The **Level of Care Guidelines** is a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”)).

The **Level of Care Guidelines** is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS’ National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The **Level of Care Guidelines** is also derived from input provided by clinical personnel, providers, professional specialty societies, consumers, and regulators.

For more information on guiding principles for the **Level of Care Guidelines** and their development, approval, dissemination, and use, please see the *Introduction to the Level of Care Guidelines*, available at: [www.providerexpress.com](http://www.providerexpress.com) > Clinical Resources > Level of Care Guidelines.

**GUIDELINES (CONNECTICUT): INTENSIVE IN-HOME SERVICES**

**Intensive In-Home Services:** Intensive In-Home Services (IIHS) are behavioral health services provided when a child or adolescent:

- Has returned from out-of-home care or hospitalization and requires intensive community-based services in order to remain in their home and community; or
- Is at imminent risk of placement due to mental health issues, emotional disturbance, or use of alcohol or drugs.

The intent of Intensive In-Home Services is to provide clinical interventions and support necessary to successfully maintain the child or adolescent in his or her home and community.

---

1 The terms “recovery” and resiliency” are used throughout the Level of Care Guidelines. SAMHSA defines “recovery” as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA defines “resilience” as the ability to adapt well over time to life-changing situations and stressful conditions. The American Society of Addiction Medicine defines “recovery” as a process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety, and also refers to the overall goal of helping a patient to achieve overall health and well-being.
Intensive In-Home Services are child-centered, family-focused, strength-based, culturally-competent, and responsive to each child or adolescent’s psychosocial, developmental, and service needs. A variety of models are used to deliver IIHS, such as (see definitions section of this document):

- Functional Family Therapy (FFT)
- Intensive In-Home Child & Adolescent Psychiatric Services (IICAPS)
- Multidimensional Family Therapy (MDFT)
- Multisystemic Therapy (MST)

The course of Intensive In-Home Services is focused on addressing the factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the factors that precipitated admission no longer require treatment.

**Intensive In-Home Services Admission Criteria**

- The member is eligible for benefits.
- AND
- There are acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors (i.e., the factors leading to admission) which suggest that the member is at risk for out-of-home care or hospitalization, or otherwise requires ongoing involvement with multiple systems due to high risk behaviors. The member’s current condition can be safely, efficiently, and effectively assessed and/or treated in this setting. Examples of factors that put the member at risk include:
  - Complex and persistent behavioral health conditions with/without co-occurring medical conditions;
  - Behavioral health conditions coupled with abuse, neglect, or other forms of trauma;
  - Behavioral health conditions coupled with delinquency, truancy, or running away.
- OR
- The member meets the target criteria for the proposed IIHS:
  - Functional Family Therapy: member is aged 11-18, and has ongoing trouble regulating his or her emotions/behavior as a result of trauma.
  - Intensive In-Home Child & Adolescent Psychiatric Services: member is aged 3-18, and presents with a severe and persistent behavioral health condition (e.g., Bipolar Disorder, Schizophrenia) with/without behavior problems secondary to the behavioral health condition.
  - Multidimensional Family Therapy: member is aged 6-17, and presents with a Substance-Related Disorder, a co-occurring Substance-Related Disorder and other behavioral health condition, or a Substance-Related Disorder along with other behavior problems such as delinquency.
  - Multisystemic Therapy: member is aged 6-17, is a juvenile offender, and presents with externalizing symptomatology consistent with a Disruptive, Impulse-Control, and Conduct Disorder (e.g., Conduct Disorder).
- AND
- The member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.
  - Failure of treatment in a less intensive level of care is not a prerequisite for authorizing coverage.
- AND
- The member and his or her parent/caregiver/guardian are willing to accept and cooperate with IIHS, including the degree of parent/caregiver/guardian participation outlined in the treatment plan.
- AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
- AND
- Co-occurring behavioral health and physical conditions can be safely managed.
- AND
- Services are medically necessary.

**Intensive In-Home Services Continued Service Criteria**

- The severity of the member's conditions and result impairment continue to require this level of service.
- AND
- Service planning is individualized to the member and his or her family's changing condition; realistic and specific goals and objectives are stated; the mode, intensity, and frequency of treatment are consistent with best known evidence-based practice(s).
- AND
- Active participation is occurring, and continued progress toward goals is expected. Progress in relation to goals is clearly evident, measurable, and described in observable terms.
  - If objectives have not yet been achieved, documentation supports continued interventions.
- AND
- The admission criteria cited in the previous section otherwise continue to be met.
Intensive In-Home Services Discharge Planning and Criteria

- The continued stay criteria are no longer met. Examples include:
  - The member’s documented treatment goals and objectives have been successfully met.
  - The member meets criteria for a less/more intensive level of care.
  - The member or his or her parent/caregiver/guardian is unwilling or unable to participate in services.
- OR
- The member moves outside the geographic area of IIHS’ responsibility.
- OR
- The member declines or refuses services and requests discharge, despite the team’s best efforts to develop an acceptable plan with the member.
- OR
- The member is no longer eligible for benefits.

Intensive In-Home Services Clinical Best Practices

- Upon referral, the provider conducts an initial evaluation. The initial evaluation:
  - Gathers information about the presenting issues from the perspective of the member and the member’s parent/caregiver/guardian, and includes their understanding of the factors that lead to requesting services;
  - Focuses on the member’s specific needs;
  - Identifies the member’s goals and expectations;
  - Is completed in a timeframe commensurate with the member’s needs, or otherwise in accordance with clinical best practices.
- The provider collects information from the member, the member’s parent/caregiver/guardian, and other sources, and completes an initial evaluation of the following:
  - The member’s chief complaint;
  - The history of the presenting illness;
  - The factors leading to the request for service;
  - The member’s mental status;
  - The member’s current level of functioning;
  - Urgent needs, including those related to the risk of harm to self, others, or property;
  - The member’s use of alcohol, tobacco, or drugs;
  - Co-occurring behavioral health and physical conditions;
  - The history of behavioral health services;
  - The history of trauma;
  - The member’s medical history and current physical health status;
  - The member’s developmental history;
  - Pertinent current and historical life information, including the member’s:
    - Age;
    - Gender, sexual orientation;
    - Culture;
    - Spiritual beliefs;
    - Educational history;
    - Employment history;
    - Living situation;
    - Legal involvement;
    - Family history;
    - Relationships with family and other natural resources;
  - The member’s strengths;
  - Barriers to care;
  - The member’s broader recovery, resiliency, and wellbeing goals.
- The provider uses the findings of the evaluation to assign a DSM/ICD diagnosis.
- In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.
- The provider, in collaboration with the member and the member’s parent/caregiver/guardian, uses the findings of the initial evaluation and the diagnosis to develop a treatment plan. The treatment plan addresses the following:
  - The short- and long-term goals of treatment;
  - The type, amount, frequency, and duration of treatment;
  - The expected outcome for each problem to be addressed, expressed in terms that are measureable, functional, time-framed, and directly related to the factors leading to admission;
  - How the member’s family and other natural resources will participate in treatment when clinically indicated;
o How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.

• As needed, the treatment plan also includes interventions that enhance the member’s motivation, promote informed decisions, and support the member’s recovery, resiliency, and wellbeing. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, and facilitating involvement with self-help and wraparound services.

• The proposed frequency and duration of treatment allows for safe, efficient, and effective achievement of treatment goals, and supports the member’s recovery and resiliency. Factors that may impact frequency and duration include the following:
  o The goals of treatment;
  o The member’s preferences;
  o Evidence from clinical best practices which supports frequency and duration;
  o The need to monitor and manage imminent risk of harm to self, others, and/or property.

• The provider informs the member and the member’s parent/caregiver/guardian of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member or their parent/caregiver/guardian gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.

• The provider also informs the member and their parent/caregiver/guardian of the process to be followed in the event of an after-hours emergency such as the availability of on-call services. The process is not solely reliant on the Emergency Room.

• Treatment focuses on addressing the factors which led to admission to the point that the member’s condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.

• The treatment plan and level of care are reassessed when the member’s condition improves, worsens or does not respond to treatment.
  o When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
  o When the member’s condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member’s condition should be treated in another level of care.

• The provider in conjunction with the member/member’s parent/caregiver/guardian develops an initial discharge plan at the time of services start, and estimates the length of services.

• The provider in conjunction with the member/member’s parent/caregiver/guardian updates the initial discharge plan during the delivery of services ensuring that:
  o An appropriate discharge plan is in place prior to discharge;
  o The discharge plan is designed to mitigate the risk that the factors which precipitated admission will reoccur;
  o The member/member’s parent/caregiver/guardian agrees with the discharge plan.

• For member’s remaining in IIHS’ geographic area of responsibility, the provider:
  o Shares the discharge plan and all pertinent information with the treatment provider(s) prior to discharge.
  o Provides the member with information about:
      • Recommended self-help and community resources; and
      • How the member can resume IIHS

• For members moving outside IIHS’ geographic area of responsibility, the provider discusses the need for and availability of IIHS with the member/member’s parent/caregiver/guardian and the member’s treating provider. As needed, the IIHS provider assists the member/member's parent/caregiver/guardian with accessing IIHS in the member’s new service area. The IIHS provider shall maintain contact with the member/member’s parent/caregiver/guardian through the transition.

DEFINITIONS

Functional Family Therapy (FFT): According to the State of Connecticut’s Department of Children & Families, Functional Family Therapy (FFT) is an evidence-based intervention program for families with an adolescent age 11-18 who experiences behavioral health issues. Sessions are scheduled with a clinician at a frequency that matches the family’s needs, typically 1-2 times per week for 1-2 hours at the family home. To ensure that the healing process occurs together, and to increase the potential for the family to continue to support one another after services have terminated, all sessions are held as a family. On average, 12 sessions are held over a 3-6 month period. FFT can provide treatment at the same time that family members are receiving individual therapy or even some more intensive services, such as PHP or IOP.

FFT address trauma in a family context, allowing family members to process the traumatic event together. In applying the FFT model of helping the family to identify the overall pattern that leads to their undesirable symptoms and
behaviors, family members are able to gain a deeper understanding of the impact of the trauma on the individual and on the family dynamic, better understand each family member’s individual healing process, and feel empowered to provide support and advocacy.

Phase One: Engagement/Motivation creates the motivation for change by looking at family members and their behaviors from different perspectives and presenting a more strength-based understanding of the problem behaviors. The clinician works with the family to identify the chain of the events that leads to conflict. Trauma-informed: When the family has been impacted by trauma, this phase often involves psycho education to help family members to understand what may appear to be oppositional behaviors, such as lying or stealing, as effects of trauma. This phase might also include the introduction of coping skills and/or a safety plan.

Phase Two: Behavior Change changes behaviors by introducing skills that interrupt the family pattern and promote positive interactions and behaviors. The skills are individualized to the family’s needs taking into account their pattern, family hierarchy, and each family member’s relational style. Skills may include communication skills such as empathy and reflective listening, parenting skills, affect regulation, conflict management, and general relationship-building. Trauma-informed: Meeting the family where they are at in the healing process, a trauma informed behavior change plan might span from basic safety planning to teaching the family how to identify various emotions in themselves and one another to introducing the necessary communication and coping skills to process the trauma aloud, as a family.

Phase Three: Generalization challenges the family to consider how newly developed skills could be generalized to address future issues that have not been the focus of treatment. These sessions also focus on decreasing risk factors, identifying other resources to sustain change and increasing protective factors. Trauma-informed: This phase focuses on enhancing future safety by identifying potentially triggering situations and creating a plan to manage such situations should they arise. By decreasing risk factors, this phase also decreases the potential for future traumatic experiences.

Intensive In-Home Child & Adolescent Psychiatric Services (IICAPS): According to the State of Connecticut Department of Children & Families, IICAPS is a home-based treatment provided to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties. Services are provided by a clinical team which includes a Master's-level clinician and a Bachelor's-level mental health counselor. The clinical team is supported by a clinical supervisor and a child & adolescent psychiatrist. IICAPS Services are typically delivered for an average of 6 months. IICAPS staff also provide 24-hour/7-day emergency crisis response.

Multidimensional Family Therapy (MDFT): According to SAMHSA’s National Registry of Evidence-Based Programs and Practices, Multidimensional Family Therapy (MDFT) is a comprehensive and multisystemic family-based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency. Working with the individual youth and his or her family, MDFT helps the youth develop more effective coping and problem-solving skills for better decision making and helps the family improve interpersonal functioning as a protective factor against substance abuse and related problems.

Delivered across a flexible series of 12 to 16 weekly or twice weekly 60- to 90-minute sessions, MDFT is a manual-driven intervention with specific assessment and treatment modules that target four areas of social interaction: (1) the youth’s interpersonal functioning with parents and peers, (2) the parents’ parenting practices and level of adult functioning independent of their parenting role, (3) parent-adolescent interactions in therapy sessions, and (4) communication between family members and key social systems (e.g., school, child welfare, mental health, juvenile justice).

Multisystemic Therapy (MST): According to SAMHSA’s National Registry of Evidence Based Programs and Practices, Multisystemic Therapy (MST) addresses the multidimensional nature of behavior problems in troubled youth ages 6-17. Treatment focuses on those factors in each youth’s social network that are contributing to his or her antisocial behavior. The primary goals of MST programs are to decrease rates of antisocial behavior and other clinical problems, improve functioning (e.g., family relations, school performance), and reduce the use of out-of-home placements such as incarceration, residential treatment, and hospitalization. The ultimate goal of MST is to empower families to build a healthier environment through the mobilization of existing child, family, and community resources. MST is delivered in the natural environment (in the home, school, or community). The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring weekly. MST addresses risk factors in an individualized, comprehensive, and integrated fashion, allowing families to enhance protective factors. Specific treatment techniques used to facilitate these gains are based on empirically supported therapies, including behavioral, cognitive behavioral, and pragmatic family therapies.
REFERENCES


HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/10/2017</td>
<td>• Version 1</td>
</tr>
<tr>
<td>3/14/2018</td>
<td>• Annual Update: Updated links</td>
</tr>
</tbody>
</table>