In-Home Therapy (IHT)

PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available documents, Plan expectations, your contract, and MassHealth guidance. This information should be and will look materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

Providers contracted for this level of care or service are expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations, and all requirements of these service-specific performance specifications. In addition, providers of all contracted services are held accountable to the General Performance Specifications. Where there are differences between the service-specific and General Performance Specifications, the service-specific specifications take precedence.

OVERVIEW

In-Home Therapy (IHT): This service is delivered by one or more members of a team consisting of professional and paraprofessional staff, offering a combination of medically necessary IHT and Therapeutic Training and Support. IHT is a structured, consistent, strength-based therapeutic relationship between a clinician, a youth, and the youth's family for the purpose of treating the youth's behavioral health needs. This treatment includes improving the family's ability to provide effective support in promoting the youth's healthy functioning with the family. Interventions are designed to enhance and improve the family's capacity to improve the youth's functioning in the home and community and may prevent the need for the youth's admission to an inpatient hospital, psychiatric residential treatment facility or other treatment setting. The IHT team develops a treatment plan and, using established psychotherapeutic techniques and intensive family therapy, works with the entire family (or a subset of the family) to implement focused interventions and behavioral techniques to: enhance problem-solving, limit-setting, risk management/safety planning, communication, build skills to strengthen the family, advance therapeutic goals, and improve ineffective patterns of interaction; identify and utilize community resources; and develop and maintain natural supports for the youth and family in order to promote sustainability of treatment gains. Phone contact and consultation are provided as part of the intervention.

IHT is provided by a qualified clinician who may work in a team that includes one or more qualified paraprofessionals.

Therapeutic Training and Support is a service provided by a qualified paraprofessional working under the supervision of a clinician to support implementation of the clinician's treatment plan to assist the youth and family in achieving the goals of that plan. The paraprofessional assists the clinician in

implementing the therapeutic objectives of the treatment plan designed to address the youth's mental health, behavioral, and emotional needs. This service includes teaching the youth to understand, direct, interpret, manage, and control feelings and emotional responses to situations and to assist the family to address the youth's emotional and mental health needs. Phone contact and consultation are provided as part of the intervention.

In-Home Therapy Services may be provided in any setting where the youth is naturally located, including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, childcare centers, respite settings, and other community settings

SERVICE COMPONENTS

1. Providers of IHT Services are outpatient hospitals, community health centers, community mental health centers, and other clinics and private agencies certified by the Commonwealth of Massachusetts.
2. IHT Services must be delivered by a provider with demonstrated infrastructure to support and ensure:
    a) Quality Management and Assurance
    b) Utilization Management
    c) Electronic Data Collection
    d) Clinical and Psychiatric Expertise
    e) Cultural and Linguistic Competence
3. IHT Services include, but are not limited to the following:
    a) A comprehensive and age-appropriate home-based behavioral health assessment, inclusive of the Massachusetts CANS, conducted by a clinician, and occurring in the youth's home or another location of the family's choice, that is signed by an independently licensed clinician.
    b) Development of a youth-and-family-centered treatment plan by the qualified clinician in collaboration with the youth, family, and other providers, subject to required consent.
    c) Review and modification of the treatment plan every 90 days at a minimum, or more, as necessary.
    d) Review/update or development of a Safety Plan and/or other Crisis Planning Tools (e.g., Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) in collaboration with the youth and parent/guardian/caregiver.
    e) Intensive Family Therapy that may include working with the entire family (or a subset of the family) to implement focused, structural, strategic behavioral techniques or evidence-based interventions to enhance problem-solving, limit-setting, risk management/safety planning, communication, skill-building to strengthen the family, and to advance therapeutic goals to improve ineffective patterns of interaction.
    f) Identification of community resources and development of natural supports for youth and family to support and sustain achievement of the youth's treatment plan goals and objectives.

g) Coordination with collateral providers, schools, state agencies, Emergency Services Program (ESP)/Mobile Crisis Intervention (MCI), Physical Health Practitioners (e.g., primary care physicians and prescribing clinicians), and other individuals or entities that may impact the youth's treatment plan, subject to required consent.

h) Referral and linkage to appropriate services along the continuum of care.

i) Coaching in support of decision-making in both crisis and non-crisis situations.

j) Skills training for youth and family.

k) Monitoring progress on attainment of treatment plan goals and objectives.

l) The IHT provider develops and maintains policies and procedures relating to all components of IHT. The provider ensures that all new and existing staff will be trained on these policies and procedures.

4. The IHT provider operates from 8 a.m. to 8 p.m., 7 days per week, and 365 days per year.
5. Services shall be provided to the youth and family in the home/community. Providers may deliver services via a HIPAA-compliant telehealth platform at the family's request and if the service can be effectively delivered via telehealth. Services delivered through a telehealth platform must conform to all applicable standards of care. When providing services via telehealth, providers shall follow the current MassHealth and MCE guidelines regarding telehealth.
6. The IHT provider has 24-hour urgent response, accessible by phone to the youth and family, 365 days a year. In the event of an emergency, the IHT provider engages the ESP/MCI (24 hours a day, 365 days a year) and supports the MCI team to implement efficacious intervention. An answering machine or answering service directing callers to call 911, the ESP/MCI team, or to go to a hospital Emergency Department (ED) is not acceptable.
7. The IHT provider, when requested by the family, will also accompany the family to meetings about the youth's behavioral health treatment needs in schools, day care, foster homes, and other community- based locations. All meetings are scheduled at a time and location that are convenient for the youth and family.
8. IHT services are delivered in a manner that is consistent with Systems of Care philosophy.

STAFFING REQUIREMENTS

1. The IHT team employs a multidisciplinary model, with both professional and paraprofessional staff. The professional staff has a degree from the MassHealth-approved list and is trained in working with youth and their families, including training in family therapy. Paraprofessional staff has a degree from the MassHealth-approved list and is trained to provide family members with therapeutic support for behavioral health needs.
2. The IHT provider has a Program Director who is an independently licensed clinician.
3. The IHT provider ensures that an independently licensed Senior Clinician provides weekly supervision to professional staff.
4. The IHT provider ensures that a licensed Behavioral Health Clinician provides weekly supervision to paraprofessional staff.
5. The IHT team will have access to psychiatric expertise for consultation as needed. The team includes a board-certified or board- eligible child/adolescent psychiatrist (ABPN) or a certified or certification- eligible child/adolescent/family-trained mental health psychiatric nurse clinical

specialist (ANCC), who is available during normal business hours for consultation related to treatment planning, medication concerns, and crisis intervention on an as-needed basis. The psychiatric clinician is available for provider consultation within one hour.

6. A senior-level, independently licensed clinician trained in working with youth is available to the staff and the supervisor 24 hours a day, seven days a week for consultation on an as needed basis.
7. Qualified staff is certified to administer the CANS-MA version.
8. The IHT provider ensures that all staff, upon employment, before assuming their duties, complete a training course that minimally includes the following:
    a) overview of the clinical and psychosocial needs of youth and families being served;
    b) systems of Care principles and philosophy, including family centered and strength-based practices;
    c) risk management/safety planning;
    d) introduction to child-serving systems and processes (e.g., DCF and mandated reporting, DYS, DMH, DESE, juvenile court, other MassHealth levels of care/services, etc.);
    e) basic Individualized Education Program (IEP) and special education information;
    f) managed Care Entities' performance specifications and medical necessity criteria;
    g) substance use disorder screening; and
    h) IHT practice profile and IHT practice guidelines.
9. All IHT staff will complete 10 hours of training annually specific to the core elements of the IHT Practice Profile. Documentation of the provider's training curriculum is made available upon request.
10. IHT Services staff is knowledgeable about available community mental health and substance use disorder services within their natural service area, the levels of care, and relevant laws and regulations, and are familiar with Systems of Care philosophy and Wraparound planning process. They also have knowledge about other medical, legal, emergency, and community services available to the youth and family.
11. The IHT provider delivers staff supervision commensurate with licensure level and consistent with credentialing criteria. Appropriately credentialed professionals with specialized training in family, adolescent, and child treatment will provide supervision. Each case will be reviewed, at a minimum, every 90 days by an independently licensed clinician.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The IHT team maintains a linkage and working relationship with the local ESP/MCI team in their area to provide youth and their families with seamless and prompt access to IHT services upon referral from an MCI team following a crisis period or to ESP/MCI team in an emergency.
2. The IHT Services team promotes linkages with outpatient treaters by assisting the youth and family in attending outpatient appointments, including medication monitoring and psychiatric services.
3. If a youth is evaluated by an MCI team and is awaiting placement for a 24-hour behavioral health level of care (e.g., Crisis Stabilization, inpatient hospital, CBAT, PHP):

a) The IHT clinician has daily contact with the caregiver to facilitate safety planning and stabilization in the home.
b) The IHT clinician has daily contact with the MCI provider for care coordination.
c) The IHT clinician re-evaluates the youth's treatment plan and makes appropriate community-based referrals to stabilize youth in the community.

4. If the youth is determined to not meet level of care for a 24-hour behavioral health placement:
    a) The IHT clinician has an immediate session with the youth and caregiver to update the safety plan and provide stabilization.
    b) The IHT clinician re-evaluates the youth's treatment plan and makes appropriate community-based referrals to stabilize youth in the community.
    c) IHT team needs to have a meeting with a family within 48 hours of MCI involvement.
5. If a youth is admitted to a 24-hour behavioral health level of care (e.g., Crisis Stabilization, inpatient hospital, CBAT, PHP), the IHT clinician contacts the facility at the time they are made aware of the admission and:
    a) provides preliminary treatment recommendations to initiate and guide treatment, and
    b) schedules a meeting at the facility within two days for care coordination and disposition planning. The meeting includes the participation of the family, facility staff, and other providers involved in the youth's care;
    c) the IHT provider and facility staff communicate and collaborate on a youth's treatment throughout his/her admission to develop, in concert with the family, a disposition plan that is consistent with his/her treatment plan. With consent, the IHT clinician is required to participate in all meetings that occur during the youth's tenure in the facility as appropriate. When the Intensive Care Coordination (ICC) is involved, the IHT clinician participates in the meeting convened by the ICC and all other treatment planning and disposition planning meetings as appropriate.
6. When state agencies (e.g., DMH, DCF, DYS, DPH, DESE/LEA, DDS, probation office, the courts) are involved with the youth, the IHT provider will include these agencies in the development of any treatment and safety planning with the youth/family. Contact with these agencies will be subject to required consent and maintained as appropriate for the duration of the service.
7. The IHT provider maintains procedures to ensure access to emergent medical care for youth and as needed.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The IHT provider is available 24 hours a day, seven days a week, and 365 days a year to take referrals. The provider must contact the family within one calendar day of referral, including self-referral, to offer a face-to-face interview with the family within 24 hours for at least 75% of the clients and no more than 14 days for 100% of clients. Providers are required to engage in assertive outreach regarding engaging in the service, track the outreach, and follow-up.
2. Fourteen (14) days is the Medicaid standard for the timely provision for services established in accordance with 42 CFR 441.56(e). The 14-day standard begins from the

time at which the family has been contacted.

3. Providers must maintain a waitlist if unable offer a face-to-face interview and initiate services within one calendar day of contact with the family
4. The IHT provider participates in discharge planning at the referring treating facility/provider location. If the referral is initiated as a diversion by a MCI team to divert out of home placement or psychiatric hospitalization, the IHT provider makes every effort to meet with the youth and family and the MCI team clinician at the time of referral or as soon as possible thereafter.
5. With the youth's and family/guardian's consent, the IHT team will visit the youth and family in any safe setting within 24 hours of the referral if referred from an inpatient unit/CBAT/Crisis Stabilization. If referred from an MCI team, the first IHT meeting will be offered within 24 hours of the initial referral or as negotiated with the youth and family/guardian and the MCI team in any safe setting. Initial treatment goals and planning will be initiated at this meeting.
6. When the youth is referred or assessed by a MCI team, inpatient unit, CBAT, or Crisis Stabilization, the IHT provider obtains a copy of the MCI team's or inpatient unit/CBAT/Crisis Stabilization's assessment and focal treatment plan (including the Massachusetts CANS, if completed) and includes their recommendations in the youth's initial IHT treatment plan.
7. The IHT provider completes an initial assessment within 7 calendar days of meeting with the youth and family, which clarifies the main need/focal problem, the contributing factors to the main need from multiple life domains, and matching interventions with an emphasis on youth/family interactions and skill building.
8. When the youth is receiving ICC, the IHT provider participates in all Care Planning Team (CPT) meetings. The IHT treatment plan must reflect all goals on the Individual Care Plan (ICP), and treatment planning and delivery must be synchronized with ICC.
9. Immediately upon gaining consent for participation, the IHT provider assesses the safety needs of the youth and family and creates an initial safety plan. The IHT provider, with the consent of and in collaboration with the youth and family, guides the family through the crisis planning process that is in line with the family's present stage of readiness for change. As the family chooses, the IHT provider engages existing service providers (e.g., ICC, outpatient provider, etc.) and/or other natural supports, as identified by the youth and family, to share in the development of the Safety Plan and/or other Crisis Planning Tools. These tools are reflective of action the family believes may be beneficial. This may include, but is not limited to, the following:
    a) contacts and resources of individuals identified by the family who will be most helpful to them in a crisis;
    b) goals of the Safety Plan as identified by the family;
    c) action steps identified by the family; and
    d) an open format (the second side of the Safety Plan) that the family can choose to use as needed.

    If a youth already has an existing set of Crisis Planning Tools, the IHT provider will utilize the tools as they apply to the current situation and/or reassess their effectiveness. Where necessary the IHT provider collaborates with the youth's family/guardian and other

providers, to build consensus for revisions to the tools and to share them as directed by the family.

The IHT provider reassesses the safety needs of youth and family as clinically indicated. The IHT provider reviews and updates the set of Crisis Planning Tools with the youth and family and others as directed by the family. The set of tools is reviewed and updated as needed, but at a minimum after an encounter with the ESP/MCI team and at the time of discharge from a 24-hour facility. With signed consent, the IHT provider ensures that a written copy of any current Crisis Planning Tools is sent to and maintained by the local ESP/MCI team as directed by the family.

10. The IHT provider completes a comprehensive clinical assessment that includes the CANS-MA version and the CRAFFT (youth 12 or older) within 21 calendar days of the initial contact. All relevant assessments or evaluations are requested from prior/current treaters with proper consent. The assessment includes the strengths and needs of the youth and family. The IHT provider completes a treatment plan, including a set of Crisis Planning Tools and strengths of the youth and family, within 21 calendar days of first contact. This includes a review and use of the set of Crisis Planning Tools (e.g., Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communications and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) where appropriate and in accordance with the Companion Guide for Providers. Evidence-based or best-practice models that match the main need/focal problem are recommended to guide treatment planning and interventions. The treatment plan is solution-focused with clearly defined interventions and measurable outcomes to assist the youth and family members in their environment to help the youth to achieve and maintain stabilization.
11. The IHT team updates the comprehensive clinical assessment, inclusive of the CANS and the CRAFFT every 90 days.
12. In developing this treatment plan, the provider consults with the youth, the family, IHT supervisors, outpatient treatment provider, agencies involved with the youth/family, and the IHT program's multidisciplinary team. All parties involved, including the youth (aged 10 or older), sign the treatment plan where clinically appropriate. In addition to the clinically appropriate parties, an independently licensed clinician must sign off on the treatment plan. The plan is updated every 90 days at a minimum and as needed. IHT provider's treatment plans must be synchronized with other provider's existing plans. The IHT provider documents all services provided (e.g., face-to-face, phone, and collateral contacts) and progress toward measurable behavioral goals in the youth's service record.
13. If the youth and/or family are unable or unwilling to keep an appointment, the IHT team attempts to contact the family immediately and documents this contact, including unsuccessful attempts, in the youth's service record.

Discharge Planning and Documentation

1. The IHT provider assists the youth and family n accessing other levels of care when clinically indicated and identified in the comprehensive assessment.
2. The IHT provider includes the anticipated date for discharge in the initial treatment plan and the comprehensive assessment.
3. When clinically or legally indicated, the youth, family members, and all providers involved in care are involved in the discharge planning process, subject to required consent. Such

involvement will be noted within the discharge summary and youth's service record.

4. If the youth and/or family terminate the services without notice, the IHT provider makes every effort to contact the youth and family to re-engage them in the treatment and to provide assistance for appropriate follow-up plans. This includes scheduling another appointment, facilitating a clinically appropriate service termination, or providing appropriate referrals. Such activity is documented in the youth's service record.
5. The IHT provider includes in the discharge plan, at a minimum:
    a) identification of the youth's needs according to life domains;
    b) a list of services that are in place post-discharge and providers arranged to deliver each service;
    c) a list of prescribed medications, dosages, and possible side effects; and
    d) treatment recommendations consistent with the service plan of the relevant state agency for youth who are also DMH clients or youth in the care and/or custody of DCF, and for DDS, DYS, and uninsured DMH clients.
6. Prior to discharge, an updated Safety Plan and/or other Crisis Planning Tools is developed in conjunction with the youth and family and all providers of care, subject to required consent. The purpose of this plan is to strengthen bridges within the family, the informal support network, and the formal treatment network as appropriate.
7. The IHT provider gives a written aftercare plan, a Safety Plan or set of Crisis Planning Tools, and treatment summary to the youth and family at the time of discharge.
8. The IHT provider gives a written aftercare plan, a Safety Plan or set of Crisis Planning tools, and treatment summary to the outpatient, ICC, or other community-based provider, primary care clinician or provider, school, and other entities and agencies that are engaged with or significant to the youth's aftercare, subject to required consent.
9. Well-child primary care visits are scheduled prior to discharge if a primary care visit is indicated based on the EPSDT periodicity schedule.

QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is utilized and may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Enrollees, including youth and their families.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.