Performance Specifications

Children's Behavioral Health Initiative
Intensive Hospital Diversion (IHD) Program

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications. Additionally, **providers contracted for this service and all contracted services are held accountable to the General performance specifications**, located at the beginning of the performance specifications section of the Provider Manual. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

The Intensive Hospital Diversion (IHD) Program 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 herein. Where there are differences between the IHT and IHD performance specifications, IHD specifications take precedence.

The **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 the age of 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.

Components of Service

1. The Intensive Hospital Diversion Program 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 Massachusetts Child Psychiatry Access Program (MCPAP) 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 the 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 hours of training per content area, annually. Training curriculum will be available upon request. These training requirements are in addition to the IHT performance specifications.
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 Member's psychopharmacological needs within seven 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 Members 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 Collateral 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 the IHD provider catchment area to facilitate clinical coordination.
2. IHD program leadership will work with regional crisis teams, EDs, and Managed Care Entities (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, EDs, 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 enrolled youth are receiving the services as they were intended and to coordinate aftercare.

Provider Qualifications

1. In order to qualify to provide IHD, providers must:
    a. Be an In-Home Therapy (IHT) provider;
    b. Have dedicated clinical staff who have CBT skills training, crisis intervention training, and de-escalation training to meet the needs of this model;
    c. Have child psychiatry or other prescriber capacity to offer emergency medication consultation within 24 hours of initial referral and to participate in weekly team meetings as needed;
    d. Have staff who can respond to enrolled families 24/7, including in-person response, when clinically indicated;
    e. Develop a memorandum of understanding (MOU) with all regional MCI teams and EDs within the IHD provider catchment area to facilitate clinical coordination;
    f. Have an agreement with the hospitals to ensure they are allowed access to a member of the clinical team, not as a "visitor"; and
    g. Have, when clinically indicated for Members with ASD/IDD, a Licensed Applied Behavior Analyst (LABA) available to provide consultation. This may include using the existing MCPAP for ASD/IDD for initial consultation.

Medical Necessity Criteria

1. The Member must meet current Medical Necessity Criteria for IHT and have additional acute needs that cannot be met by IHT, as defined by the following:
    a. The Member is in acute crisis and at imminent risk of 24-hour level of care and has been evaluated by an MCI team or an ED clinician.
    b. The MCI team or other crisis evaluation indicates the need for more-intensive treatment than IHT and MCI together, and the Member can safely be maintained in the community with IHD in place as agreed upon by the family and crisis clinician.

Exclusionary Criteria

1. The Member is concurrently receiving IHT or other intensive home-based services, including those provided by other state agencies.
2. The Member has reached their 21st birthday.

Discharge Criteria

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 (QM)

1. The facility and/or program will develop and maintain a quality management plan that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is used and will include outcome measures and satisfaction surveys to measure and improve the quality of care and service delivered to Members, including youth and their families.
3. Clinical outcomes data must be made available upon request and must be consistent with performance standards for this service.
4. All Reportable Adverse Incidents will be reported within one business day of their occurrence per policy and DMH licensing requirements. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of a Member, or to others by action of a Member, who is receiving services, or has recently been discharged from services.
5. The facility and/or program will adhere to all reporting requirements of the Department of Public Health (DPH) and/or Department of Mental Health (DMH) regarding Serious Incidents and all related matters.