Intensive Hospital Diversion (IHD)

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

Intensive Hospital Diversion (IHD) program will provide intensive short-term (on average, 4 to 6 weeks) in-home crisis stabilization and treatment to youth and their families to support diversion from psychiatric hospitalization and other out-of-home placements. The clinical goal of this program is to provide youth under 21 and their parents/caregivers with the intensive short-term treatment and support needed to maintain the youth at home safely and to (re)connect them to ongoing outpatient and/or community-based services.

IHD is a specialized service of In-Home Therapy (IHT). As such, IHD providers are expected to adhere to IHT performance specifications in addition to those contained within. Where there are differences between the IHT and IHD performance specifications, IHD specifications take precedence.

SERVICE COMPONENTS

1. IHD requires a multidisciplinary clinical team, including a clinical team lead and a consulting psychiatrist. Clinical team leads are required to have crisis intervention training and will be responsible for ongoing supervision and coaching of other team members. The IHD team will be supported by psychiatry and autism spectrum disorder/intellectual and developmental disability (ASD/IDD) expertise through consultation.
2. A Master's level clinician must respond to the family at the point of crisis (emergency department or in the community) within 24 hours of referral, after the initial crisis evaluation and intervention has been rendered. Intake should be completed in collaboration with crisis evaluation clinician(s) to ensure continuity.

3. Within 24 hours of intake, the team must begin intensive individual and family therapy including Cognitive Behavioral Therapy (CBT) skills building, parent support, psychopharmacological evaluation, and behavioral consultation, as needed.
4. The IHD team will work directly with the child and family 3-7 times per week.
5. The IHD team lead is expected to convene weekly team meetings on each youth on their caseload. The team meeting is expected to include IHD team, other community-based providers, the prescribing clinician, a representative from the youth's school, the caregiver and youth, and a representative from the youth's health plan.
6. It is expected that youth will be attending school as clinically appropriate, and that the IHD team will coordinate with any therapeutic supports at the youth's school to ensure the youth has appropriate support across community settings.
7. The IHD team will provide care coordination throughout their work with the youth and family, including making appropriate referrals and "warm hand offs" to follow-up providers, as indicated.
8. The team must provide 24/7 crisis response for youth/families, including in-person, when clinically indicated.

STAFFING REQUIREMENTS

1. Dedicated clinical staff will have CBT, crisis management and de-escalation training to meet the needs of this model. Staff will complete and document two (2) hours of training per content area, annually. Training curriculum will be available upon request. These training requirements are in addition to the requirements outlined in the IHT performance specification.
2. Child psychiatry or other prescriber capacity will be available to offer emergency consultation to staff within 24 hours of initial referral, when clinically indicated. The prescriber will assess the Enrollee's psychopharmacological needs within seven (7) days of initial referral, as clinically indicated and in consultation with any existing providers, including the youth's primary care doctor. The prescriber is expected to be available for ongoing consultation throughout the duration that the youth is receiving IHD services.
3. When clinically indicated for Enrollees with ASD/IDD, a licensed Applied Behavior Analyst (LABA) must be available to provide consultation. This may include using MCPAP for ASD/IDD for initial consultation.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. Any agency providing IHD is expected to develop a formal, documented communication and referral strategy with all regional Mobile Crisis Intervention (MCI) teams and Emergency Departments (EDs) within IHD provider catchment area to facilitate clinical coordination.
2. IHD program leadership will work with regional crisis teams, EDs and MCEs to develop a minimum weekly cadence to review and track possible referrals.
3. The IHD program will have a dedicated program staff person to meet weekly with local MCI, Emergency Departments, and anyone else identified as necessary to ensure that the program is functioning as intended.
4. MCE representatives and the IHD program will be in regular contact to ensure that Enrollees are receiving the services as they were intended and to coordinate aftercare.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

None

Discharge Planning and Documentation

1. The youth no longer meets admission criteria for this level of care, or meets criteria for a less or more intensive level of care.
2. The treatment plan goals, and objectives have been substantially met and continued services are not necessary to prevent worsening of the youth's behavioral health condition.
3. The youth is no longer living in a home setting.

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.