech-disabled) to learn more.

** MassHealth lists the services and benefits currently available. To access the list, visit [Overview of MassHealth Services](#) on the MassHealth website or call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648).

Appendix B: Incorporating Positive Behavior Supports in IHBS

The principles of Positive Behavior Supports (PBS) are highly aligned with the values of CBHI and Systems of Care. Many resources on PBS are available at www.apbs.org/files/apbs_standards_of_practice.pdf.

One free resource is *Facilitator's Guide: Positive Behavioral Support*. Tallahassee, FL: Bureau of Instructional Support and Community Service, Florida Department of Education, Positive Behavioral Support Project (1999). The guide is available at www.apbs.org/files/pbswhole.pdf.

Appendix C: IHBS Service Definitions

<https://www.masspartnership.com/pdf/IHBSServiceDefinitions3.2.15.pdf>

Appendix D: IHBS Performance Specifications

<http://www.mass.gov/eohhs/docs/masshealth/cbhi/ps-behmgmt-therapy-and-monitoring-ps.pdf>

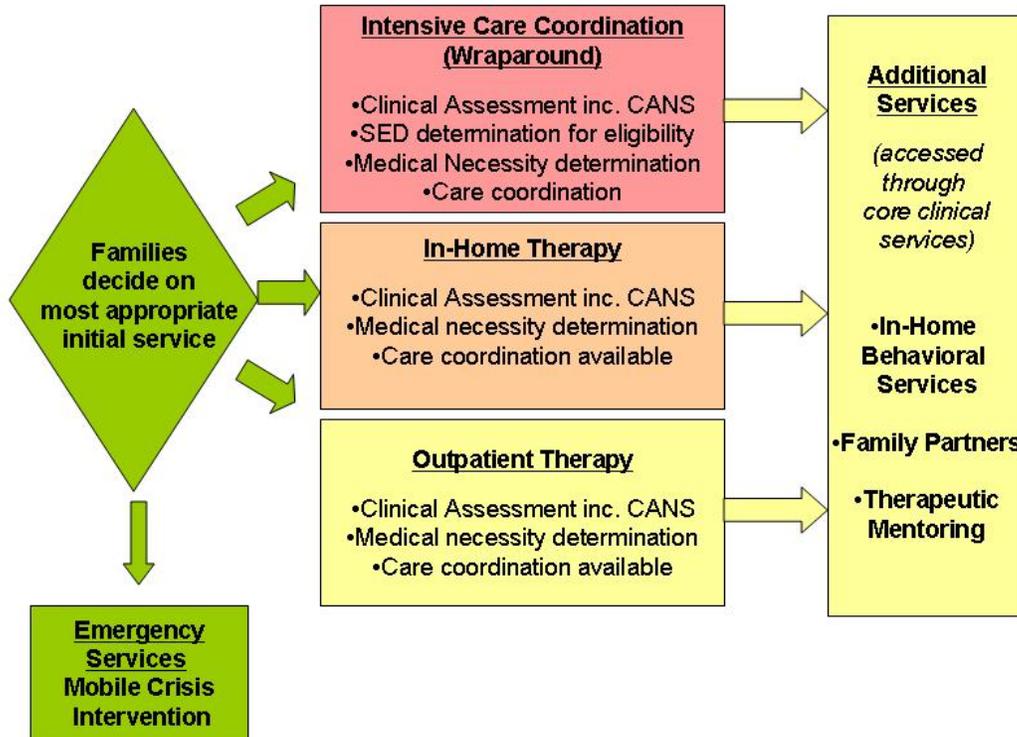
Appendix E: IHBS Medical Necessity Criteria

<http://www.mass.gov/eohhs/docs/masshealth/cbhi/mnc-in-home-behavioral-services.pdf>

Appendix F: MCE CBHI Health Record Documentation Standards

<http://www.masspartnership.com/pdf/MCE%20CBHI%20Health%20Record%20Doc%20Standards%20March%202013.pdf>

Appendix G: CBHI Clinical Pathways Grid



Appendix H: Tip Sheet for Outpatient Clinicians: Roles and Responsibilities as a CBHI Hub Provider

<https://www.masspartnership.com/pdf/OPCBHItipsheet42814.pdf>

Appendix I: Crisis-Planning Tools

<https://www.masspartnership.com/provider/CrisisPlanning.aspx>

Appendix J: MCE CBHI Waiver Request Form

<https://www.masspartnership.com/pdf/MCECBHIWaiverRequestForm.doc>

Appendix K: Guidelines for Ensuring Timely Access to CBHI Services

<https://www.masspartnership.com/pdf/GuidelinesforEnsuringTimelyAccessToCBHIServices522011.pdf>

Appendix L: Access to Care Protocol

<https://www.masspartnership.com/pdf/AccessToCareProtocol082012.pdf>

Appendix M: CBHI Referral Log Waitlist v4

<https://www.masspartnership.com/pdf/ReferralLogWaitlistTemplate090512.xls>

Appendix N: MCE Common IHBS Clinical Review Questions

<https://www.masspartnership.com/pdf/MCEClinicalReviewQuestionsforTM-IHT-FST-IHBS.pdf>

Appendix O: MCE IHBS Initial and Subsequent Authorization Processes

Beacon Health Strategies: www.beaconhealthstrategies.com

BMC HealthNet Plan: www.bmchp.org

Fallon Community Health Plan: www.fchp.org

Neighborhood Health Plan: www.nhp.org

Network Health: www.network-health.org

Health New England: www.healthnewengland.com

Appendix P: Crisis-Planning Tools for Families: A Companion Guide for Providers

<http://www.masspartnership.com/pdf/Crisis-Planning-Crisis-Planning Tools for Families: A Companion Guide for Providers>

Appendix Q: Safety Plan Form

English –

https://www.masspartnership.com/pdf/CBHI_Safety_PlanFinal.pdf

Spanish –

https://www.masspartnership.com/pdf/CBHI_Safety_PlanFinal_ES.pdf

Appendix R: List of Approved Degrees

<http://www.masspartnership.com/pdf/CBHIListofApprovedDegrees.pdf>

Appendix S: Definition of Terms

ABC: A short way of referring to the construct of “antecedents, behavior, and consequences.” *Antecedents* are stimuli or situational cues that precipitate the behavior; *behavior* is the target behavior that will be measured and modified through intervention; and *consequences* are events that follow the target behavior and that maintain, increase, or decrease the occurrence of the behavior. Consequences are also known as reinforcers.

Applied Behavior Analysis (ABA): ABA uses principles of learning to devise behavior-change interventions.¹⁷ ABA often uses principles of operant conditioning (i.e., rewards following desired behaviors) in order to shape behavior, but also can use principals of respondent (classical) conditioning (for example, to help people reduce their anxious response to a feared stimulus). ABA is one evidence-based practice that may inform the delivery of IHBS. *Positive Behavior Supports (PBS)* builds on ABA in a way that is highly consistent with the values of CBHI, providing a foundation for the delivery of IHBS within the wraparound treatment model. All IHBS clinicians are expected to employ collaborative, strengths-based approaches to fostering behavior change, while promoting positive skill development among youth and families in service.

*Behavior Support Monitoring (BSM)*¹⁸: This component of the IHBS service is provided by a person with a bachelor’s or associate’s degree, supervised by the Behavior Support Therapist. The behavioral-support monitor provides support in gathering data for assessment and ongoing monitoring, and in implementing the Behavior Support Plan. The BSM may spend more time in the home than the BT and so may develop a very important relationship to support data gathering and success in following the Behavior Support Plan.

Behavior Support Therapy (BST): This component of the IHBS service is provided by a master’s- or doctoral-level clinician who meets requirements for training in behavior therapy. The behavior therapist has primary responsibility for the functional behavioral assessment, development of the Behavior Support Plan, oversight of the work of a Behavior Support Monitor, and training other interveners to address specific behavioral objectives.

¹⁷ The following definition is frequently cited: “Applied Behavior Analysis is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior.” Cooper, J. O., Heron, T. E., and Heward, W. L. (1987). *Applied Behavior Analysis* (first edition). Columbus: Merrill.

¹⁸ While the Performance Specifications and Medical Necessity Criteria refer to Behavior Management Therapist and Behavior Management Monitor, IHBS guidelines reflect the Positive Behavior Support (PBS) approach that seeks to support the child, rather than simply manage a behavior. We encourage use of the newer terminology as found in these guidelines.

Behavior Support Plan: According to the IHBS service specification, “The Behavior Support Therapist completes a written functional behavioral assessment and develops a highly specific Behavior Support Plan with clearly defined interventions and measurable goals and outcomes within 14 to 28 days of the first meeting with the family.” The targeted behaviors in the plan are defined by the overall treatment plan or Individualized Care Plan (for youths in ICC) of the referring hub.

Care-Planning Team (CPT): In Intensive Care Coordination, a CPT includes the youth and caregivers as well as both formal and natural support people (such as extended family, friends of the youth and family), representatives of child-serving state agencies, school personnel, and advocates, who assist the family in identifying goals and developing and implementing an Individual Care Plan (ICP). A CPT must include more than the youth, caregiver, and care coordinator.

Child and Adolescent Needs and Strengths (CANS): The CANS is a tool that provides a standardized way to organize information gathered during behavioral health comprehensive assessments. There are two versions of the Massachusetts CANS, for two age groups: birth through age four, and age five through 20. The hub service is responsible for updating the CANS every 90 days. The IHBS provider is not required to complete the CANS, but should obtain the initial CANS and updates from the referring hub, should use information from the CANS to inform its work with the child and family, and should provide feedback to the hub to inform CANS updates.

Community Service Agency (CSA): A CSA provides Intensive Care Coordination using the high-fidelity *Wraparound* model, and provides the Family Support and Training Service (Family Partners). CSAs also are responsible for convening a local System of Care meeting to strengthen local communication and collaboration. There are currently 29 geographically based CSAs, as well as three CSAs specially dedicated to meeting the needs of underserved populations.

Comprehensive Assessment: A clinical assessment completed by the hub provider that includes, but is not limited to, the concerns that the youth presents; developmental history; psychiatric history; substance-use history; medical history; allergies or adverse reactions; medications; risk assessment; mental-status exam; strengths; DSM-5 diagnosis; and clinical formulation. A comprehensive assessment includes the CANS. The CANS is not a replacement or substitute for the complete comprehensive assessment. This information is collected for the purpose of assessing the youth’s treatment needs and strengths, as well as informing treatment and determining the youth’s need for hub-dependent services and goals. In-Home Behavioral Service providers are expected to obtain a copy of the most recently completed comprehensive assessment for the youth they serve.

Family Partner: A Family Partner is an individual who delivers Family Support and Training (FS&T) services. This individual has experience as a caregiver of a youth with mental health or other special needs. Family Partners “do for, do with, and cheer on” caregivers and family members in stages to provide for the needs of the youth. Family

Partners often share parts of their own story as an intentional way of helping caregivers develop motivation and actionable insight.

Family Support and Training Services (FS&T): This is a service provided by a Family Partner to the parent or caregiver of a youth younger than age 21, in any setting where the youth resides, such as the home (including foster homes) and other community settings. FS&T services are available to caregivers of youth who meet the medical-necessity criteria for this service, and who are receiving one of the hub services. FS&T is provided by a Family Partner, an individual who has experience caring for a youth with special needs.

Functional-Behavioral Assessment (FBA): A functional-behavioral assessment gathers information about the youth and family in service, including, but not limited to, pertinent history; clinical diagnoses; social and other developmental skills; the nature and quality of personal relationships; and environments in which day-to-day activities occur. The FBA is the foundation for the Behavior Support Plan and is used to understand the environmental context for target behavior (i.e., the antecedents and consequences of those behaviors); for identifying strategies and the range of potential supports and interventions that may be used to replace distracting, disruptive or destructive behaviors with appropriate, prosocial responses; and to establish baseline data for assessing the effectiveness of the behavior plan.

The IHBS service specifications require that the behavior therapist conduct an initial FBA as part of the comprehensive intake and assessment, and update that assessment, as needed, over time. FBA findings are documented by the IHBS provider and discussed with the care-planning team, including the youth and family. These findings and related discussion are then used to develop the Behavior Support Plan and to integrate that plan into the hub provider's existing plan of care.

Hub Service: Hub services include Outpatient Therapy, In-Home Therapy (IHT), and Intensive Care Coordination. Hubs serve as the primary behavioral health care provider for a youth. They assess the youth's clinical need for various supports and services, including hub-dependent services, and refer and link youth to those services. Hubs collaborate with collateral supports and services to integrate interventions.

Hub-Dependent Service: Hub-dependent services include In-Home Behavioral Services, Therapeutic Mentor services, and Family Support and Training. They provide a specialty service that augments the interventions of the hub provider.

Individual Care Plan (ICP): An ICP is a care plan for youth enrolled in Intensive Care Coordination (ICC) that specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed by the youth and family. Developed by the Care Planning Team (CPT), it incorporates the strengths and needs of the youth and family. The ICP is the primary coordination tool for *Wraparound* care planning.

In-Home Behavioral Services (IHBS): IHBS is a hub-dependent service, for youth aged 20 years and younger, that addresses behaviors that affect a child or youth's full participation in family, school, social relationships, and successful functioning in the community. Services are delivered by a master's-level Behavior Support Therapist (BST), often in partnership with a Behavior Support Monitor (BSM).

In-Home Therapy Services (IHT): A service that provides intensive therapy in the home or community, through a master's-level clinician, and often incorporating a bachelor's-level person providing the service of Therapeutic Training and Support (TT&S). If the youth is not enrolled in Intensive Care Coordination but is enrolled in IHT, then IHT is responsible for hub functions, including planning treatment, communicating with other providers, and coordinating care.

Intensive Care Coordination (ICC): ICC provides care planning and care coordination using the high-fidelity *Wraparound* model. Collaborating with the family, ICC conducts an initial comprehensive assessment, facilitates the ongoing process for building a team, develops an Individual Care Plan to address the youth's needs and to support the goals identified by the youth and family, and then monitors and improves the plan until goals are met. The Intensive Care Coordinator works with the youth, caregivers, supports, providers, schools, state agencies, and others who play a key role in the youth's life, to facilitate the development of a care-planning team for the youth. Care planning is driven by the needs of the youth and developed through a *Wraparound* planning process consistent with Systems of Care philosophy.

Managed-Care Entity (MCE): The MassHealth-contracted organization that manages the MassHealth member's care, including authorization and payment.

Mobile Crisis Intervention (MCI): MCI is the youth-serving (age 20 and younger) component of an emergency service program (ESP) provider. MCI provides a short-term service that is a mobile, onsite, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation, and reducing immediate risk of danger to the youth or others consistent with the youth's risk-management/safety plan, if one exists. This service is provided 24 hours a day, seven days a week. It includes a crisis assessment; development of a risk-management/safety plan, if the youth/family does not already have one; up to seven days of crisis-intervention and stabilization services, including onsite, face-to-face, therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), MCI staff will coordinate with the youth's ICC Care Coordinator throughout the delivery of the service. MCI also will coordinate with the youth's primary care physician, any other care management program, or other behavioral health providers providing services to the youth throughout the delivery of the service.

Parent or Caregiver: Parent or caregiver refers to any biological, kinship, foster, or adoptive family or caregiver responsible for the care of a youth. “Parent” and “caregiver” are used interchangeably throughout this document.

Positive Behavior Supports (PBS), alternately known as Positive Behavior Intervention and Supports (PBIS): “Positive behavioral support is an approach to intervention that integrates technical features of applied behavior analysis with person-centered values. It offers a process for designing individualized approaches to support students experiencing behavioral difficulties in school, home, and community environments. Positive behavioral support incorporates functional behavioral assessment and leads to behavioral intervention plans that are positive (i.e., proactive, educative, and functional) in nature.”¹⁹

PBS builds on a foundation of Applied Behavior Analysis. It originally was developed primarily for school settings, but the principles are applicable in all settings. In practice, PBS emphasizes the importance of environmental factors in understanding behavior and focuses on skill development, including the development of positive replacement behaviors, consistent with the individual youth and family’s unique needs and goals. In 2014, the Massachusetts Department of Developmental Disabilities officially adopted a positive behavioral approach in their regulations found at *115 CMR 5.00*.²⁰ Note that some of the functions expected of a full PBS intervention (such as identifying and building a support team) are expectations of the hub service under MassHealth and therefore are *not* expected of the IHBS provider.

System of Care: A System of Care is a cross-system, coordinated network of services and supports organized to address the complex and changing needs of youth and families.²¹

Therapeutic Mentoring: This service offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for addressing daily living, social, and communication needs.

Wraparound: *Wraparound* is a structured, team-based planning process involving the youth and family, which results in a unique set of community services and natural supports individualized for that youth and family to achieve a positive set of outcomes.

¹⁹ Positive Behavioral Support Project. Facilitator’s Guide: Positive Behavioral Support. Tallahassee, FL: Bureau of Instructional Support and Community Service, Florida Department of Education, 1999. Many other resources are available at www.pbis.org, a TA website supported by the U.S. Department of Education’s Office of Special Education Programs (OSEP).

²⁰ The Department of Development Services (DDS) lists many PBS resources on its website. Visit <http://ddslearning.com/dds-pbs-initiative>.

²¹ Stroul, B., Blau, G., and Friedman, R. (2010). Updating the system of care concept and philosophy. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health.

For more information about *Wraparound*, visit the National Wraparound Initiative website, www.nwi.pdx.edu.

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