Clinical Performance Standards:

Intensive Behavioral Health Services (IBHS)

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Member Services Hotline
888.545.2600
888.436.7482 *(TTY)*

Mental Health Delegate Hotline
215.685.6440

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1. PURPOSE OF INTENSIVE BEHAVIORAL HEALTH SERVICES (IBHS) PERFORMANCE STANDARDS

The purpose of the Community Behavioral Health (CBH) IBHS Performance Standards is to establish expectations for high-quality IBHS for children, adolescents, young adults, (hereafter often referred to as "youth"), and their families so that they may achieve success and build capacity in their living, working, and learning communities. Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery, and to improve outcomes for members. These Standards articulate requirements for IBHS and provide a guide for providers to design and monitor their programs. Nothing in this document is meant to supersede state or federal regulatory requirements or CBH Quality, Compliance, and Credentialing requirements. It is CBH's expectation that providers apply these Performance Standards when developing internal quality monitoring activities. CBH will use this document as a guide when conducting quality reviews.

The Performance Standards reflect the core values of the City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) **Practice Guidelines for Resilience and Recovery Oriented Treatment**, **Child and Adolescent Social Service Program (CASSP),** and **System of Care** principles and align recommendations of **The Mayor's Blue Ribbon Commission on Children's Behavioral Health (2007)**. These standards were developed through collaboration with youth and family members, providers, and system stakeholders.

These standards apply to Regionalized IBHS, which includes Individual IBHS delivered in all settings, Group IBHS delivered in school settings, and Group IBHS delivered in community and community-like settings.

The Standards emphasize alignment of services based on needs to promote accessibility, quality of care, and treatment that is culturally and linguistically competent way for youth and families while addressing the social determinants of health. Treatment should encompass the whole health of the youth with attention to their physical, educational, family, and social/recreational needs in addition to addressing their behavioral health challenges. This requires consistent and active family, school, and stakeholder engagement and inclusive treatment planning, progress monitoring, community supports, and discharge planning.

Failure to adhere to IBHS Performance Standards—including consistent inability to adequately staff cases, resulting in failure to provide treatment at the intensity, frequency, and duration as prescribed—may result in remediation through technical assistance, a corrective action plan, or termination of IBHS from a provider's contracted services. Providers must notify CBH immediately of their inability to comply with these standards and implement an interim plan to ensure continuity of care for members at all times.

2. IBHS OVERVIEW

IBHS is a voluntary, non-urgent mental health service for Medical Assistance eligible youth, ages 0 to 21, and their families. The Pennsylvania Department of Human Services describes IBHS as treatment services that "support children, youth, and young adults with mental, emotional, and behavioral health needs. IBHS offers a wide array of services that meet the needs of these individuals in their homes, schools, and communities. IBHS has three categories of service:

1. Individual Services, which provide services to one child at a time

2. Applied Behavior Analysis (ABA), which is a specific behavioral approach to services

3. Group Services, which are most often provided to 2 or more children at the same time

Evidence-based treatment (EBT) can be delivered through Individual Services, ABA Services, and Group Services." Initial assessment and initiation of treatment services can occur simultaneously, "which allows for continuity of care, a smoother transition to service provision, reduction in inconsistencies in treatment approach, and less delay in beginning treatment."[1]

IBHS agencies must enroll in the Medical Assistance (MA) Program and meet conditions for the MA Program. IBHS agencies must also obtain IBHS licensure from the Office of Mental Health and Substance Abuse Services (OMHSAS). OMHSAS mandates additional supervision and training requirements and promotes evidence-based treatments (EBTs). The goal is to develop a more qualified IBHS workforce to deliver treatment services that reduce the need for higher levels of care or out-of-home placements and contribute to better clinical outcomes for youth. Additionally, as part of the transformation of school-based services, CBH is requiring contracted IBHS providers to implement specific EBTs, described later in this manual.

Per the CBH procurement, delivery of Individual and Group IBHS in schools and surrounding communities is based on assigned and contracted "clusters" defined by school location. The IBHS agency assigned to a cluster is designated as a preferred provider. The preferred provider functions as the primary point of contact for IBHS-enrolled youth and families and for school leadership for behavioral health services for all Medical Assistance-eligible youth in the school. In addition to school-based services, IBHS providers are responsible for delivering services to youth and families as clinically indicated across home and community settings, even if those settings are outside of the provider's cluster. The IBHS agency for each cluster is responsible for coordinating treatment services within each school building, including coordinating across providers who are involved in the youth's care. Assigned cluster providers may also offer Group Services at designated sites within each cluster in alignment with OMHSAS-approved service descriptions. Families will continue to be the primary decision makers with regard to the care of their children, so family choice will take precedence in recognizing and accommodating the unique needs of children.

Each in-school team is comprised of licensed, master's-prepared clinicians, bachelor's-prepared staff, care coordinators, and family peer specialists who work together to serve a flexibly sized caseload of youth and families. Staff who meet the requirements to deliver IBHS Individual Services will also work with youth and families in home and community settings. Because the role of care coordinator and family peer specialist rely heavily on local knowledge and lived experience, CBH is not setting a minimum educational or experience requirement.

3. SCOPE OF SERVICES

IBHS provides the opportunity for individualized, culturally and linguistically competent treatment and supports, ongoing assessment, and skill-building tailored to the needs of youth and family through Individual and Group Services. Assessment and treatment are delivered in the home, school, and community settings as is clinically indicated.

Individual Services involve interventions designed to reduce and manage behaviors of concern while increasing coping skills and prosocial behaviors, with the goal of keeping children in school, with their families, and in their home community. Individual and family therapy should work to identify and treat the drivers of internalizing and externalizing

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[1] Volume 49, Issue 42, 49 Pa.B. 6088, Intensive Behavioral Health Services RULES AND REGULATIONS, Title 55—HUMAN SERVICES, DEPARTMENT OF HUMAN SERVICES, [55 PA. CODE CHS. 1155 AND 5240], Intensive Behavioral Health Services, [49 Pa.B. 6088], [Saturday, October 19, 2019]

behaviors that present as the reason for referral or are further identified as a part of the clinical formulation. Evidence-based practices for individual therapy and consultation with school staff are required. It is expected that the clinical team engages the family, minimally includes a family goal in the treatment plan, and provides family therapy as clinically indicated. Individual services include: Behavior Consultation Services, Mobile Therapy, and Behavioral Health Technician Services. While it is expected that IBHS providers deliver family therapy through the modality of mobile therapy, youth whose symptoms meet the medical necessity criteria for targeted evidence-based interventions like Functional Family Therapy, Multisystemic Therapy for Problem Sexual Behaviors, and Family-Based Services, may be referred for those services in lieu of MT. The full scope and referral requirements for those EBT's lies outside the scope of these standards.

Group therapy is offered in schools, and, as part of the package of group services, IBHS providers will be required to offer specific evidence-based group interventions in their assigned schools to reduce behavioral problems, symptoms of Post-Traumatic Stress Disorder (PTSD), and to improve functioning across settings. IBHS in-school services are integrated with school interventions and include evidence-based clinical interventions, evidence-based teacher consultation and training, care coordination to address social determinants of health, crisis intervention support, and family engagement.

Community-based and community-like group therapy may be offered by the designated cluster provider throughout the school year and during times when school is not in session. Youth may be identified for group participation based upon presenting common issues such as grief, anger management difficulties, bullying, social skill development, diagnostic symptom-specific needs, or any other identified needs within the cluster population. In such cases, it is expected that group treatment interventions are research-based and, whenever possible, that those interventions are evidence-based. The specific group treatments being utilized should be described within the OMHSAS-approved service description. It is also expected that those providers that are providing additional evidence-based groups will achieve EPIC designation.

For children receiving IBHS, additional behavioral health services are not expected to be needed, except for psychiatric evaluations, medication management, and substance use disorder treatment. Case management services from a licensed case management provider may be considered in addition to IBHS for children and families assessed to be at high risk for poor outcomes related to social determinants of health and/or who require more intensive case management interventions. If another behavioral health service is necessary, the IBHS provider is expected to initiate coordination of care from the point of admission and continue until the youth is discharged from the concurrent service.

IBHS will not be permitted to occur concurrently with the following levels of care:

- Support Team for Education Partnership (STEP): Although an IBHS agency may provide treatment onsite at a STEP school to other children, individual children cannot receive IBHS and STEP concurrently. It is the expectation that STEP teams, in collaboration with school counselors, make appropriate referrals to IBHS agencies.
- Family-Based Services: Children referred to FBS will have their individual and family therapeutic needs met within that service. Therefore, FBS and MT cannot co-occur. If clinically indicated, Behavior Consultant and Behavior Health Technician support may still occur in school with ongoing and regular collaboration with family-based providers.
- Acute Partial Hospitalization Services: Whenever a youth is placed in an APHP, IBHS cannot occur in the school setting; however, services can continue in the home or community, as clinically indicated and with ongoing, regular collaboration with partial hospital.
- Psychiatric Residential Treatment Facility Services: Youth placed in a PRTF setting cannot concurrently receive IBHS in that setting. Behavior Consultant and Behavior Health Technician support may still occur in community school settings with ongoing, regular collaboration with residential providers. Service intensity

will change as the youth's, the family's, and the school's needs change. Discharge from IBHS should occur when clinically indicated and/or at the family's request.

3.1. Provider Clinical Outcomes

Providers are responsible for the following desired treatment outcomes for Individual and Group Services:

- Improvement in clinical symptoms, evidenced by lower symptomatology scores on the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) screening tool (as well as completion of treatment plan goals and objectives).
    - Providers will be expected to utilize the Trauma Exposure Checklist (TEC) for all youth receiving CBITS and the Traumatic Events Screening Inventory: Child (TESI-C) for all youth receiving Bounce Back. Providers must enter pre and post measures in QuickBase application (Access provided by CBH). Providers are required to enter data beginning the academic year following the completion of CBITS/Bounce Back training and consultation.
- Improvement in aggregate scores on a measure of Social Determinants of Health.
    - SDOH measurement is expected for all youth who entered IBHS after October 1, 2021, at minimum at intake and at discharge. Many IBHS providers have adopted periodic assessment practices, such as every 6- to 12-months. CBH will analyze and evaluate SDOH data annually. CBH has provided QuickBase application access for providers choosing to use the *Arizona Self-Sufficiency Matrix* or the *OneCare Vermont: Self-Sufficiency Outcomes Matrix*. Providers are also free to use another tool of their choice through August 2023, and must submit aggregate change scores for each domain annually.
    - Effective September 2023, all providers will be expected to use either the *Arizona Self-Sufficiency Matrix* or the *OneCare Vermont: Self-Sufficiency Outcomes Matrix* and to submit intake and discharge scores through the CBH Quickbase database. At this time, data submission via Quickbase is only required for youth in schools included in the scope of the Regionalized IBHS procurement.
- Community tenure, as evidenced by decreased utilization of high-acuity behavioral health services (e.g. crisis services, Acute inpatient, partial hospitalization services, PRTF), allowing children to remain in their home communities and schools.
    - CBH will evaluate this quarterly using claims-based data and the CBH IBHS Dashboard
- Data driven and evidence-based, individualized treatment, as evidenced through evaluation of Functional Behavioral Assessments and Progress Monitoring Reviews.
    - CBH will use the CBH Functional Behavior Assessment and Progress Monitoring Tools to evaluate this regularly and provide feedback through the CBH FBA and Progress Monitoring Dashboards.

All metrics associated with IBHS Performance Standards may be shared publicly.

4. PHILOSOPHY OF SERVICES

The IBHS Performance Standards have been guided by best practices and seek to emphasize:

- Individualized, culturally and linguistically competent, strength/resiliency-based, trauma-informed services with a focus on skill building through implementation of evidence-based practices
- Accessible, coordinated, and comprehensive services across child-serving systems
- Focus on the interrelationship between the youth, their environment, family, and the school system while using positive approaches to behavior support to strengthen these relationships
- Youth/family voice and choice in all treatment, support, and program decisions
- Comprehensive and immediate family engagement and partnerships to support sustained, successful outcomes for youth with their families in the home and community

4.1. Cultural Competency

It is expected that children and families referred to IBHS will comprise varying racial and socioeconomic backgrounds, and the provider must be culturally and linguistically competent and have experience working with families with diverse backgrounds, identities, and related needs. They must be prepared to treat and support families whose treatment needs are heavily impacted and informed by social determinants and risk factors, including health complications, substance use challenges, poverty, histories of homelessness, unstable or inadequate housing, and violence in their communities. Providers should also be affirming of LGBTQIA populations. The provider must ensure that services are delivered in a manner that is welcoming to people from diverse cultures and have the resources to work with individuals and families who speak languages other than English.

All IBHS providers are expected to support the development of cultural literacy regarding gender, age, race, ethnicity, spirituality/religion, gender identity, and sexual orientation within their programs and amongst their staff through adherence to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). These **standards** and an **implementation guide** are available through the Department of Health and Human Services, Office of Minority Health.

Key components include:

- Open, respectful communication with youth and families to better understand culturally based values and belief systems that need to be considered when learning and practicing new self-regulation/supportive skills
- Documentation of all initiatives to further develop the cultural literacy and sensitivity of staff and interventions to improve the overall equitability of their programs
- The presence of a diverse and culturally and linguistically competent workforce (all levels of agency leadership and direct care professionals)
- Ability to accept and accommodate the needs of LGBTQIA youth, including respecting and accounting for gender identity and sexual orientation in treatment, ensuring special medical needs are met for transgender youth and that youth-selected names and pronouns are used consistently

The IBHS provider must ensure knowledge and skills to meet all special communication needs (e.g. deaf, hard-of-hearing, visually impaired, ASD), reaching out to the broader community to increase their expertise and/or bringing in experts/peers/families with similar needs to support the individual youth and family, or minimally obtaining interpretation and translation services, as indicated for each youth and family.

5. SUMMARY OF REQUIRED ELEMENTS

IBHS required elements are listed below and will be elaborated upon elsewhere in the document.

- Adherence to IBHS access, service initiation, and assessment as outlined in the IBHS regulations
- Family-driven, youth-guided, and culturally and linguistically competent organizational culture demonstrated through family engagement and treatment
- Achievement of or adequate progress towards provider clinical outcomes
- Adherence to the Provider-School Agreement as evidenced by CBH and self-audit
- Evidence-based treatment
- Regionalization of providers to align services to best meet community and school behavioral health needs
- Care coordination and collaboration with school, provider, and community entities for resource linkage and natural supports
- Assessment of and interventions related to social determinants of health to inform treatment planning
- Family engagement strategies that leverage natural resources and supports in schools and in the community
- Hiring, supervision, and training practices that support quality care and staff retention
- Submission of CBH required data, including clinical outcomes tools, social determinant of health metrics, and provider/school data as outlined in the memorandum of understanding.

6. IBHS ACCESS AND REFERRAL PROCESS

The IBHS provider accepts referrals from families, an evaluator, another service provider, or from a school's progressive intervention and identification process within the Multi-Tiered System of Support (MTSS) framework, as appropriate.

IBHS providers are expected to inform referral sources, youth, and families about their IBHS program, why IBHS is being recommended, and how they can meet the youth's and family's needs. Providers are expected to maintain up-to-date, family-friendly literature for families and referral sources, including schools. The provider must also maintain an ongoing accurate record of enrolled and referred youth to ensure effective cross collaboration with school and other serving or referring entities.

In schools, youth referred from sources other than the school may be referred to the school's MTSS Tier 2-3/Student Assistance Program (SAP) team to ensure that school-based, behavioral, and academic supports are appropriately considered and integrated with IBHS. The IBHS provider should participate in discussion of the referral in the Tier 2-3/SAP team meeting to help identify the youth's previous and current interventions, strengths, and needs and to identify those students who are not responding to school-led climate and behavioral interventions. The MTSS process and discussion should also determine if the youth is appropriate for SAP referral for modification of the school-led intervention, for referral to IBHS, or for referral to an alternative treatment.

Once a referral is received, the provider reaches out to the family to engage in services within 7 days of receipt of referral. IBHS is only accessed via a Written Order completed by an appropriately qualified and licensed Behavioral Healthcare Provider. Written Orders can be generated by a Physician, Psychologist, Certified Registered Nurse Practitioner, or other licensed professional whose scope of practice includes diagnosis and treatment of behavioral health, as per the IBHS regulations. Written Orders require a face-to-face therapeutic encounter with the youth and family. Once a Written Order has been completed, initial assessment and treatment should begin within 15 calendar days. Some IBHS Services require prior authorization from CBH. All IBHS Providers are responsible for providing timely assessment and treatment to all referred youth referred.

7. INFORMED CONSENT

Consent for treatment should be obtained in accordance with all state and federal regulations and laws for age and guardian consent and for authorization to release information. Youth aged 14 or over must consent to their own treatment and be an active partner in assessment, goal selection, plan development, and the treatment process. Verification of legal guardianship should be obtained for children residing in out-of-home placements, or whenever consent is not able to be obtained from all possible legal/custodial parties. Youth aged 14 or over must sign their own treatment plan.

8. IBHS INITIATION AND ASSESSMENT

Please see **55 PA. Code CHS. 1155** and 5240 for timelines and staff requirements related to IBHS assessment and service initiation.

An assessment can be completed by a Master's level professional qualified to complete an assessment per the regulations and includes, at a minimum, all elements required in an assessment as indicated in the regulations. The IBHS Assessment must be completed within 15 days of initiation of Individual and Group Services.2 The assessment should include the structured tools associated with the evidence-based treatment that will be utilized. For youth being considered for enrollment into CBITS or Bounce Back group, the screener is completed during the assessment period. The social determinants questionnaire is also completed during the assessment period. For youth being considered for other group treatment modalities, other appropriate screening tools to identify those additional treatment needs should also be administered during the assessment period. For youth whose IBHS array may include a Behavioral Health Technician (BHT), a Functional Behavior Assessment (FBA) is also required.

If a youth requires a psychological evaluation or other specialized assessment, the IBHS provider shall ensure that the youth receive the clinically appropriate assessment. A Licensed Psychologist or Licensed Psychiatrist should assess any youth for whom additional, in-depth evaluation is needed; for whom there are concerns about clinical risk and/or mental status; for youth that have made limited therapeutic gains and/or have presented for a higher level of care; for cases that have multiple system involvement, concurrent services, or multiple family members receiving services; for cases presenting with increased diagnostic complexity; or instances for which stabilization or progress are limited.

A Functional Behavior Assessment (FBA) is required if BHT is being requested following initial assessment. An updated FBA is required for continued stay or increases to BHT hours. A new FBA should be completed whenever new behaviors of concern present, current behaviors increase, or when the current treatment plan is not beneficial. The clinician must

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[2] Volume 49, Issue 42, 49 Pa.B. 6088, Intensive Behavioral Health Services RULES AND REGULATIONS, Title 55—HUMAN SERVICES, DEPARTMENT OF HUMAN SERVICES, [55 PA. CODE CHS. 1155 AND 5240], Intensive Behavioral Health Services, [49 Pa.B. 6088], [Saturday, October 19, 2019] § 5240.21

work in conjunction with the parent or caregiver and any other professionals working with the youth to identify the problem behaviors and skill deficits. Target behaviors must be clearly and operationally defined. Operational definitions must be clear, objective, and complete.

Although a specific format is not dictated, an FBA should minimally include the following components:

- Indirect assessment of the behavior(s) via structured or semi-structured interview with a parent, caregiver, or the youth
- Interviews to obtain collateral, cross-setting information about the child's behaviors and functioning
- Records review, including previous history of behavioral health and special education services, Initial Family Service Plan or Individualized Education Plan (IEP) services and supports, and utilization and impact of less restrictive treatments
- Indirect rating scales, such as Motivational Assessment Scale (MAS), Questions about Behavioral Function (QABF), or Functional Analysis Screening Tool (FAST), with data summarized in graphic or chart form (i.e. average scores and hypothesized function), including at least one informant from each identified setting in which the behavior is likely to occur
- Direct observation and data collection, including observed setting events, antecedents, and consequences, in all locations and settings in which the behavior has been reported as likely to occur, based on the results of the parent/caregiver interview
- Line graphs of baseline data, in whatever measurement form collected (e.g., frequency, rate, duration, percent of opportunities)
- Summary of all assessment data, in table or graph form, including but not limited to data identifying the percentage of time the behavior occurred during particular activities, percentage of times the behavior occurred after each antecedent (i.e., antecedent analysis), and/or percentage of time the behavior occurred followed by each identified consequence
- Hypothesis statements based on the results of the assessments and conditions under which the target behavior is more likely to occur
- Skill acquisition

To support appropriate assessment, youth can receive the continuum of IBHS care within the initial assessment period for stabilization and treatment, as clinically needed, provided an initial treatment plan is developed for the delivery of these services. The only exception to the FBA requirement may be for children stepping down from PRTF or AIP settings, if the WO for IBHS is completed by an attending Licensed Psychiatrist or Psychologist and an FBA is not possible in that setting. In those instances, youth may receive one authorization of BHT in the absence of an FBA and it would then be the responsibility of the receiving IBHS provider to complete an FBA in the first 15 days of service initiation. All concurrent requests for BHT must include an FBA that has been updated within the last 60 days and reflects current data in support of the continued medical necessity for the type, amount, and duration of BHT.

Following the IBHS assessment, the IBHS provider is responsible for recommending appropriate behavioral health services that may or may not include continued IBHS. If IBHS is clinically indicated, the IBHS provider shall generate an updated Written Order to reflect ongoing services needed, for up to 365 days. If the youth's needs can be better met by a service other than IBHS, for example FBS or outpatient, referrals should be made to initiate those services in lieu of IBHS.

9. IBHS TREATMENT PLANNING

It is the responsibility of the provider to ensure adequate staffing so that services in the Written Order and included in the treatment plan are delivered as prescribed.

In addition to requirements in **55 PA. Code Ch. 5240**, the Individual Treatment Plan (ITP) must be:

- Based on assessment and completed within 30 days of initiation of individual and group services
- Strength-based
- Inclusive of interventions needed to address specific skills and targeted behaviors for improvement with clear documentation of progress toward goals, including:
  - Baseline data on all target behaviors and skill acquisition targets
  - Results of any assessments, including structured tools where appropriate and indicated
  - Behaviors targeted for decrease objectively defined
  - Replacement behaviors identified and objectively defined
  - Specific, objective, and measurable treatment plan goals
  - Method for collecting data for all behaviors
  - Graphs of behavior (including baseline data)
  - Interventions for target behaviors
  - For services that include BHT level of care:
    - Interventions that are function-based and refer to the results of the FBA
    - Selected reinforcers and the reinforcement schedule
    - Consequences for the occurrence of target behavior
  - Criteria and schedule for determining when a goal should be revised, specified clearly (i.e. advancement and regression criteria)

Treatment plans must also include de-escalation and safety plans for any target behaviors that risk harm or injury to self or others. It should be individualized, emphasize antecedent management to prevent crisis situations, and be written so that the youth, families, and school staff can easily understand and follow it.

Although the IBHS regulations do not require psychologists to perform initial assessments, providers are encouraged to have them function in the role of Clinical Director. In addition to Psychological Evaluations and Psychological Testing, involvement of the psychologist is particularly important to drive the clinical thinking and creation of the ITP, particularly

for children and families who are not making progress and provide an overall more consistent presence in the treatment environment.

State regulations require that a parent/legal guardian sign the treatment plan, including a de-escalation and safety plan, for children under 14. Youth 14 and over may consent to their own treatment and must sign their own treatment plans. It is best practice for treatment plans to be signed by all parties who participated in the development or updating of the plan.

10. REQUIRED SERVICES

IBHS is intended to complement and build upon existing School District interventions including Positive Behavior Supports (PBS), Support Team for Education Partnership (STEP), and the Multi-Tiered System of Support (MTSS) framework.

Within the school setting, the IBHS team will work with the school to help create a culture to decrease the development of new problem behaviors; prevent the worsening of existing problem behaviors; eliminate triggers and maintainers of problem behaviors; and teach, monitor, and acknowledge prosocial behavior. Treatment provided in the home and other community settings is intended to help the youth capitalize on family and community resources, address barriers to progress that exist outside of the school environment, and assist with skill generalization.

Integration into the school community and culture is vital to understanding the needs of the children in the schools and the needs of the adults to best support the children. As such, IBHS providers in schools are expected to adhere to the provider-school agreement (“Exhibit A”; see Appendix A).

10.1. Individual Services

Individual Services can be conducted by a Mobile Therapist (MT), Behavior Consultant (BC), or Behavior Health Technician (BHT). Interventions for individual therapy must be person-centered and culturally competent with an emphasis on evidence-based approaches to the individual needs of each youth. The frequency of individual therapy should be based on the youth and family’s progress in developing the skills and support needs for the youth’s successful discharge from IBHS.

10.2. Group Services

OMHSAS conceives of Group Services as the interventions that are conducted in school or the community. These interventions can include individual and/or group therapy, depending on the clinical needs of the youth. Group Services can be conducted by an MT or BC.

Community-based and community-like group treatment follows the IBHS regulations regarding staff qualifications and staff supervision for group IBHS. A graduate-level professional provides individual, group, and family psychotherapy, designs psychoeducational group activities, and shall be present during all group activities.

10.2.1. Group Size

Consistent with MA regulations for group therapy, groups must include at least two and no more than 20 participants. For children under the age of 36 months, the group size is not to exceed six children as is consistent with PA Commonwealth regulations for center-based childcare centers. For groups of mixed age children that include children under 36 months as well as older children, the maximum number of children is six.

10.3. Psychiatry

IBHS providers are expected to develop a plan for ensuring access to Psychiatry as part of their IBHS service delivery. If an IBHS provider does not have access to psychiatry within their own organization, the IBHS provider shall coordinate referral and linkage to psychiatry through available CBH resources. This may be an appropriate task for Care Coordinators or Family Peers who help the child and family with this and other linkages.

10.4. Evidence-Based Practices (EBP)

IBHS requires implementation of evidence-based clinical interventions that are developmentally appropriate and consistent with the needs identified in the youth's comprehensive assessment. Required EBPs include:

- Cognitive Behavioral Therapy (CBT)
- Cognitive Behavioral Interventions for Trauma in Schools (CBITS)
- Bounce Back
- Bridging Mental Health and Education in Urban Schools (BRIDGE)

Other evidence-based practices that could be utilized include those identified per IBHS regulations, as well as Trauma-Focused Cognitive Behavior Therapy (TF-CBT); Ecosystemic Structural Family Therapy (ESFT); Motivational Interviewing (MI); Trauma Systems Therapy (TST); Attachment, Regulation, and Competency (ARC); Risking Connections, Collaborative and Proactive Solutions (Dr. Ross Greene); Collaborative Problem Solving.

In addition to participating in training and consultation in the required EBPs, providers are expected to achieve EPIC designation in each required EBP. Providers are expected to achieve EPIC designation no later then the end of the academic year following the year in which training and consultation was provided, as outlined below:

Academic Year of Training and Consultation	*EPIC Designation required by*
2021-2022 AY	End of 2022-2023 AY
2022-2023 AY	End of 2023-2024 AY
2023-2024 AY	End of 2024-2025 AY
2024-2025 AY	End of 2025-2026 AY

10.5. Linkages and Coordination of Care

Each IBHS staff member must have an active role in securing and sustaining linkages to community resources and other providers to plan a successful discharge for each youth and family. IBHS providers must also establish working relationships with outside medical providers and specialists to address routine and complex medical needs of youth.

The IBHS provider will coordinate care with the school (including related therapies such as speech, occupational, and physical therapies), other providers, and service systems at the time of admission to IBHS and throughout the course of care to discharge.

The IBHS provider must work in conjunction with the school and family to facilitate a youth's successful transition into and back from out-of-school placements such as acute inpatient, partial hospitalization, and residential treatment facilities.

11. STAFF REQUIREMENTS

In addition to the MT, BC, BHT, and Clinical Director roles specified in the IBHS regulations, the IBHS team must also include a Care Coordinator and Family Peer Specialist.

The Care Coordinator is expected to engage youth, families, and other significant persons involved in the youth's treatment in a collaborative relationship to promote positive outcomes, assess youth and family social determinants of health, and provide supports to address identified physical and behavioral health needs. There are two recommended Social Determinant of Health Scales for care coordinators to utilize: the *Arizona Self-Sufficiency Matrix* or the *OneCare Vermont: Self-Sufficiency Outcomes Matrix*. The outcomes from these scales should be incorporated into a robust treatment and support package for each family. The Care Coordinator should also be well-versed not only in supports and resources available throughout the City of Philadelphia but also within the local community surrounding the child's school and home. They should interface as needed with other relevant systems (i.e. Juvenile Justice, Department of Human Services) to connect families to resources in the community when appropriate. They should work as part of the service team in the implementation of service plans with goals of retaining or re-engaging the child when needed.

The Family Peer Specialist is an adult with lived experience as a family member of a child with behavioral health challenges who supports initial and continuing engagement with IBHS, incorporates youth and family voice into treatment, empowers the family to understand their role as a member of the treatment team, provides support and coaching during meetings, works with families to develop natural resources, and provides other resources as needed.

11.1. Service Intensity and Capacity

Services are expected to be delivered in a flexible manner. Provider presence in schools should accommodate varying needs of students in schools with different support needs. The amount of each IBHS provider's physical presence needed on-site should be flexible and individualized by need on a school-by-school basis.

IBHS providers are responsible for covering the behavioral health needs across schools in their cluster(s). Daily cross-cluster check-ins are strongly encouraged so that providers can assess coverage and significant incident needs to dispatch staff in such a way as to best meet the needs across the entire cluster of schools.

11.2. Guidelines for Staffing Ratios

Because IBHS is a highly individualized service, it is difficult to set fixed staffing ratios for MT, BC, and BHT. Providers must use their discretion in determining case load size to ensure that the clinical needs of children are met and that prescriptions can be filled in their entirety. This may vary from individual to individual based upon the clinical needs of the children on their caseload and the hours the clinician is scheduled to work. Suggested ratios are as follows:

- Mobile Therapist (MT): 1 FTE per 13 youth.

- Behavior Consultant (BC): 1 FTE per 13 youth
- Behavior Health Technician (BHT): 1 FTE per 1-3 youth (depending upon intensity of prescription)
- Clinical Director or Psychologist presence in schools is encouraged to drive the clinical thinking and creation of the ITP, particularly for children and families who are not making progress and to provide an overall more consistent presence in the treatment environment

Because these roles work across the cluster, the minimal staffing ratios are:

- Care Coordinator: 1 FTE per cluster
- Family Peer Specialist: 1 FTE per cluster

It is recommended that IBHS staff are full or part-time employees, salaried and with benefits. An exception to this would be non-routine times to fill a gap in staffing on a temporary basis while active recruitment is occurring to hire full-time or part-time employees.

Staffing ratios for group therapy should be determined by the individual clinical need of the children participating in the group and provisions in the staffing pattern should be readily available to make adjustments as needed.

12. PLACE OF TREATMENT AND HOURS OF OPERATION

Assessment and treatment should occur across settings. Staffing patterns must ensure the ability to deliver active treatment during nontraditional clinical hours such as during evenings and weekends and planning treatment times around youth and family's preference and schedule and must be flexibly delivered. In the educational setting, the IBHS agency provides IBHS in the school, regardless of the youth's designated educational placement. Enrollment in special education classes does not rule out participation in IBHS. Designated cluster providers may provide group treatment within community-based and community-like settings.

13. MANAGEMENT OF CONCERNS

Concerns related to providers and schools may arise as both parties work on aligning efforts.

- Initial, minor concerns should be addressed in meetings between the school and the provider.
- If unresolved at this level, the issues should be addressed via meetings with the school, CBH school-based liaisons, and the District Office of Prevention and Intervention
- For persistent or significant concerns regarding the school, the provider must notify the CBH school-based team for resolution via the District.

14. SUPERVISION AND TRAINING

The provider has a written policy for clinical supervision of all staff providing IBHS to ensure the delivery of services are consistent with the IBHS regulations and the youth's treatment plan. The IBHS Clinical Director has overall responsibility that supervision activities are carried out. In-vivo observational supervision of the Behavior Health Technician is a requirement. In schools, this requires coordination with school leadership and staff.

In addition to participating in all OMHSAS and CBH mandatory trainings, all IBHS in-school staff must be trained as follows:

- All clinical supervisors and staff who deliver Mobile Therapy must complete the CBITS/Bounce Back training
- All Staff who deliver Mobile Therapy must complete CBT training and participate in the coaching, consultation, and implementation support sessions
- All staff who deliver Behavior Consultation must complete BRIDGE training and participate in the coaching, consultation, and implementation support sessions. Consultations with teachers around observed classroom interactions and target behaviors and to coach teachers to use classroom-wide and targeted strategies.
- Those Staff providing BHT services who are qualified with a high school degree must complete a 40-hour training covering the RBT Task List, as evidenced by a certification that includes the name of the responsible trainer, who is certified as a BCBA or BCaBA, prior to servicing any CBH members. Staff prepared for BHT roles with more than a high school diploma must complete a 40-hour training covering the RBT Task List and obtain a certificate within 6 months of hire.

IBHS providers are expected to complete initial EBP training through DBHIDS's Evidence-Based Practice and Innovation Center (EPIC) and will achieve EBP Designation in CBT, CBITS/Bounce Back, and BRIDGE as a result. IBHS providers must internally sustain training in CBT, CBITS/Bounce Back and BRIDGE. Additionally, all IBHS providers must develop approaches to supervision that ensure fidelity to selected interventions.

APPENDIX A: EXHIBIT A DRAFT: EXPECTATIONS FOR IBHS IN SCHOOLS

Please note that this is only a draft of the Exhibit A for the purposes of illustration. This document is not in any way binding and serves purely as an example.

This “Exhibit A” outlines expectations for IBHS providers and School District schools to ensure effective behavioral health supports for children receiving IBHS.

School Contact Information

This document describes the expectations for IBHS at the following School District location:

- School Name: ____
- School Address: ____
- School Principal: ____

The School designates the following individual to serve as the point person for communication at the School (it should be noted that IBHS is not just for MA-eligible children and is covered under private insurance for those who have it, but for the purposes of this agreement with CBH, it is only for MA):

- Name: ____
- Title: ____
- Contact Information: ____

Provider Contact Information

The Provider’s Responsible Official has designated the following individual to serve as Provider’s primary representative for the services provided at the School:

- Name: ____
- Title: ____
- Contact Information: ____

The Provider designates the following individual to serve as the point person for communication at the School (see “Communication” section below):

- Name: ____
- Title: ____

- Contact Information: ____

Signatures

I have received and read "Expectations for Intensive Behavioral Health Services in Schools" and agree to abide by its terms during our professional relationship.

School Administrator or Designee:

Signature: ________________________________ Date: ___________________________

Print: ________________________________ Title: ___________________________

Provider Director or Designee:

Signature: ________________________________ Date: ___________________________

Print: ________________________________ Title: ___________________________

Background: Definitions, Parties, and Legal Requirements

- ***Child or Children***
  The term "child" or "children" is being used to describe a child or youth eligible to receive IBHS school-based services from Kindergarten through 12th grade.

- ***School District and School***
  The term "School District" is defined in the Memorandum of Understanding. The term "School," used herein, refers to a school that is owned, operated, and wholly controlled by the School District of Philadelphia. Individual School District schools and staff, including, but not limited to, principals, have no legal authority to bind the School District. This "Exhibit A" has been prepared to outline expectations and facilitate ongoing communication and collaboration between the Provider and School-level leadership. This "Exhibit A" is subject to and should be interpreted in accordance with the Memorandum of Understanding between the School District of Philadelphia and the Provider. In the event of a conflict between the Memorandum of Understanding and this "Exhibit A," the Memorandum of Understanding will control.

- ***Information Sharing***
  This document discusses collaboration, which assumes sharing of information about a child. Sharing of identifying information, such as child's diagnosis, interventions, medications, etc., are subject to HIPAA and FERPA regulations for providers and schools, respectively. The School District will not provide any information about an individual child that is protected by Applicable Law, including, but not limited to, the Family Educational Rights and Privacy Act (FERPA), to the Provider without a written authorization from the child or the child's parent, as applicable, on a form acceptable to the School District.

- ***IBHS Regulations***
  School District and Provider agree that, to the extent possible, this document should be interpreted in accordance with the applicable IBHS regulations which govern Provider and Provider's IBHS. These regulations require, inter alia, a meeting at least every six months between the Provider and School administration to review performance, collaboration issues, and the written agreement.

Background: IBHS

- IBHS is available to children who are Medical Assistance (MA) eligible. IBHS treatment is voluntary and requires consent from a legal guardian or from the child (if 14 or older) for the child to participate.
- The Provider has been licensed by the Pennsylvania Department of Human Services Office of Mental Health and Substance Abuse Services (OMHSAS) to provide IBHS services, in accordance with Applicable Law.
- The Provider has also entered into a Provider Agreement with Community Behavioral Health (CBH), under which the Provider is authorized to provide and seek reimbursement for these services.
- ***Individual Services*** involve interventions designed to reduce and manage behaviors of concern while increasing coping skills and prosocial behaviors, with the goal of keeping children in school and children and families in the community of their choice. These services are provided across settings as clinically indicated by an assessment. Evidence-based practices for individual therapy and consultation with School staff are required per CBH IBHS Performance Standards. It is expected that the Clinical Team (see "Background: Provider Clinical Team – IBHS Roles" below for a list of the team members) engages the family and includes a family goal in the treatment plan.
- ***Group Therapy*** is offered in schools, and, per CBH IBHS Performance Standards, the Provider is encouraged to offer evidence-based group interventions to reduce behavioral problems, symptoms of Post-Traumatic Stress Disorder (PTSD), and to improve functioning across settings.

Background: Provider Clinical Team – IBHS Roles

- ***Behavior Consultant (BC)***
  Provides clinical direction of services, develops treatment plan, oversees its implementation, and consults with adults across settings regarding treatment planning
- ***Mobile Therapist (MT)***
  Provides individual, family, or group therapy, develops or revises the treatment plan, assists with stabilization as needed, and assists in addressing problems the child has encountered
- ***Behavioral Health Technician (BHT)***
  Implements the treatment plan to fidelity
- ***Clinical Director***
  Provides clinical and quality oversight and ensures Provider staff receive required training

Additional Expectations and Provider Roles in Philadelphia Schools

- ***Family Peer Specialist***
  Provides support through family engagement, shared lived experience, and ensures that families have a voice in their services
- ***Care Coordinator***
  Addresses family or child service engagement concerns, conducts evidence-based assessments to identify

social determinants of child and family wellness needs to inform treatment planning, and identifies and links child and family to appropriate community-based resources

- BC, MT, and BHT will use evidence-based interventions practices for consultation with adults.

Note: *IBHS regulations requires the agency to employ a sufficient number of qualified staff to comply with the administrative oversight, clinical supervision, and monitoring requirements.*

Note: *frequency of staff on-site may vary based on utilization needs of the school. The number of Provider staff and frequency of on-site visits is based on the clinical needs, as per Medical Necessity Criteria, for students with Medical Assistance.*

Establish Shared Expectations

- Provider and School will ensure a **mutual understanding** of their respective mission, roles, and functions. At a minimum, the Provider will educate School leadership and staff on their operational and clinical requirements, and the School will inform the Provider about their behavioral climate interventions and expectations.

- Both the School and Provider will make every effort to **support the child in their natural settings**. Children receiving IBHS should not be excluded from universal (Tier 1) reinforcers solely based on their receiving of IBHS.

Communication

- Provider and School will **designate a point person** responsible for ensuring information gets shared as needed, in accordance with Applicable Law and the appropriate authorizations.

- **Face-to-face, structured communication** should occur in a regularly scheduled meeting at a mutually agreeable time at the school. School leadership shall identify the meetings which require Provider participation for coordination of educational and behavioral health supports.

- **Daily communication** should occur as needed, initiated by both the School and the Provider, to share information about School or behavioral interventions, any changes, or concerns.

- **Information to be shared by School and Provider**, in accordance with Applicable Law and appropriate authorizations, including treatment plans, teacher or counselor behavior plans, referral and service initiation tracking information, behavior progress monitoring data from school and/or provider, IEP, and 504 Service Agreement plans.

- Communication regarding **identifying child information** is contingent on obtaining **FERPA consent and/or HIPAA authorization, as applicable, to release information.**

Needs Assessment

- Provider and the School counselor or STEP clinician, as applicable, should collaboratively **map resources** available for children in the School and community. If Provider serves a child in a community outside of the school region, they are responsible for knowing resources available for the child in that community as well.

- Provider and School should understand **the climate and behavioral interventions across all three Tiers** (Tier 1, universal for all students, Tier 2, targeted interventions, and Tier 3, intensive interventions), to ensure coordinated efforts for children, and to target appropriate consultative support for School teachers and support staff.

Identification and Referral

- School counselor and Provider collaborate in **Tier 2/3 meetings** to identify children who are not responding to school-led climate and behavioral interventions, and to discuss if the child is appropriate for a **Student Assistance Program (SAP) referral** (i.e. for substance use concerns), for an **IBHS referral**, or for a **referral to an alternative treatment.**

- After IBHS and data sharing have been appropriately authorized, School should help facilitate a **warm hand-off** to IBHS (i.e. phone call or meeting with the parent to describe the services, get parent buy-in, introduce parent to provider, etc.).

Initiation of Services

- IBHS are recommended via a Written Order generated by a licensed professional authorized to create a Written Order under IBHS guidelines. Provider will then initiate services with **assessment, treatment, and stabilization services as clinically indicated, over the course of one month**. This can be done through observation, data collection, interview of child, school staff, and family, across settings.

- Provider will then corroborate or request an updated Written Order for the level of services based on their assessment.

- An ITP must be developed by provider and include input from the teachers and school counselors directly involved with the child.

School District-Wide Operational Expectation

- Providers are responsible for serving all the needs of MA-eligible children within their assigned schools in their geographical area as well as in the settings where the child resides or participates in community activities, as clinically needed.

- The School District and the Provider will collaborate to identify an appropriately safe and private space for Provider to run therapeutic groups, provide individual therapy and assessments, and store child records (in a room with a locked door and locked cabinet provided by the Provider), in accordance with the School District's policies, procedures, and directives. The Provider acknowledges and agrees that access, in order to access and use School District space in connection with the Memorandum of Understanding and this Exhibit A, Provider may be required to execute additional agreements and/or forms, as applicable, governing the use of School District facilities, in accordance with School District policies and procedures.

- Providers must keep records of sessions, as well as trackers of referrals, initiation of services, and discharges.

- CBH's School Consultation and Liaison team will be responsible for monitoring adherence to the agreement and collaborating with the School District and Provider to update this Exhibit A, as needed.

- The IBHS agency staff and school administration must meet at least every six months to review performance, collaboration issues, and the written agreement.

Tier 3 Expectations

- **Evidence-based practices** of Cognitive Behavior Intervention for Trauma in Schools (CBITS) or Bounce Back for groups is required, and Cognitive Behavior Therapy (CBT) for individual therapy are required per CBH IBHS Performance Standards. These include some teacher and parent consultation interventions.

- Evidence-based consultation practice, called Bridging Mental Health and Education in Urban Schools (BRIDGE), is required for school staff consultation as per CBH IBHS Performance Standards. Teachers are required to attend one two-hour professional development. Additional consultation time between the provider and teacher can be done in a flexible, as-needed basis.

- **Progress Monitoring** is required for each child receiving IBHS, every 90 days. The child's progress should be discussed in collaboration meetings with the School, Provider, family, and any other identified necessary entities to discuss whether the child is ready for titration of services, discharge from services, or needs increased IBHS or alternative treatment or supportive options.

- **Coordination of Care** requires that both the Provider and School collaboratively engage with other agencies supporting the child, as well as engage the family in this process.

  - Providers and School counselors should collaborate with the acute inpatient, partial hospital, or residential treatment facility regarding the child's transition into and back from out-of-school placements.

  - School and Provider will collaborate with all treating entities including psychiatry, primary care physician, nursing care, adjunctive care such as occupational, physical, and speech therapy, DHS agencies, etc.

- **Family Engagement** is gained by collaboration between the School and Provider. Both School and Provider must set clear and consistent expectations and collectively work on removing barriers to school engagement and treatment engagement. School administration and Provider are expected to invite the child, parent, or legal guardian and other professionals as requested by the child, parent, or legal guardian to progress meetings. Outcomes of such meetings shall be documented by the Provider as specified in IBHS regulations.

- **Crisis Response** is led by School District protocol, with Provider consultation and support in accordance with School District policies and procedures.

- **Supervision and Training** of Provider staff is an enhanced requirement within IBHS.

  - Evidence-based practices require a variety of manualized training of the Provider at the School, via in-person, online, or telephone consultation. Provider must keep School informed of the training requirements and work together to ensure appropriate coverage.

  - Providers must also conduct observational supervision of the Behavior Health Technicians in the School. Again, both School and the Provider should work together on communicating and coordinating so that this can occur most effectively and with the least disruption.

Management of Concerns

- **Concerns related to Provider and School** may arise as both parties work on aligning efforts.
- **Initial, minor concerns** will be addressed in meetings between the School and the Provider.
- **If unresolved** at this level, the issues will be addressed via meetings with the School, the provider, School District Prevention and Intervention liaisons, and CBH school-based liaisons.
- **For persistent or significant concerns, regarding:**
    - **Provider:**
        1. The School will notify the School District Office of Prevention and Intervention.
        2. Office of Prevention and Intervention will notify CBH school-based team.
        3. CBH school-based consultation and liaison team will refer the concern to CBH Quality Department to address via the quality improvement process.
    - **School:**
        1. The Provider will notify CBH school-based consultation and liaison team.
        2. CBH school-based consultation and liaison team will notify the School District Office of Prevention and Intervention.
        3. The School District Office of Prevention and Intervention will refer the concern to be addressed by Deputy Chief, Office of Student Rights and Responsibilities.