Title:	Residential Services- Complex Needs	**Code:**	H0018
Effective Date:	9/1/21, Revised 2/2/2022	**Units:**	Per diem

Service Description

Residential Services – Complex Needs is a short-term residential treatment service focused on treatment of member with cooccurring conditions and complex presentation. The members being served through Residential Services – Complex Needs will benefit most from a multi-disciplinary approach with staff who are trained to treat I/DD, mental health and severe behaviors.

Population to be Served

This service is available to children and adults, ages 5 through 21 with either:

- Primary mental health (MH) diagnosis **and** I/DD diagnosis or borderline intellectual functioning with traits that inhibit optimal functioning OR
- Primary I/DD diagnosis with co-occurring MH diagnosis.

Children with complex needs per the Settlement Agreement between the North Carolina Department of Health and Human Services (DHHS) and Disability Rights North Carolina (DRNC) can be served as a priority population with this service.

Treatment Program Philosophy, Goals and Objectives

Through use of a comprehensive team model, members will be able to receive more integrated treatment interventions that ensure all diagnoses, including medical needs, are being fully assessed and treated. Residential Services – Complex Needs is provided in a behavioral health residential level 2 family/group type setting or alternative family living (AFL) setting with very structured supports. If member is under 21 years old, AFL must meet requirements for 5600F licensure.

The service is supported by a team of professionals with expertise in working with individuals with behavioral challenges. This team includes psychologists and/or licensed clinicians who are routinely involved and readily accessible for the development of behavioral intervention plans and during crisis events to provide support for assessment and de-escalation. A licensed clinician, psychologist, psychiatrist or other physician with behavioral health expertise within the provider organization or contracted with the provider organization will be available for consultation, and close coordination with outpatient psychiatric care will be ensured. Modalities and interventions are individualized based on the unique needs of the members, but behavioral plans will be developed and implemented for all members.

Families/caregivers/guardians will be actively engaged in the treatment program and coached on strategies and interventions that could be replicated in non-residential settings, such as the members' own homes or family homes. Comprehensive coordination will occur with other stakeholders such as schools, employers, natural supports and primary care providers. The focus will be on strategic planning across systems, with the ongoing development of a strong natural support structure to reduce the need for paid supports. At a minimum, family therapy or training/supportive

services will be provided to the family/caregiver/guardian twice per month or more frequently, if needed. During therapeutic leave visits, the residential provider staff will provide consultation/coaching in his/her home environment for a portion of that time to offer in home supports and training to the caregiver and other family members to generalize skills to the home environment as necessary. In the 30 days prior to discharge, the frequency of these visits and coaching will increase. The residential provider will also ensure that the caregivers are connected to local supports through community organizations, support groups or individual services when it is determined necessary for optimal family functioning.

A key component of this service is assessing members' preferences, strengths, and helping connect members to community activities and interests. The goal is to develop natural supports that can be sustained as the residential services fade. Whenever possible, providers will connect members to activities that can be maintained as members transition back to their homes. When the distance between the residential setting and the home community makes this challenging, the residential provider will connect members with similar activities in their local communities prior to discharge to ensure continuity of these supports.

Education and vocational components are key to successful outcomes for members with complex needs. The residential provider will be expected to work jointly with the schools for these members. In cases where a school transfer does occur due to the location of the residential setting, the provider will coordinate with both schools to ensure continuity. The residential provider will assist the family in advocating with the school to ensure that appropriate components are in place (such as a 504 Plan or IEP) and that the behavior plans are used consistently across all settings with modifications as needed. This support may involve the residential provider working directly with the member in the school setting to provide temporary coaching for consistency across settings for members' adjustment and transitioning. Vocational interests also will be assessed by the residential provider and the member will be provided opportunities to engage in employment. This support may occur through connections to formal resources such as Vocational Rehabilitation, Supported Employment, occupational tracks in school or informal connections with local community businesses willing to support the member. When necessary, the residential provider will assist in transitioning these formal resources or helping with informal resources in members' home communities in preparation for discharge.

Trauma is expected to be common amongst the recipients of this service. While not all members may require formal trauma-focused therapy, a trauma-informed approach is necessary to ensure past experiences are considered and that the member has a positive treatment experience. Whenever possible, appropriate specific evidenced-based interventions/best practices will be incorporated into individual treatment programming. These interventions may include, but are not limited to: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Motivational Interviewing (MI), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Positive Behavior Supports (PBS), Functional Behavioral Analysis/Assessment, etc.

Expected Outcomes

- Reduction in behaviors
- Improvement in skill development
- Reduction in crisis episodes
- Reduction of mental health symptoms
- Able to transition back to the family setting or less restrictive setting home within six months
- Improvement on standard outcome measures utilized at routine treatment intervals, at completion of treatment and during follow up care whenever possible
- Objective improvement in school or work as indicated in progress notes, employee reviews, treatment team meetings, etc.
- Improved coordination with physical health stakeholders to promote wellness, stability and whole person care

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

Residential Services – Complex Needs will be delivered by practitioners employed by mental health or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by Division of Health Benefits (DHB);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS); and

Fulfill the requirements of 10A NCAC 27G.

Providers are required to have access to Licensed Clinical Staff, Psychologists and medication prescribers in accordance with 10A NCAC 27G as appropriate. Based on the members' individual needs, other services (such as Nursing Services, Occupational Therapy and Physical Therapy) also may be utilized as adjuncts to treatment. The level of involvement of these additional services will be based on the comprehensive clinical assessment and psychiatric assessments of the members and adjusted throughout treatment. Routine nursing or occupational therapy may be a standard part of the Residential program, if indicated based on the population served.

- At a minimum a Qualified Professional (QP) will always be available for crisis response and will serve as the first responder. The licensed clinician may be consulted and assist with recommendations of strategies/interventions that can be done via phone, two-way audio/visual, or face-to-face intervention.

- A psychologist or licensed clinician must be involved in the programming and consultation and available for crisis response via telephone at a minimum with face-to-face or two-way audio/visual follow up within 24 hours, as necessary.

- Psychiatric Involvement – All members are expected to receive a full psychiatric assessment in person or by two-way audio/visual telehealth, preferably by a Child and Adolescent Psychiatrist for members under 18, by an MD or DO within 14 business days of admission if the member is not currently under the care of a psychiatric prescriber These services can be billed separately, but the residential provider is responsible for coordinating and ensuring this assessment occurs. Any exceptions based on clinical needs of the member must be requested in writing and will be reviewed by the Chief Medical Officer (CMO) or designee. For members already established with psychiatric providers, all efforts should be made to maintain continuity with these practitioners whenever possible.

- The residential provider is expected to have access to a psychologist, psychiatrist or other physician (on staff or contracted) with behavioral health experience/training with the population being served (e.g., developmental pediatrician) who can provide consultation to the treatment team as necessary and who can assist with interfacing with the community psychiatrist, if different.

Credentialing Process: Clinicians associated with the program will be credentialed according to Partners' standard process.

Supervision: Supervision must be provided according to the requirements specified in 10A NCAC 27G.0203 and according to licensure or certification requirements of the appropriate discipline.

Appropriately qualified staff will complete an Adaptive Skills Assessment (i.e. Checklist of Adaptive Living Skills (CALS) or Vineland), and Functional Behavioral Assessment, as well as any other needed assessments within the first 30 days of treatment. At a minimum, each assessment will be revisited according to the following schedule.

- Adaptive Skills Assessment: annually
- Functional Behavior assessment: annually or monthly when there is no evidence that behavioral progress is occurring (active progress monitoring should occur weekly).
- Other assessments: when clinically appropriate

- Goals are individualized and based on information obtained from the identified assessments.
- Treatment interventions reflect evidence-based practices or best practices as a standard part of the treatment programming.
- At a minimum for children (ages 5-17), Child and Family Treatment teams will occur monthly, increased as necessary due to active incidents, crises or other concerns. Every effort will be made for these meetings to involve all stakeholders such as schools, employers and natural supports, in addition to the provider and the family. When other service providers are unable to attend, input should be sought from them prior to the meeting. Meeting outcomes should be shared with them after the meeting occurs. Providers will maintain documentation of this communication in their records.
- At a minimum for adults (ages 18-21), treatment teams will occur monthly and be increased as necessary due to active incidents, crises or other concerns to ensure proactive planning. Every effort will be made to include all providers, involved stakeholders and natural supports. When other service providers are unable to attend, input should be sought from them prior to the meeting. Meeting outcomes should be shared with them after the meeting occurs. Providers will maintain documentation of this communication in their records.
- Providers will work intensively with the member to develop skills to reduce acting out behaviors and develop supportive strategies that can be utilized in both the treatment and home settings. Providers will implement a behavior plan and modify as frequently as necessary for effective strategic interventions. This will be completed through access to a psychologist or other qualified professional who is engaged as part of the treating team and can be accessible during crisis episodes. The planning will be shared with all supports that interact with the individual such as the school, therapist, primary care physician, psychiatrist and family.
- At a minimum, family therapy or training/supportive services will be provided to the family/caregiver/guardian twice per month or more frequently, if needed.

Targeted Length of Service

Residential Services: Complex Needs is a short-term residential service, with an average length of stay of approximately 120 days. The service is provided in a behavioral health residential level 2 family/group type setting or alternative family living (AFL) setting with very structured supports. Comprehensive care coordination will occur with other stakeholders such as schools, employers, natural supports and primary care providers. In the 30 days prior to discharge, the frequency of home visits and coaching will increase, to ensure member is on track for step-down. The residential provider will also ensure that the caregivers are connected to local supports through community organizations, support groups or individual services when it is determined necessary for optimal family functioning.

Initial requests can be requested for up to 60 days. Concurrent requests can be requested for up to 60 days.

Utilization Management

Prior authorization is required on or before the first day of service. This service is authorized per diem up to 60 days. Expected length of stay is approximately 120 days.

Entrance Criteria

A. This service is available to children and adults, ages 5 through 21 with either:
   a. Primary mental health (MH) diagnosis **and** I/DD diagnosis or borderline intellectual functioning with traits that inhibit optimal functioning OR
   b. Primary I/DD diagnosis with co-occurring MH diagnosis.

B. Based on the current Comprehensive Clinical Assessment or equivalent assessment, this service is indicated, and in-home or office-based treatment services were considered or previously attempted, but were found to be inappropriate or not effective

C. The beneficiary's symptoms and behaviors at home, school or in the community are due to the beneficiary's mental health condition and are moderate to severe in nature and require intensive, coordinated clinical interventions

D. Evidence of problems in at least two major life domains, which are significantly affecting the beneficiary's behavioral health needs as evidenced by at least two of the following:
    a. Housing (problems with safety/stability)
    b. Education/school – inability to remain in the typical school environment due to behavioral issues.
    c. Vocational issues – inability to retain employment due to behavioral issues.
    d. Serious deficits or significantly impaired social skills/community integration issues
    e. Significant aggression or significant safety risk at home
    f. Involvement with one or more of the following:
        i. 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)
        ii. 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)
        iii. 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)

E. Imminent risk of out of home placement based on diagnosis AND has accessed crisis services (ER evaluation, hospital admission, Mobile Crisis etc.) within the last 6 months.

F. 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).

Continued Service Criteria

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the beneficiary's service plan or the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Beneficiary has achieved initial service plan goals and additional goals are indicated.
B. Beneficiary is making satisfactory progress toward meeting goals.
C. Beneficiary is making some progress, but the service plan (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid level of functioning, are possible or can be achieved.
D. Beneficiary is not making progress; the service plan must be modified to identify more effective interventions.
E. Beneficiary is regressing; the service plan must be modified to identify more effective interventions.

Discharge Criteria

The beneficiary shall be discharged from this level of care if any one of the following is true:

A. The level of functioning has improved with respect to the goals outlined in the service plan and the beneficiary can reasonably be expected to maintain these gains at a lower level of treatment.
    OR
B. The beneficiary no longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available.
    OR

C. Discharge or step-down services can be considered when in a less restrictive environment, the safety of the beneficiary around sexual behavior, and the safety of the community can reasonably be assured.

Service Order

A signed service order must be completed by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Licensed Psychologist, Physician Assistant (PA), or a Nurse Practitioner (NP) according to his or her scope of practice. Each service order shall be signed and dated by the authorizing professional and shall indicate the date on which the service was ordered. A service order must be in place on or before the first day of service. The service order is valid for one year from the date of the original service order. Service orders may not be back-dated.

Documentation Requirements

Treatment Plan - Each individual receiving Residential Complex Needs services 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. If additional services are received, they should be reflected on a unified Person-Centered Plan. A PCP is required to be updated with any concurrent request.

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, and child and family team will be documented. A documented discharge plan shall be discussed with the individual and included in the service record.

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.

Service Exclusion

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

- State funded services
- Other waiver services such as the Innovations waiver or CAP waiver
- Intensive In-Home Services (IIHS)
- Multisystemic Therapy (MST)

- Family Centered Treatment (FCT)
- Family therapy (billed as separate services, as this intervention is part of this service)
- Child residential treatment services
- Psychiatric Residential Treatment Facility (PRTF)
- Substance abuse residential services

Early Periodic Screening, Diagnosis and Treatment (EPSDT) criteria will be considered on an individual member basis.