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| **Title:** | In Lieu Of Service: In Home Therapy Services (IHTS) | **Code:** | H2022 HE U5 U1 Encounters: H2022 HE U5 TS |
| **Type:** | | **Group Code:** | n/a |
| **Effective Date:** | 9/1/21 | **Units:** | 1 unit= week |

## Service Description

In Home Therapy Services (IHTS) is a combination of evidence-based therapy services and coordination of care interventions to be provided in the home setting for individuals with complex clinical needs that traditional outpatient cannot adequately address in a time limited fashion. For some individuals in high-risk situations, such as families involved in domestic violence or child protective services, traditional outpatient services alone are not sufficient to address the needs and prevent future incidents. The population targeted for this program is children and adolescents in need of individual and family therapy services, as well as coordination of care due to complex psychosocial situations and/or multisystem involvement. These are not individuals whose mental health needs are yet at a severity that is putting them at risk for residential treatment or other forms of out-of-home placement, but rather individuals who need focused family systems work and coordination. Children and adolescents appropriate for IHTS have family systems issues that are complicating factors placing them at risk rather than the severity of the diagnosis alone. The use of this service will prevent consumers from receiving more restrictive levels of care and will intensively engage the families in treatment, which has been demonstrated to lead to successful outcomes. These activities also can be provided through face-to-face interventions with schools, juvenile justice system, etc. – beyond the scope of traditional outpatient therapy (even when provided in the home). This will make the service delivery seamless for the consumer and family and allow for flexibility in the intensity of coordination over the course of treatment with the ability to quickly address any issues that arise rather than having to wait for issues to become so severe that the individual meets special population criteria for care coordination.

## Populations to be Served

This service is available to children/adolescents, ages 3-21 with diagnosis(es) of MH, MH/IDD, and/or MH/SUD OR potential diagnosis based on current symptoms/behavioral health needs. Members needing this services are those with behavioral health needs with multi-system involvement.

## Treatment Program Philosophy, Goals and Objectives

Service Type/Setting: IHTS is a direct and indirect, periodic, rehabilitative service in which the team members provide medically necessary services and interventions that address the diagnostic and clinical needs of the individual. Additionally, the team provides interventions with the family and caregivers on behalf of and directed for the benefit of the individual as well as plans, links, and monitors services and coordinates care on behalf of the individual. This service is provided in any location. IHTS providers shall deliver services in various environments, such as homes, schools, court, homeless shelters, libraries, street locations and other community settings. IHTS also includes telephone time with the individual and his or her family or caregivers, as well as collateral contact with persons who assist the individual in meeting his or her rehabilitation goals specified in the PCP. IHTS includes participation and ongoing clinical

involvement with the Child and Family Team and meetings for the planning, development, implementation, and revision of the PCP.

**Program Requirements:** The team structure will be varied and is intended to provide some flexibility; however, it would always involve at least two staff. In some cases, the structure would involve two fully licensed clinicians who would provide both the therapy and coordination of care interventions. In other cases, a licensed therapist would provide all therapy interventions and would oversee coordination of care interventions provided by either a QP or an AP who has Family Partner training and qualifications. Typically, the need for coordination of care can be resolved within a few interactions, having this provided directly by the treating agency increases efficacy through direct communication of the information. This can lead to more timely resolution of issues identified than can occur within basic outpatient services that do not allow time for this coordination. The licensed therapist will have a caseload of up to twelve IHTS consumers. The licensed therapist may additionally provide outpatient therapy to members not enrolled in IHTS outside of the times that IHTS is scheduled to be provided. It would be expected that IHTS consumers would step down into basic, office-based therapy services with the same licensed therapist after discharge from IHTS to ensure treatment continuity and engagement.

The agency providing IHTS is required to have telephonic crisis response 24/7 but this may be other clinical agency staff rather than someone directly involved in IHTS. However, the agency staff would have access to the consumer's crisis plan developed with IHTS. The expectation, if any crisis occurred, would be that these plans are reviewed and modified. These are lower acuity patients, who do not typically require crisis response, and do not require a three-person team. These are children with moderate to severe unmanageable conditions with multisystem involvement. This service will also encompass similar service requirements, except that IHTS is less restrictive on the team makeup, more focused on family systems work through more intensive use of the licensed staff and will not be required for an in-person first responder during crisis situations. The service would be time limited, estimated at no more than 6 months.

The service is intended to accomplish the following:

- Reduce presenting psychiatric or substance use disorder symptoms;
- Ensure linkage to and coordination with community services and resources; and
- Prevent out of home placement for the beneficiary.

**Monitoring Activities:** Self-report with follow-up MCO audit to evaluate:

- Availability of 24-hour telephonic crisis response with agency staff who have access to the consumer's specific crisis plan.
- Enhanced crisis plan to be uploaded to Provider Direct initially and adjusted as appropriate
- Minimum 60% of therapy interventions include family/caregivers.
- Minimum 85% of therapy services are in the home or community settings over the course of treatment (expectation is that this may be higher initially with titration over time)
- 60% of total encounter time consists of therapy (vs. case management/case coordination activities).
- CANS-MH assessment completed at admission, every 60 days, and at discharge

Service exclusions are adhered to (does not occur during the same authorization period)

- Intensive In Home Services (IIHS)
- Multisystemic Therapy (MST)
- Day Treatment
- Individual, group, and family therapy (billed as separate services, as these interventions as part of IHST service)
- Substance Abuse Intensive Outpatient Program (SAIOP)
- Child residential treatment services
- Psychiatric Residential Treatment Facility (PRTF)
- Substance abuse residential services.
- Service is not to be billed on dates when consumers are receiving inpatient hospitalization services but may facilitate coordination of discharge plans if admission occurs.
- Monitoring of adherence to supervision plans

## Expected Outcomes

Expected clinical outcomes include but are not limited to the following:

- Prevention of crisis episodes
- Reduction in symptomatology
- Beneficiary and family or caregivers' engagement in the recovery process
- Improved beneficiary functioning in the home, school, and community settings
- Ability of the beneficiary and family or caregiver to better identify and manage triggers, cues, and symptoms
- Beneficiary's sustained improvement in developmentally appropriate functioning in specified life domains
- Beneficiary's utilization of increased coping skills and social skills that mitigate life stresses resulting from the beneficiary's diagnostic and clinical needs
- Reduction of symptoms and behaviors that interfere with the beneficiary's daily living, such as negative effects of the substance use disorder or dependence, psychiatric symptoms, or both
- Decrease in delinquent behaviors when present
- Increased use of available natural and social supports by the beneficiary and family or caregivers
- Prevention of out of home placement
- Improvement in CANS score

## Staffing Qualifications, Credentialing Process, and Levels of Supervision Administrative and Clinical) Required

**Provider Requirements:** IHTS is provided by staff employed by a mental health, substance use, or intellectual and developmental disability (MH/SU/DD) provider organization that meets all the following requirements:

- Meets the provider qualification policies, procedures, and standards established by NC Medicaid for Intensive In Home Services (IIHS) outlined in NC Medicaid Clinical Policy 8A Enhanced Mental Health and Substance Abuse Services
- Meets the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse 2 revised 4-1-19 Services and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services.
- Enrolled with Partners Health Management as a Medicaid provider of IHTS
- Established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina
- Achieve national accreditation with one of the accrediting bodies approved by the N.C. Department of Health and Human Services (DHHS) within one year of enrollment as a provider with NC Medicaid

**Staffing Requirements:** Clinicians would follow the standard credentialing process. QP/APs would receive supervision as outlined in an individualized supervision plan. Licensed Professional (LP) Fully licensed professional who has the knowledge, skills and abilities required by the population and age to be served. For services focused on substance use disorder interventions, the therapist must be either a certified clinical supervisor (CCS) or a licensed clinical addiction specialist (LCAS). May also use Qualified Professional (QP) in addition to the LP QP who has the knowledge, skills and abilities required by the population and age to be served to provide coordination of care and case coordination tasks May also use Associate Professional (AP) in addition to the LP AP who has been trained as a Family Partner and who has the knowledge, skills, and abilities required by the population and age to be served to provide coordination of care and coordination of care functions.

Training as a Family Partner includes the following trainings, at minimum.

- Family Partner 101
- Motivational Interviewing
- CFT 1
- Trauma Informed Care

- WRAP (Wellness Recovery Action Planning)

The licensed professional will be responsible for all therapy provision and may also perform the coordination and coordination of care functions.
The QP and/or AP would perform only the coordination and coordination of care functions, although they may reinforce some of the skills and interventions being implemented through the therapy sessions.

The LP, QP and, AP must complete the following trainings:

- All mandatory state and employee training as required by North Carolina General Statutes.
- 1 hour of crisis response training
- Training on crisis plan development to be able to develop enhanced crisis plan for all youth under this definition
- A minimum of 24 hours of training, completed within the past 10 years, in therapy practices, clinical interventions and treatment modalities to the population being served
- For the selected evidence-based treatment modality, LP would have completed training as required for the treatment modality by the developer of the model or qualified trainer. For trauma-focused treatment, this would include participation in the yearlong learning collaborative.
- Annual follow-up training and ongoing continuing education as required for the chosen modality (a minimum of 10 hours annually in the chosen modality would be required, unless best-practice training recommendations for the specific modality recommend more).

## Utilization Management

An IHTS unit is a per diem event with a minimum of two hours combined therapy and coordination of care. Only one unit may be billed per week. To be able to bill for this service, the provider must have provided a minimum of two hours of treatment during the week (Sunday to Saturday). The average consumer will receive this service for up to six months, so the expected utilization is 24 units.

**Utilization Management:** Prior Authorization for IHTS is required. Initial authorization for services may not exceed six months. Re-authorization must be conducted every six months.
Entrance Criteria: The beneficiary (ages three to 20) is eligible for this service when ALL of the following criteria are met:

A. there is a mental health or substance use disorder diagnosis (as defined by the DSM5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability
B. based on the current comprehensive clinical assessment, this service was indicated and traditional office-based outpatient treatment services were considered or previously attempted, but were found to be inappropriate or not effective
C. the clinical assessment identifies the need for linkage and/or coordination with other service systems or community resources to prevent family disruption or need for more intensive levels of care
D. the beneficiary's symptoms and behaviors at home, school, or in other community settings due to the beneficiary's mental health or substance use disorder condition, are moderate to severe in nature and require intensive, coordinated clinical interventions
E. evidence of problems in at least two major life domains, which are significantly affecting the consumer's behavioral health needs, as evidenced by at least two of the following:
    - housing (problems with safety/stability)
    - education/school
    - physical health care linkage or access needs
    - involvement with one or more of the following:
        - Department of Social Services (involvement due to allegations of abuse, neglect, etc. or involvement for prevention based on identification of at risk factor for potential removal of children from the home; safety concerns identified; reports that were unsubstantiated, but some concerns still identified or consumers in custody working towards family reunification)

- Department of Juvenile Justice or other legal system (individuals actively on probation, on diversion contracts, being discharged from jail or youth detention or identified as at risk for involvement due to criminal activities)
- Exceptional Children's Program (actively involved with IEP, 504 plan, or alternative school setting; individuals identified as in need of these school services that are not yet actively in place; individuals that may be able to be maintained in traditional settings with some additional support and coordination, such as behavior plans or early intervention)

F. The consumer does not present with an imminent risk of BOTH out of home placement based on MH/SA diagnosis AND does not have a history of multiple crisis events within the last 6 months
G. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

## Service Criteria

**Continued Service Criteria**

The CANS and CALOCUS tools will be used to guide the determination of whether an IHTS recipient continues to meet the entrance criteria above. The service would be time limited, estimated at no more than 6 months. The beneficiary is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP; or the beneficiary continues to be at risk for out-of-home placement, based on current clinical assessment, history, and the tenuous nature of the functional gains. AND One of the following applies:

- The beneficiary has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms;
- The beneficiary is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;
- The beneficiary is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible; or
- The beneficiary fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The beneficiary's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

**Discharge Criteria:**

- The individual has made significant progress toward rehabilitation goals and discharge to basic, office-based therapy services with the same licensed therapist is indicated.
- Individual requires a more intensive level of care or service.

A discharge Service Authorization Request (SAR) should be submitted at the time of discharge.

**Service Orders:** A Master's level behavioral health professional fully licensed in the state of North Carolina with at least two years of post-Master's Degree experience with the population served orders this service.

Documentation Requirements Treatment Plan Each individual receiving IHTS is required to have a Person Centered Plan (PCP) that is fully complete prior to or on the first date of service. The PCP must meet all the requirements, including an enhanced crisis plan, as outlined in the NC PCP Instruction Manual. The amount, duration, and frequency of the service must be included in the PCP.

**Service Documentation**: A full service note that meets the requirements per APSM 45-2 is required for each contact or intervention (such as individual session, case management, crisis response) for each date of service. Each service note must include the following information:

- Recipient's name
- Service record number
- Medicaid identification number (as applicable)
- Name of service provided
- Full date of service
- Place of service
- Type of contact (face to face, telephone call, collateral, etc.)
- Purpose of contact as it relates to the goal(s) on the PCP
- Description of the interventions provided
- Time spent providing interventions (i.e. duration)
- Assessment of effectiveness of intervention and/or the recipient's progress towards the goal(s)
- Signature and credentials of the staff member(s) providing the service

**Discharge Planning:** Beginning at the time of admission, all interventions/activities regarding discharge planning and transition with the member, family/caregiver/legally responsible person, and child and family team will be documented. A documented discharge plan shall be discussed with the individual and included in the service record.

**Service Exclusions/Limitations:** Service exclusions (do not occur during the same authorization period):

- Intensive In-Home Services (IIHS)
- Multisystemic Therapy (MST)
- Day Treatment
- Individual, group, and family therapy (billed as separate services, as these interventions as part of IHTS service)
- Substance Abuse Intensive Outpatient Program (SAIOP)
- Child residential treatment services
- Psychiatric Residential Treatment Facility (PRTF)
- Substance abuse residential services
- IHTS is not to be billed on dates when consumers are receiving inpatient hospitalization services but may facilitate coordination of discharge plans if admission occurs.

- In Lieu Of services are not included in the Medicaid state plan and are provided only when they are expected to be a cost-effective alternative to state plan services which result in as good as or better outcomes than would the state plan service.

- In Lieu Of services may be provided to individuals who participate in NC Innovations or other home and community-based waiver programs, such as CAP/C and CAP/DA, as long the alternative services are not duplicative of waiver services

- If a request for authorization of this service is denied, or if an authorization of this service is terminated, suspended, or reduced, then appeal rights will be provided in accordance with applicable law.

## Targeted Length of Stay

This is a time-limited services, estimated at no more than 6 months.