Report:
Provider Survey

of the

Youth Empowerment Services (YES)

Quality Review (FY 2021-2022)

Provided by:

Union Point Group, LLC

for the

Idaho Department of Health and Welfare

Division of Behavioral Health

Fall, 2022

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Questions this Provider Survey Report Answers

The Jeff D Settlement requires that Idaho adopt and implement a meaningful annual Quality Review process. The purpose of Idaho's annual Quality Review is fourfold. Namely, to:

objectively assess and improve clinical practice and program effectiveness systemwide;
identify program strengths and needs;
develop actionable clinical data / information;
identify targeted areas for system improvement.

Each year, that purpose is applied to a central, clinical question. The central question addressed by this year's Quality Review is: How well are youth with intensive treatment needs initially connected to timely, appropriate care?

What…impacts the expansion of intensive community-based treatment?

The central question of this year's Quality Review originates from the findings of last year's Quality Review. In last year's Quality Review, we found that youth with intensive treatment needs experienced:

- Delays in the initial access to care;
- Infrequent treatment sessions;
- Care coordination that did not successfully engage partners at school or in the community;
- Disparities in both care and outcomes for persons who identified as culturally diverse.

In collaboration with the Plaintiffs, the Idaho Department of Health and Welfare (IDHW) identified a need for a closer look at the process of connecting youth with intensive treatment needs to appropriate services. IDHW and the Plaintiffs identified four related questions for further study:

(1) What barriers do youth and their caregivers experience when trying to access and participate in intensive community-based treatment services?
(2) To what extent are providers serving youth with intensive treatment needs with care that is timely, appropriate, collaborative and ultimately effective?
(3) What capacity do providers currently have for intensive community-based treatment?
(4) What state-level barriers and supports impact the expansion of intensive community-based treatment?

These last two questions are the central focus of this report.

Executive Summary and Recommendations:

Provider Survey

This Provider Survey was designed to answer two questions:

(1) What capacity do providers currently have for intensive community-based treatment?
(2) What state-level barriers and supports impact the expansion of intensive community-based treatment?

In terms of capacity for intensive community-based treatment, we found that:

a) Individual practitioners, as a group, do not provide intensive, community-based treatment services;
b) Very few provider agencies (5-10%) currently offer intensive, community-based treatment services;
c) The service array is currently contracting, rather than expanding. Providers overwhelmingly attribute this to IDHW's lack of meaningful supports for care expansion. Providers do not attribute this to temporary constraints, such as the conditions created by the COVID pandemic.

IDHW must make providing intensive community treatment attractive to providers.

Barriers and supports impacting the expansion of community based treatment services were readily and consistently identified by providers. Barriers highlighted by providers included:

- unsustainable reimbursement rates;
- administrative burdens to standing up and continuing to provide a service;
- lack of qualified and willing workforce;
- high costs and productivity losses associated with training staff to work with new populations.

The results indicate that a substantive shift in the orientation and actions of IDHW personnel is needed if service expansion is to occur. We provide examples of barriers and supports for expansion, which illustrate the needed shift, in the words of practitioners and providers themselves (Table 1).

Table 1. **Barriers and Supports Associated with Service Expansion**

Supports	Barriers
Start-up Process and Requirements	
A person that had time to Zoom [conference] or visit so I could talk through the requirements and make sure what we have in place is still compliant and appropriate.	Too much work for the reimbursement amount and difficulty understanding all the processes.
The on-site assessor was very easy to work with and our local Optum representative was very quick to process the approval.	Can't get credentialed to start the program. Optum and the state do not know how to get us started for the new TBS program.
Sustainable Reimbursement	
Reimbursement rate that was feasible.	Idaho pays meager reimbursement rates compared to states with populations that match our locale.
	Reimbursement rates are ridiculously low.
Staffing	
[None identified.]	Can't get people to do the service [and] limited hours once they start to do the service.
	[L]ack of qualified workforce.
Staff Training	
…[L]ow cost training.	....cost of training to get people trained and costs of learning new material.
	Finding training that was cost effective for counselor.

Recommendations.

Providing intensive community treatment, and expanding care in general, is currently seen as an onerous, fiscally unsustainable proposition. To address this, IDHW needs to:

> Aggressively pursue system development models, such as Certified Community Behavioral Health Clinics, which simultaneously address multiple concerns including reimbursement rates, staff training, and intensity of care offered;
>
> Use existing administrative structures such as the Center of Excellence to clearly identify and prioritize no-cost clinical training;
>
> Create and continuously update real-time capacity tracking for intensive treatment options so that providers can make referrals electronically, with high confidence that the care is available.

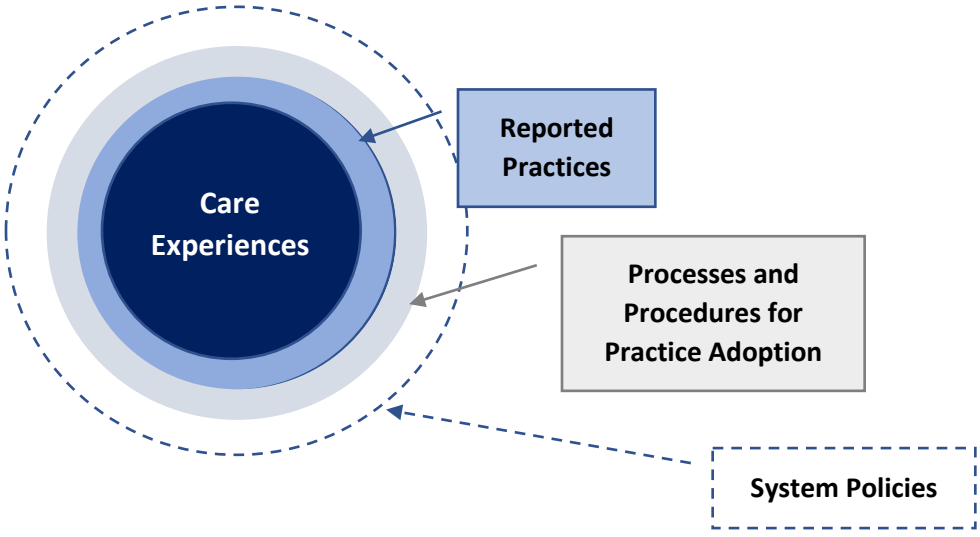
The Quality Review Process and the Provider Survey Design.

A Quality Review process is designed to understand variation in practice. From a practical standpoint, we also want to identify the drivers of these variations in practice. This is because we want to use the findings of the Quality Review. We want to identify a brief set of system actions likely to result in more youth having better experiences and outcomes of care.

The Quality Review we used this year first identifies youth and families' experience of care. We interview youth and their caregivers. In the interviews we ask about the care received, and the emotions evoked during that care process. This way we can understand how care experiences affected motivation for treatment and treatment outcomes.

Then we review all clinical documentation provided to us. This includes assessments, plans of care, encounter notes, crisis plans, transition plans and any other practice documentation. We rate care in terms of its appropriateness and the collaboration providers documented. We follow up with structured interviews with the primary clinician delivering care. We ask clinicians about their decisions during treatment and policies and procedures which may have affected those decisions.

Figure 1. **Assessing the Ecology of Idaho's Youth Empowerment Services**



Then we survey agency representatives and individual practitioners regarding the continuum of care they currently provide, and expansion intentions within the next six months. This year we also asked about what supports are important to expand the services they offer, and how well IDHW supports efforts to expand care.

Method

Provider Survey. A statewide survey of providers was used to gauge how well the YES system of care provides the continuum of care needed by children and youth. The use of a core set of questions across survey administrations allows us to identify how the continuum of care is developing in response to policy changes. Last year we asked about the practices currently provided by agencies and practitioners. This year we asked the same set of questions, in order to understand whether there have been any changes in the care available to YES members.

A second section of the survey focused on the drivers of care expansion (or contraction). We used the responses from open ended items in last year's Provider Survey to generate an initial list of implementation supports. Then we asked providers to rate the importance of those supports, and how well the IDHW provides those supports. This year's provider survey also asked whether the agency or practitioner had, in the past year:

Begun offering one or more new services;
Worked to implement a new service, but then paused or stopped implementation;
Stopped providing one or more services.

Then we asked these respondents open-ended items about the drivers of their decisions to expand, pause expanding, or end services. Responses to these items were grouped by themes. These themes point to specific policies and procedures that affect the growth of the YES continuum of care.

Sampling. An invitation email with a survey description and link was provided to all individual practitioners, and all agency representatives in Optum Idaho's statewide behavioral health provider network. The provider list was obtained from Optum Idaho. De-duplication procedures are described more fully in the report "Quality Review Process and Recommendations, 2022." We initially removed exact duplicate email addresses. We also removed email addresses which did not have an identified Region.

We sampled all resulting individual practitioners. In order to reduce the burden on agencies, we sampled one agency representative per location address in a given region. Regions with fewer agency providers (more individual practitioners) are more likely to have a higher percentage of unduplicated contacts. We retained 550 unduplicated agency contacts or individual practitioners. Each were contacted by e-mail for participation in the survey. Three of these individuals opted out of the survey. They indicated that they did not provide behavioral health services to youth in the previous year.

Of the 547 remaining respondents, 121 did not open the survey (22%). Fifty-eight of the e-mails bounced back, indicating an invalid or inactive e-mail address (11%). The remaining 368 respondents (67%) opened the survey. One hundred and eighty of these respondents clicked through the survey. One hundred and fifty-eight respondents provided partial (55; 35%) or complete (103; 65%) responses.

Survey invitations were first sent out on June 29th, 2022. Automated reminders were sent out weekly to persons who had not opened or had not completed the survey. The survey was closed on July 22nd, 2022.

Results

Capacity for community-based treatment. Chart 1 (below) identifies agencies' self-reported service array. Response percentages are based on survey responses from 38 child-serving agencies who participated in the Summer 2022 survey. Service descriptions are lightly edited versions of the descriptions appearing in the Optum Provider Handbook; they are included in Appendix A for reference.

Chart 1. Agency Respondents' Current and Planned Services

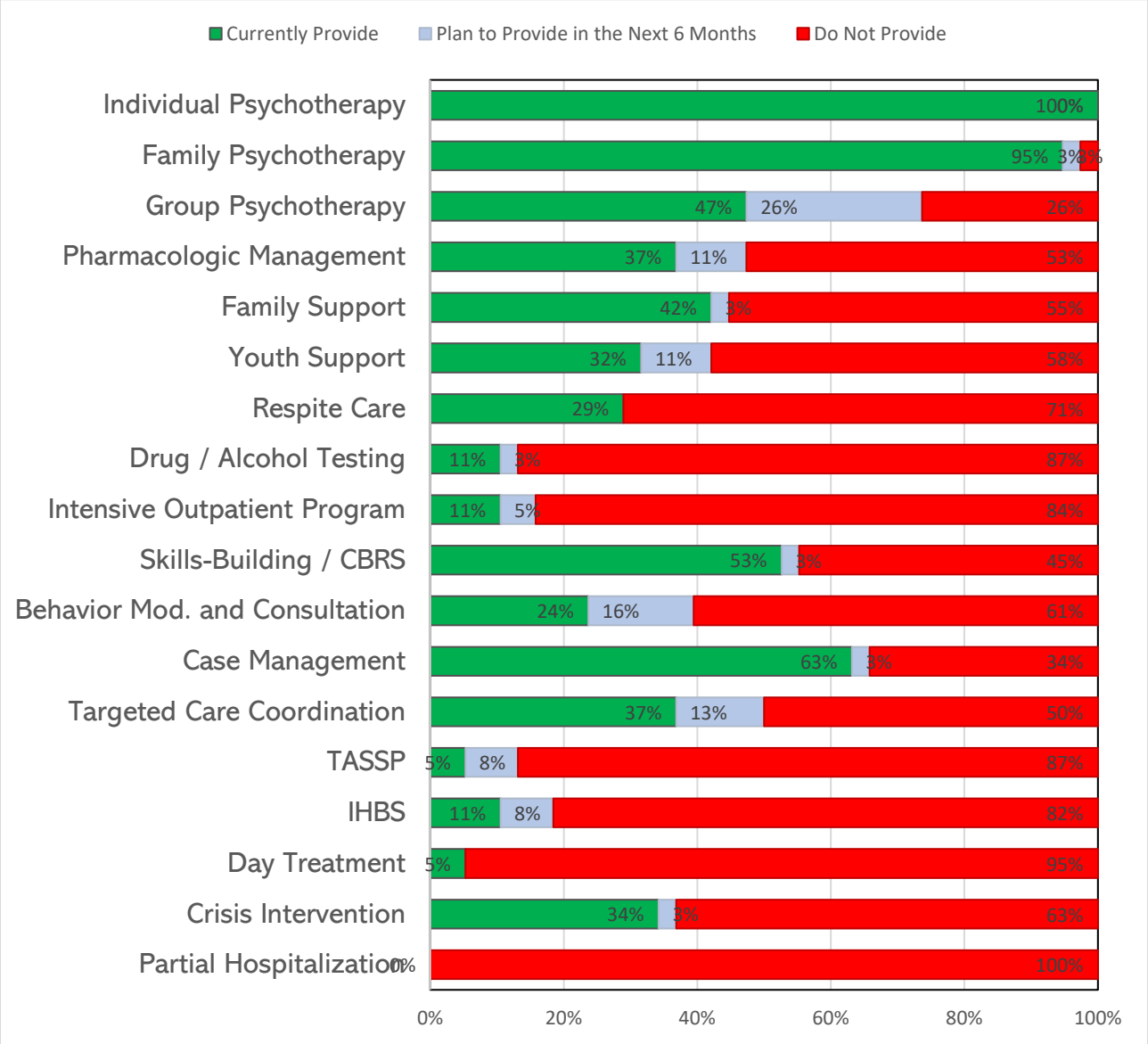
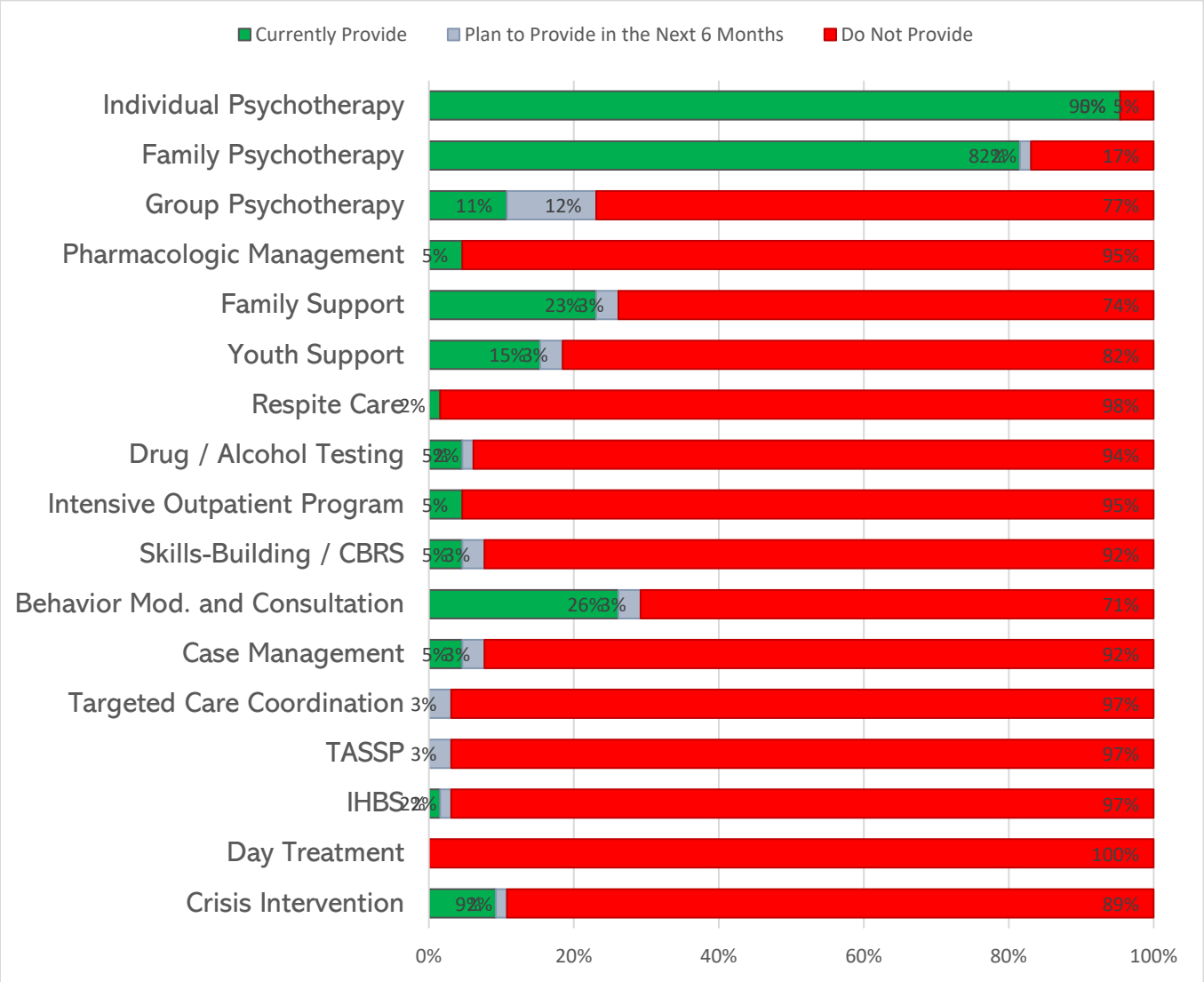


Chart 2 (below) identifies individual practitioners' self-reported service array. Response percentages are based on survey responses from 65 child-serving practitioners who participated in the Summer 2022 survey.

Chart 2. Individual Practitioners' Current and Planned Services



Summarizing the Current Service Array

Idaho's YES population includes a high proportion of youth who need intensive services provided in their community. Analyses from last year's QR sampling data indicate that 40% of youth completing an Initial CANS may have intensive treatment needs. The service arrays we see in Charts 1 and 2 are disproportionately focused on services which are appropriate for youth with mild to moderate behavioral health concerns. Only about 5% of individual practitioners provide services targeted towards youth with severe or complex behavioral health needs.

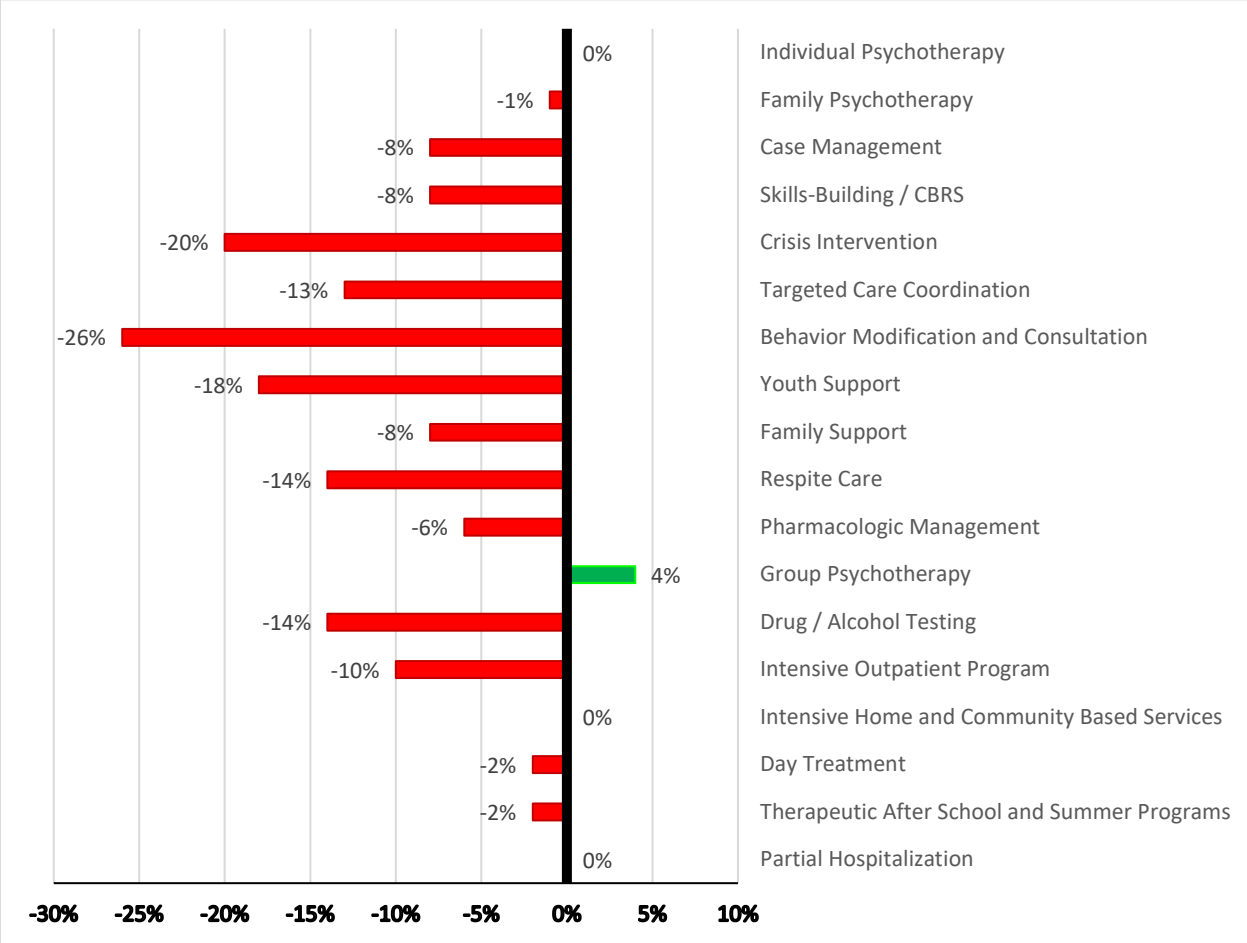
Across multiple service types, provider agencies are also unlikely to provide the intensive treatment options best suited for youth with severe or complex needs. Only about 10% of agencies indicate that they provide Intensive Outpatient Programs, Intensive Home and Community-Based Services, or Drug and Alcohol Testing. Only about 5% indicate that they provide Day Treatment or Therapeutic After School and Summer Programs.

Recent data in the Annual Availability Assessment that the State of Idaho submitted to the Centers for Medicare and Medicaid Services (CMS) indicated that there are currently ~ 50 beneficiaries with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED) for every Medicaid enrolled practitioner licensed to independently treat mental illness. The ratio of Medicaid beneficiaries with SMI/SED to Medicaid-enrolled providers offering intensive outpatient services is more than 2500-to-1. These 50-to-1 and 2500-to-1 ratios contrast sharply with the fact that at least 12% and as many as 40% of youth entering the YES program likely require intensive community treatment. Youth served in the YES program also need access to psychiatric prescribers, as many experience serious mental health concerns for which psychotropic medication is the first line treatment. The ratio of medication prescribers to beneficiaries with SMI/SED is greater than 1000-to-1. These data from the Annual Availability Assessment converge with the data from the Quality Review survey. The lack of providers able to provide a full array of services is creating particularly acute care shortages for youth with the greatest community treatment needs.

Projected versus Actual Growth in Service Capacity

In the 2021 QSR Pilot we asked respondents about their intentions to add a new service type in the next six months. Across services, about 9% of providers indicated that they planned to add a specific service in the next 6 months. However, when this year's respondents were asked about services they currently provide, they were 8% less likely than last year's respondents to currently be providing a given service (Chart 3). Across eighteen different types of services, providers were only more likely to provide one type of service (Group Therapy) in 2022 than they were in 2021. Three services were offered at the same rate. Fourteen services were less likely to be offered in 2022 than in 2021. Though there were some sampling and response rate difference between the two years' surveys[1], the consistent trend across nearly all services indicates that this bears further understanding.

Chart 3. Net Change in Care Types that Agencies Currently Provide (2021-2022)



[1] For details, see the Report, "Quality Review Process and Recommendations, 2022."

Unpacking the Results. In this year's survey, we asked providers if they had stopped providing one or more services in the past year. Twenty-seven percent of agency respondents indicated that they had stopped providing at least one service in the past year. Sixteen percent of individual practitioners indicated that they had stopped providing at least one service in the past year.

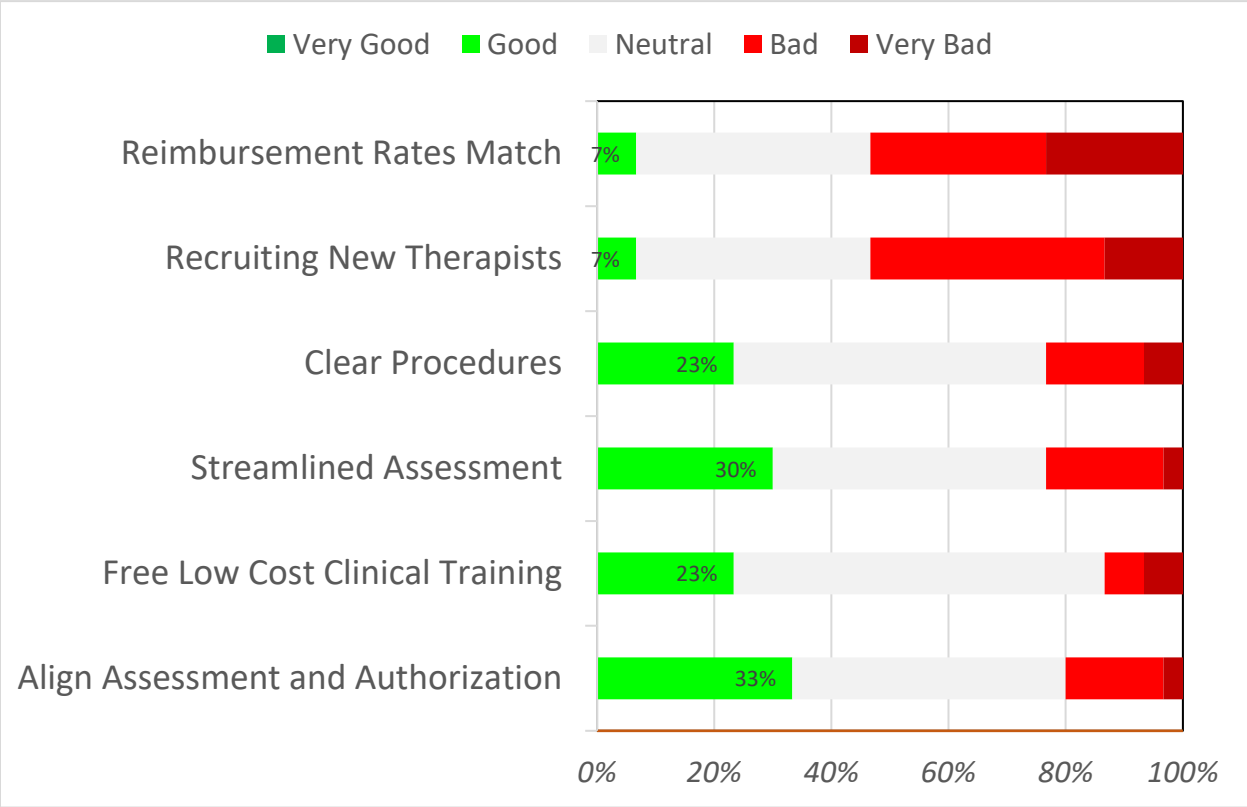
We also asked if providers had initiated a new service in the past year. Twenty-three percent of agency respondents indicated that they had initiated a new service in the past year; only 4% of individual practitioners indicated that they had initiated a new service in the past year. For both agency respondents and individual practitioners, the results indicate a net reduction in the continuum of services being offered to YES recipients. These within and cross-year results indicate that it is more likely that the public behavioral health continuum of care in Idaho is contracting than that it is expanding.

Understanding Why Services are Expanded or Reduced. We then investigated the reasons for service expansion and reduction among this year's respondents. In the previous year's Quality Review, individual practitioners and agency representatives identified a series of barriers to expanding the continuum of care they offered. These included:

- A lack of clear procedures for service initiation;
- Reimbursement rates which did not keep up with the costs of doing business;
- Difficulty recruiting therapists willing to work in the public sector;
- Dearth of affordable, high-quality training needed to provide effective services;
- Confusing and mis-aligned assessment and service authorization procedures;
- Onerous and duplicative assessment processes.

We used these responses to construct a scale asking how well or poorly IDHW addressed these barriers and provided incentives for service expansion (Chart 4).

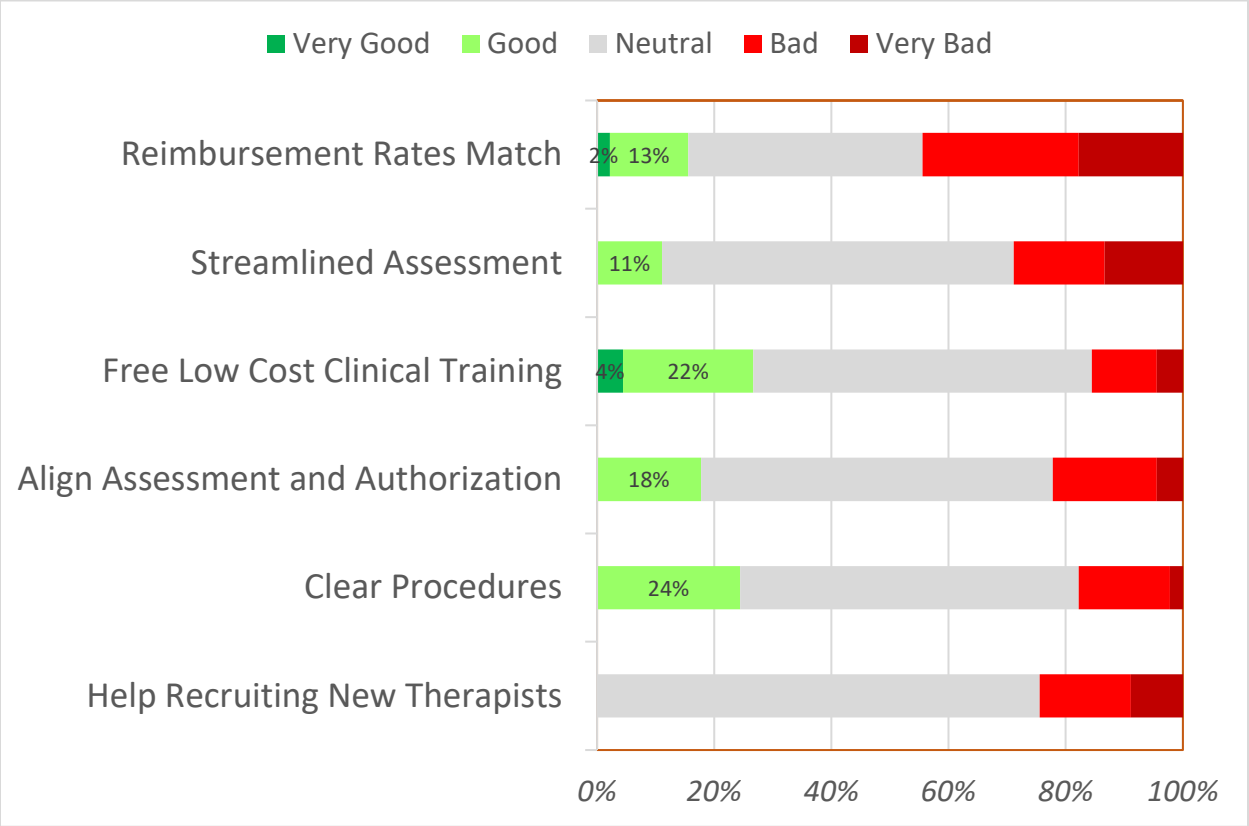
Chart 4. Agency Respondents' Satisfaction with Supports for Service Expansion



We asked agency representatives to rate, on a scale ranging from "Very Good" to Very Bad" how well IDHW currently provides these supports for service expansion. These supports are listed from most important ("Reimbursement Rates Match Costs") to least important ("Align Assessment and Authorization Procedures"), as rated by providers. Consistent with industry standards, we calculate satisfaction as the percentage of respondents indicating that the State of Idaho does a Good or Very Good job at providing these supports.

The percentage of respondents satisfied with the State's supports for expanding the continuum of care ranged across items from 7% to 33%, averaging 21% across all supports. Of greatest note, the most important supports for service expansion ("Reimbursement Rates Match Costs", "Help Recruiting New Therapists") had the lowest rates of satisfaction.

Chart 5. Individual Practitioners' Satisfaction with Supports for Service Expansion



For service expansion, Individual Practitioners and agency representatives had the same top priority: that reimbursement rates are adjusted to match the costs of delivering care. However, Individual Practitioners were more focused on improving processes directly related to care delivery (assessment, clinical training, aligning assessment findings and service authorization) than were Agency respondents. Across support types, satisfaction with supports ranged from 0% to 27%. Practitioners were satisfied with supports, on average, 16% of the time.

These rates of satisfaction have a very practical implication. Persons who are satisfied with the State's supports for expansion represent the fraction of providers who are likely to engage with the State to expand services in the near future. Per these findings, we estimate that only about one-sixth of individual practitioners and one-fifth of agencies are currently receptive to State efforts to expand their services. These results indicate that the State must take a substantially more proactive stance to improving high priority supports for expanding the continuum of care. Otherwise, the continuum of care is likely to further shrink.

Identified Drivers of Change among Persons Actively Expanding or Cutting Back Care

In our survey, we further identified three groups of providers with recent, grounded experience of expanding or reducing their care offerings. Providers who:

added a new service in the past year;

tried to add a new service, and then stopped;

eliminated an offered service.

Nine respondents (out of seventy-five; 12%) indicated that they had added a service in the past year. Thirteen of seventy-five respondents (17%) indicated they began work on expanding at least one service, and then stopped that effort. Fifteen of seventy-four respondents (20%) had eliminated at least one service they offered in the past year. We asked these providers about what were the most important drivers of their decisions.

Service Expanders

Agencies and individual practitioners who expanded services indicated that the ease of working with IDHW and Optum was a key driver in their ability to expand the service. Also mentioned were “feasible” reimbursement rates and “low cost training.”

Respondents who Tried to Expand Services, and Stopped

Eight individuals provided a description of the barriers that caused them to pause or stop expanding their services. Half of the individuals identified multiple barriers to expanding their services. Five of the eight individuals mentioned that funding for beginning (and continuing) a new service was inadequate. As one provider stated, "[It's] too much work for the reimbursement amount. ...Idaho pays meager reimbursement rates compared to states with populations that match our locale."

Three of the eight respondents indicated that the process of starting a new service was too burdensome or unclear to risk continuing to move forward with initiating a new service. One provider stated, "[Our agency] can’t get credentialed to start the program. Optum and the state do not know how to get us started for the new TBS program."

Two persons identified problems finding new staff. One person identified a lack of cost-effective training as a barrier to expanding services.

Providers who Stopped Providing One or More Services

Six agency providers indicated that a lack of staff forced them to cut back their services. They indicated both that current practitioners had left, and that there was not a set of willing and capable providers to replace or supplement staff who had left. Two respondents indicated that staff who do stay on are only willing to work limited hours, restricting their ability to provide the service.

Four respondents indicated that ongoing costs and inadequate reimbursement drove the decision to stop providing a service. One stated, “Poor reimbursement / dealing with Optum,” drove their decision. Three agency respondents indicated that training costs, and time lost to training also factored in the decision to cut back service.

Three individual practitioners indicated that paperwork and regulations made it too difficult to continue to provide service. One noted, “I'm tired of Medicaid's never ending list of requirements without removing any. They continue to pile on the paperwork making it impossible to do my job.” Another stated that, “Overly complicated and rule bound requirements for treatment” had prompted them to stop providing service.

One Missing Support

Providers were also asked to identify the one most important missing support for service expansion. The most frequently identified missing support was a reduction in the complexity of the process for initiating and continuing to provide services (identified in seven responses). The second most frequently missing support was a lack of acceptable reimbursement rates (six responses). Within this response, several providers indicated that the scope of services covered for reimbursement is currently inadequate. Respondents specifically stated the need to, “increase rate reimbursement,” “broaden [the] scope of service,” and “increase the number of allotted [service] hours per client.

Other missing supports included the need for help recruiting practitioners (two responses) and to provide training (one response).

Summary of Drivers of Service Expansion and Contraction

The comments provided by agency respondents and individual practitioners were largely consistent with the themes identified in last year’s QSR Pilot. The vast majority of comments revolved around the need for:

reimbursement rates consistent with service costs;

less onerous paperwork and more understandable policies and procedures;

specialized training that is accessible and low cost;

assistance in developing and recruiting from a sufficient pool of practitioners.

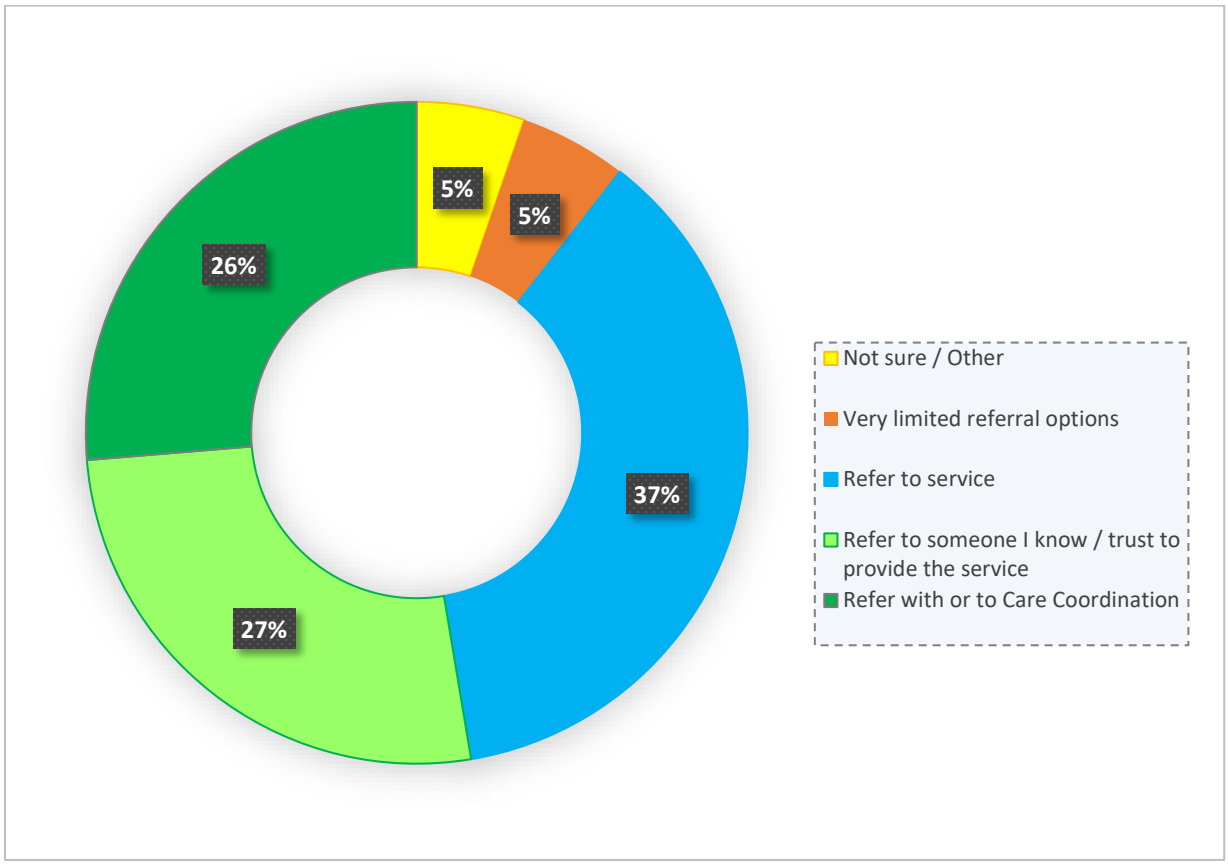
Two observations were of note in this year's responses. First, only one response indicated that the COVID pandemic had affected their decision to reduce or expand their service offerings. Though the pandemic was clearly a driver of myriad changes in behavioral health care policy and practice nationally and in Idaho, this did not appear to be on the forefront of most providers' minds in this year's survey. It may be that the pandemic has surfaced or exacerbated the limitations agencies and individual practitioners have been dealing with for many years, and providers' narratives simply reflected those longstanding limitations.

Second, one new variation on a theme did emerge in this year's responses. Several times, respondents alluded to or explicitly described the importance of having access to knowledgeable, personalized help in working to initiate services or address regulations. Agency and individual providers appear to be operating under substantial fiscal pressure and have limited staff resources to initiate new services. Should the State of Idaho decide that expanding the continuum of care is a high priority, creating accessible, individualized, in-person help for providers. Providers noted the need for help in understanding the process and completing the paperwork necessary to move forward with service expansion. One provider summarized it as, "A person that had time to zoom or visit so I could talk through the requirements and make sure what we have in place is still compliant and appropriate."

Service Continuum Implications for Care

Agency Respondents. Agency respondents indicated that about four in ten youth served in their agency will need additional behavioral health services not provided by that agency (Arithmetic Mean = 37%, Median = 40%). When asked what happens when a youth has these needs, respondents provided a variety of answers. These were classified by theme. Their frequencies are represented in the chart below (Chart 6). Of note, only one quarter of respondents included a mention of the use of care coordination or care coordinators to facilitate effective linkages to outside services. Providers appear to rely heavily on the providers they have personal knowledge of in order to make referrals. New providers, or providers with limited networks of connections, may be at an important disadvantage in trying to find help for youth with complex needs. Two providers explicitly stated that they have very limited referral networks or local treatment options when youth have more complex needs.

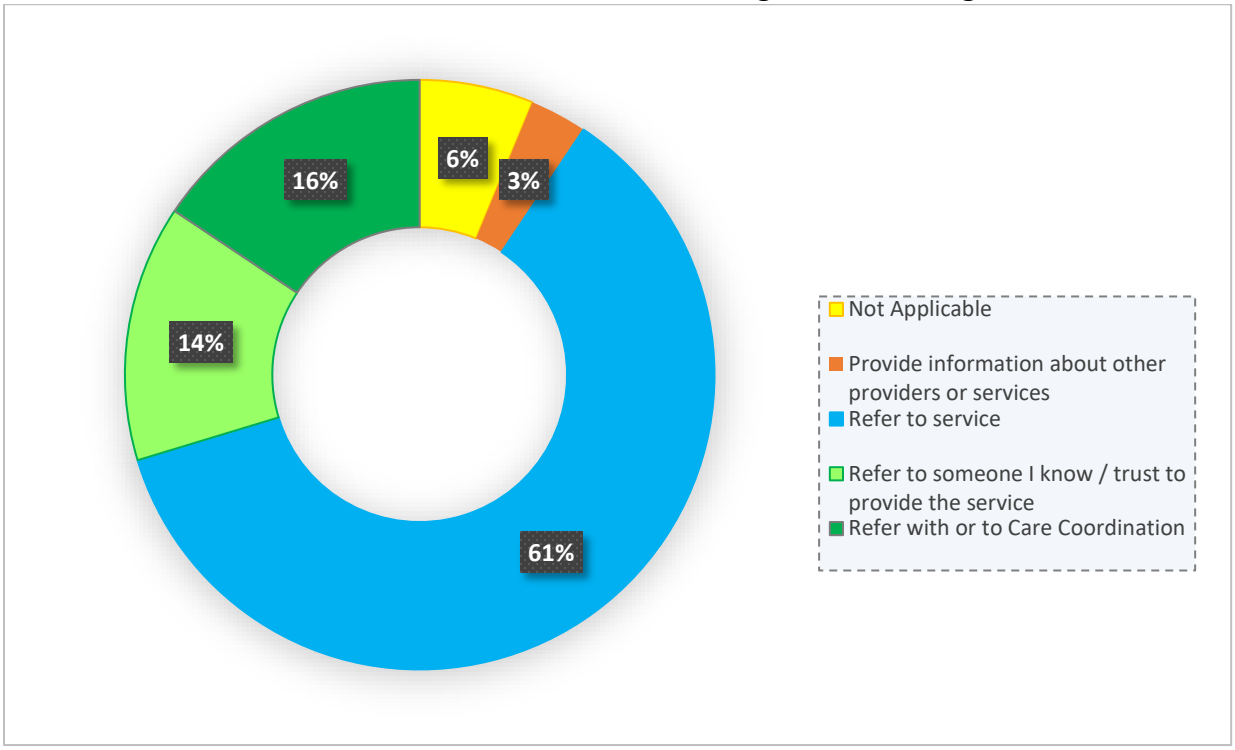
Chart 6. Agency Respondents' Processes for Connecting Youth Needing Other Services



Individual Practitioners. Individual Practitioners indicated that about one in five youth served in their agency will need additional behavioral health services not provided by that agency (Arithmetic Mean = 22%, Median = 15%). One quarter of providers indicated that none of the children or youth they see have needs requiring outside services. One sixth of providers indicated that 50% or more of the youth they see require outside services. When asked what happens when a youth has these needs, respondents provided a variety of answers. These were classified by theme. Their frequencies are represented in the chart below. Approximately one in six respondents included a mention of the use of care coordination or care coordinators to facilitate effective linkages to outside services. Surprisingly, individual practitioners with higher percentages of youth with complex needs were not more likely to indicate that they used care coordination services.

Individual practitioners appear to rely on their personal referral networks even more heavily than do agency providers. As care coordination services become more available, it will be important to provide targeted outreach to individual practitioners who indicate that they routinely service youth with complex needs. Connecting these providers with care coordination services is likely critical to their ability to consistently link children and youth with complex care needs to the appropriate supports.

Chart 7. Individual Practitioners' Processes for Connecting Youth Needing Other Services



Summary.

In short, there are a readily identifiable set of barriers to providing behavioral healthcare in Idaho's public sector, particularly to youth with intensive treatment needs. Youth with intensive treatment needs routinely require care outside of the initial setting in which they are provided care. That care is not consistently accessed through a coordinated care linkage process. Rather, it is frequently dependent on individual providers' own connections to specialized care providers. The care network for youth with intensive treatment needs is inadequately developed, and the processes for connecting people to resources across the network are also inadequately developed.

Diverse providers consistently identify similar barriers. The identified barriers have remained stable across two years of survey administration. Many of the same barriers and supports were identified by both individual practitioners and provider agencies. Similar barriers and supports were identified across ratings of implementation needs and free-response prompts. These barriers are:

unsustainable reimbursement rates;

administrative burdens to standing up and continuing to provide a service;

lack of qualified and willing workforce;

high costs and productivity losses associated with training staff to work with new populations.

IDHW has not addressed these barriers satisfactorily. Providers have opportunities to pursue work with higher reimbursement rates, substantially fewer authorization and documentation requirements, and better hours. They are choosing those opportunities. IDHW must make providing care, particularly intensive community treatment, attractive to providers. Otherwise IDHW will continue to see a shrinking provider pool and will not be able to meet its obligations for care under the terms of the Jeff D Settlement Agreement.

References.

Israel, N. *for* State of Idaho, Department of Health and Welfare (2021, Spring). *Pilot Quality Review of Youth Empowerment Services.* Boise, ID: Author.

State of Idaho, Department of Health and Welfare (2022, Spring). *Annual Availability Assessment for the 1115 Behavioral Health Transformation Waiver.* Boise, ID: Author. Accessed at: https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=22958&dbid=0&repo=PUBLIC-DOCUMENTS

Appendix A: Service List and Descriptions

Below are the service types, service type abbreviations, and service descriptions provided in the Provider Survey. Descriptions are lightly edited versions of the service descriptions provided in the Optum Idaho Provider Manual.

Table 2. Service Types and Descriptions

Service Type	Description
Individual Psychotherapy.	Youth can talk with a behavioral health care professional about emotional issues youth may be having and learn coping skills to help them manage them.
Family Psychotherapy.	Families can talk with a behavioral health care professional about emotional problems youth and their family may be having and learn coping skills to help youth and their family manage them.
Group Psychotherapy.	Youth meet with a group of people with similar emotional issues and a behavioral health care professional. Group members share experiences and practice coping skills to learn how to manage issues as independently as possible.
Pharmacologic Management (Medication Management).	A doctor or nurse meets with youth to discuss the medicines youth are taking and order new prescriptions youth might need.
Family Support.	Family support helps a youth's family learn to how to help manage their treatment. This service is provided by a parent who also has lived experience of caring for a child with behavioral health issues, and specific specialist training.
Youth Support.	Youth support helps youth learn how to manage their treatment, makes sure that youth know their rights, and helps youth speak for themselves. This service is provided by someone who also has lived experience of mental health issues as a child or youth, and specific specialist training to teach them how to work with youth. This can be done individually or in groups.
Respite.	Respite care is a short-term or temporary care so youth and their primary caregiver can have a break, and to give relief to the person who usually takes care of the youth.
Drug/Alcohol Testing.	A test to see if a youth has been using chemical substances or alcohol.

Table continues on next page.

Table 2. Service Types and Descriptions (cont.)

Service Type	Description
Intensive Outpatient Program (IOP).	This service gives youth outpatient therapy to help manage their behavioral health or substance use disorder needs and meet their treatment goals. Adolescents participate at least two hours per day, three times a week.
Skills Building / Community Based Rehabilitative Services.	Services are provided in a youth's home or community to help them gain skills for successful living, overall wellness, independent living.
Behavior Modification and Consultation.	The provider works with youth to develop strategies to improve skills for identified behavior; this support can be provided at any time and in any setting to meet the youth's needs.
Case Management.	A behavioral health care professional helps youth learn how to coordinate and access their medical, mental health, and community-living supports.
Targeted Care Coordination.	A trained individual helps youth access services and coordinate care between various providers and agencies. The Coordinator may: help navigate the system of care; run Child and Family Team (CFT) meetings; link the youth to services and supports; develop, implement, and monitor the youth's person-centered service plan; update the CANS assessment for the youth if requested by the treating clinician.
Therapeutic After School and Summer Programs (TASSP).	Qualified behavioral health professionals work with youth on behavioral goals in a recreational or after school setting.
Intensive Home and Community Based Services (IHBS).	Provided for children and youth who have severe needs. Intensive Home and Community Based Services include specialized treatments, and are used to increase stability and help prevent out of home placements.
Day Treatment.	This service provides therapeutic outpatient care for severe needs that require more than intensive or routine outpatient care. This service may include managing medication, skills building or group, individual, and family therapy. Youth are in therapy at least 3 to 5 hours per day, 4 to 5 days a week. Day Treatment providers coordinate and communicate with other agencies, including coordination with schools.

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Table 2. Service Types and Descriptions (cont.)

Service Type	Description
Crisis Intervention.	Crisis Intervention services allow youth to talk to a behavioral health professional in a face-to-face setting, and are available 24-hours a day, seven days a week.
Partial Hospitalization.	Partial Hospitalization is a structured program that you attend for 20 or more hours a week and you do not spend the night in the hospital. Services may include: individual, group and family psychotherapy, cognitive behavioral therapy, substance use monitoring, and more.

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