Intensive Home Based Treatment (IHBT) Frequently Asked Questions

CERTIFICATION	
Question	**Answer**
1) What ODMH services must our agency be certified in to provide IHBT?	• Behavioral Health Counseling & Therapy, • Mental Health Assessment, • Community Psychiatric Supportive Treatment (CPST), and • Intensive Home Based Treatment
2) How do I become certified for IHBT?	• If agency is currently certified, send letter to ODMH Office of Licensure and Certification requesting to add new service and copy your local board. • Attach the policies and procedures governing IHBT. • If not certified…follow certification procedures in 5122-25-04 http://www.mh.state.oh.us/licensurecert/general/lc.form.html
3) What happens after we submit our request?	1) The Lead Surveyor will review your submission, and request any additional documentation, if needed 2) Certificate is produced and mailed to agency 3) We will copy: • MH Board(s) • Area Director • Center for Innovative Practices (CIP)
4) How do we stay certified for IHBT?	• Meet requirements of the rule • Maintain appropriate behavioral health accreditation (CARF, COA or JCAHO). • Meet outcomes thresholds (Appendix A) • In addition, maintain compliance with ODJFS Medicaid rules for all agency services funded by Medicaid, if applicable.
5) Can you be certified for IHBT if you are an MST provider? If so, then where does the intensive consultation piece fit in? (MST requires weekly consultation with MST consultant)	Yes. Consultation is an additional component that MST and many IHBT programs include. This exceeds the IHBT standards and is not a problem.
6) When do we apply for the new standards?	At any time. The IHBT service rule went into effect as of July 1, 2005.

ACCREDITATION	
Question	**Answer**
1) Is IHBT one of the services that require behavioral health accreditation?	IHBT is one of eight ODMH Certified services which require appropriate behavioral health accreditation (5122-25-02) • Deadline is September 30, 2006 • Appropriate is further defined in the ODMH "Behavioral Health Accreditation Crosswalk," dated June 2005, or subsequent revisions
2) My agency provides IHBT and had our accreditation survey prior to the IHBT rule going into effect, and therefore did not include this service in our survey. Do we need to schedule a supplemental survey/additional service review/extension survey with our accrediting body?	No. An agency can request and ODMH can grant a one-time waiver. IHBT services must be included in your next accreditation survey.
3) What is Deemed Status?	"The department shall accept, as evidence of compliance with Chapters 5122-26 through 5122-29… the agency's appropriate behavioral health accreditation…" Be aware, however, that some certification standards are exempt from deemed status. The list can be found in OAC 5122-25-03 (A)(1).
4) If I achieve deemed status for my agency, is there anything additional I need to do to become/remain certified for IHBT?	Yes. OAC 5122-25-03 (A)(1) lists the certification standards which are exempt from deemed status. The following are the specific IHBT requirements which are exempt from deemed status recognition: • Certified for BH Counseling, MH Assessment & CPST services • Submit IHBT service description, and policies & procedures with Certification application • Collect & submit Consumer Outcomes data and comply with the other provisions of the Outcomes Rule, i.e., the use of Outcomes data in both treatment planning and quality improvement activities. • Complete IHBT fidelity rating tool & report scores/results

OUTCOMES	
Question	**Answer**
1) What is the outcomes reporting process?	Complete and submit The Ohio Scales through the board to ODMH on the following schedule: intake, at 6 months if case remains open, and discharge. Collect (on the same schedule as above) and submit these to CIP using the attached Excel spread sheets (Web data entry coming) the following outcomes to ODMH's designee, CIP: • Whether the child lived at home at time of IHBT discharge • Whether the child lived out of home for more than 14 days during the measurement period
2) How are outcomes going to be collected?	Outcomes will be collected in the following two ways: a) The Ohio Outcomes (Ohio Scales) currently required will be collected in the same manner they are now (submitted through your local Mental Health board to ODMH). b) Outcomes specific to the IHBT rule are submitted directly to ODMH's designee, the Center for Innovative Practices. The two additional outcomes are (1) Whether the child lived in out-of-home placement for more than a total of 14 days from IHBT admission to discharge and (2) whether child is living at home at time of discharge from IHBT.
3) Are fidelity ratings scores tied to certification?	No, they are used for program CQI and for statewide benchmarking. The only requirement is that they are completed every 12 months.
4) Is there any way to differentiate outcomes between youth at risk of out-of-home placement and those returning home? For example: youth who are returning home are often rated very high by parents on the Ohio Scales based on the last 30 days.	No. The IHBT thresholds are the same for all youth receiving IHBT services regardless of their status prior to referral.
5) What reports will we receive?	CIP will merge and analyze IHBT team's outcomes data. You will receive individual client and benchmarked reports.
6) Where can I find the outcomes thresholds?	In the Appendix A to the IHBT rule (5122-29-28)
7) What if my team does not make the outcomes thresholds? Will I be decertified?	CQI is the first step taken if a team does not meet the designated thresholds. The second step would be a plan of correction. If after both of these steps the team is unsuccessful in meeting thresholds the decertification process could be initiated by ODMH.

STANDARDS	
1) Is the face to face contact requirement of Paragraph F(1) of the rule with the youth, collateral contacts, or both?	Can be any combination as long as the conditions of F(1) are met.
2) If a 2 person team visits a home at the same time — one works with kid; one works with parent for 1 hour each. Does this count for 2 hours of service or just one?	It counts as two different contacts. Documentation will need to reflect the two different contacts.
3) Is the 3 hours per week an average during the course of IHBT treatment?	No. The child/family must receive 3 hours of IHBT service each week.
4) Would non-Medicaid cases served by our department count towards the three hours?	Yes. IHBT rules are applicable to all clients receiving the service, regardless of funding source.
5) If, for instance, an agency is providing FFT that does not meet the IHBT standards, can FFT still be provided and billed as it has been before this IHBT, i.e. billed as counseling and assessment and CPST?	Yes. A provider has the option whether they chose to become certified for IHBT. If they chose not to they could continue billing services as they do now.
6) "Home" excludes short term placement. What about when working towards reunification for a youth from a foster placement? Will IHBT be a Medicaid eligible service in this venue?	Only if the youth is being reunified with his or her biological, custodial, or kin family within 30 days. To receive IHBT the youth needs to be in a long term, committed family unit.
7) In our department we utilize 2 best practice models (MST & FFT) both in ways that meet criteria for IHBT. Are we able to be considered one department despite using 2 different models? Can we aggregate caseload size averages, etc over 2 models?	An agency certified for IHBT must be in compliance with all certification standards, even if it utilizes an evidenced based practice model to provide IHBT. The caseload requirements are per each individual providing IHBT, and cannot be aggregated either within an IHBT team/department/model, etc.
8) How do you define "at risk" of out-of-home placement? Who decides the child is at risk? E.g. trips to detention are considered "out-of-home placement".	The provider agency defines and documents "at-risk" for out-of-home placement.
9) Re: staff requirements: If I have an IHBT team of 2 and one resigns? Can the other provider continue to bill IHBT?	Yes. It is expected that the agency is making efforts to recruit new staff.
10) Does my IHBT have to be on call throughout the week or can we utilize another source to be on-call for the family?	The IHBT team is ultimately responsible for being on-call for all families they serve. Other on-call systems can only be used if the IHBT remains directly available to each family served 24/7, including direct crisis contact if needed.
11) Can supervisor do 2 hours of group supervision, as opposed to 2 hours of individual supervision for each staff in the program? This is very burdensome for clinical supervisors who have a 5 provider team of IHBT service.	Yes. The rule does not dictate the kind of supervision (group, individual etc) only that it be at least 2 hours or more.

COSTING/BILLING	
1) Has the funding model been piloted?	This model has not been piloted, however, the Department has reviewed reimbursement methodologies used in several other states and has developed a model consistent with current reimbursement of other mental health services being provided.
2) If an agency is Medicaid only how are they to be reimbursed for the non-Medicaid services? (IHBT clinical and IHBT non-clinical)	The provider of IHBT services will need to secure other sources to provide funding for the non-clinical components of the service.
3) Is Crisis Intervention in the bundled rate? *4) Is Crisis Intervention service billed over and beyond the IHBT service if provided by a staff not involved with IHBT team?*	Crisis intervention is not included in the IHBT rate, but crisis response is included. Crisis response is defined as the "immediate access and availability of the IHBT provider, by phone and face-to-face, as clinically indicated, to the youth and family, which may include crisis stabilization, safety planning, and the alleviation of the presenting crisis. Yes. Crisis intervention is billable as a separate service.
5) Need clarity on dual rates (clinical/non-clinical) and how they are actually billed.	Costs for both components of the IHBT service will be developed in the same manner as all other services and must be established in accordance with 5122-26-19.
6) Need clarification of the purpose or reasoning behind the two categories of billing – clinical and non-clinical.	Certain components of the service are not reimbursable under the Medicaid program.
7) What about group (CSP/counseling) Is it included in the bundled rate?	Group CSP may be provided and reimbursed as a component of the IHBT service.
8) What is the status of IHBT becoming a Medicaid eligible service?	The Ohio Department of Mental Health and the Ohio Department of Job and Family Services continue to work with the Centers for Medicare and Medicaid to add ACT and IHBT as Ohio Medicaid covered services.

DOCUMENTATION	
1) Can each discipline do their own weekly summary?	Yes, however, the rule requires only one weekly progress note that summarizes the treatment provided in that week.
2) What are the documentation requirements for a service contact note?	Must meet the requirements in OAC 5122-27-~~16~~ 06 These include: 1. The date of the service contact. 2. The time of day of the contact. 3. The duration of the service contact. 4. Brief description of therapeutic intervention 5. Signature/credentials of provider
3) What does the standard say about documentation?	For the IHBT Program services, agencies will have the choice of 1. Brief documentation of every contact (duration, time, service, where, who) defined as service contact notes, ***and*** an individualized weekly summary of the IHBT program treatment services that were provided and client's progress toward meeting the mental health treatment goals, or 2. Following the current system, (i.e. progress notes for each service contact. If Agencies select Option 1, they may still document using progress notes if the clinician desires.
4) Re: ACT and IHBT contact notes: *Does the signature and credential need to be dated? (or is the date of service sufficient?)*	For the contact note, the signature, credentials, and date of service is sufficient. For the weekly summary progress note the date(s) of the signature(s) need to be documented.

TRAINING	
1) What does "documented competency" mean?	Documented competency is a formal review of a person's education, training and experience to determine their ability to perform job responsibilities. Competency can be verified by references, college transcripts, training certificates, resumes, agency written/verbal test results, etc.
2) How should our agency verify and document competency?	ODMH purposely chose to allow individual agency flexibility in determining how to best meet this standard. In addition, JCAHO, COA & CARF all have standards around staff competency.

If you do not see your question addressed, please refer to the following resource directory of ODMH and IHBT staff that can help you with your questions.