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**Feature Article March 2016**

**IHT Practice Guidelines – Establishing Quality Standards for In-Home Therapy Services**

As required by the Court’s Judgment in*Rosie D*. and ongoing disengagement efforts, the parties have established clinical practice standards for the delivery of remedial services under the Children Behavioral Health Initiative (CBHI).   Informed by subject matter experts, community stakeholders and Massachusetts providers, CBHI Practice Guidelines set expectations for youth and family engagement, assessment, treatment planning and intervention, transitions, and clinical supervision.  Provider training and coaching on implementation of the Practice Guidelines is ongoing.  This is the second in a series of features highlighting the new Practice Guidelines and their role in the evolving remedial service system.

In January of 2015, the Commonwealth released Practice Guidelines for the delivery of In-Home Therapy (IHT).  These Guidelines cover the full spectrum of IHT activities and responsibilities, from intake and engagement to initial clinical assessments, treatment planning and care coordination. A number of key IHT practice standards are highlighted below.

**Assessment**

In-Home Therapists are required to complete an initial assessment within 24 hours of the initial service intake.  This initial assessment is then followed by a comprehensive assessment, to be completed within 10 days.  A comprehensive assessment includes, but is not limited to: presenting concerns; medical history; psychiatric history; substance use history; developmental history; allergies/adverse reactions; medications; risk assessment; mental status exam; child and family strengths; clinical formulation and DSM V diagnosis. The comprehensive assessment must include relevant assessments and evaluations from prior/current providers (with written consent from the family), as well as clinical observations gleaned from talking with identified providers or natural supports, meetings in the family home, and interactions with the youth.  IHT will assist the family in identifying areas where updated or specialized evaluations are needed, arranging for those evaluations to occur, and incorporating relevant clinical recommendations into the treatment planning process.  Although focusing on the problems that demonstrate medical necessity for treatment, the IHT assessment process also is expected to identify, learn from, and build upon the youth and families’ unique strengths and abilities.

After considering the youth’s range of service needs; the presence of, or need for, other service providers; and the involvement of other state agencies or special education providers, the IHT clinician makes a recommendation regarding the youth and families need for either IHT or the more intensive care coordination available from ICC.  IHT providers are expected to assist with any ICC referrals and to participate, as needed, in the intake process.

Since the comprehensive assessment is an organic document, and the youth and families’ needs and preferences change over time, it must be reviewed at minimum of every 90 days, including any changes in the youth and families’ need for care coordination.  Especially for families who have multiple providers and state agency involvement, IHT must regularly re-evaluate the need for more intensive care coordination and engage the youth and family around the potential benefits of the team-based, wraparound treatment planning process provided by ICC.

**Care Coordination**

As part of the assessment and treatment planning process, IHT practitioners make informed judgments, in partnership with the family, about whether intensive care coordination is indicated.  The IHT clinician should offer reassurance that he or she will oversee the care coordination transition to ensure it is managed in a seamless manner and that, with the families’ permission, IHT will continue delivering home-based clinical services as part of the new Individual Care Planning Team.

If IHT continues to serve as the responsible care coordination entity, the IHT clinician is expected to develop a treatment plan which addresses the youth and families’ overall clinical needs and goals, including referrals to other medically necessary, home-based service providers.  The resulting plan must include the development of goals and objectives for the delivery of each hub-dependent remedial service, as well as strategies to ensure effective collaboration with other medical or behavioral health providers, or state agency staff whose involvement is requested by the youth and family. The IHT provider should convene an in-person meeting early in the treatment process, to ensure that all those involved with the youth and family understand the purpose of plan, the family’s individual goals, the proposed interventions, and their roles in the delivery of each service or support.

Once the youth and families’ treatment plan is in place, the IHT provider is expected to communicate regularly with identified team members to ensure that interventions are effective, that treatment objectives are modified or updated as needed, and that there is a timely, coordinated response to any unexpected crisis situation.  Regularly planned meetings are highly recommended to ensure the IHT provider can respond proactively to changing circumstances.  When effective interventions lead to improvement in areas initially prioritized for intervention (i.e. safety; reduction of aggression), but the child still meets Medical Necessity Criteria, IHT providers are expected to identify new goals with the youth and family, building on their progress and addressing other challenges like effective communication, enforcing household/community expectations, and enhancing problem-solving skills.  When other services or supports in the treatment plan are expected to end, IHT must assist the youth and family in planning for and managing that transition.

**Therapeutic Training & Support (TT&S)**

A typical IHT team includes a primary, licensed clinician and qualified, professional support staff.  This staff person works in concert with, and under the supervision of, the IHT clinician to support implementation of the In-Home Therapy treatment plan.  Implementation activities may include teaching the youth to understand, direct, interpret, manage, and control feelings and emotional responses to situations.  TT&S staff also help parents/caregivers to practice and generalize the skills needed to safely and effectively respond to their child’s behavioral or emotional needs.  The IHT clinician and TT&S support staff work closely together to ensure that they are communicating consistently with the youth and family, sharing observations of measurable progress, and up-to-date on the perspectives of all team members.

**Transition Planning**

From the earliest phases of treatment, theIHT team is expected to discuss what is necessary to achieve the youth’s and family’s goals, how to adjust to setbacks, and what activities or less intensive services will sustain the youth once IHT is no longer needed.  Before any anticipated transition from IHT services, the IHT provider must develop a plan to sustain the youth’s treatment gains, including the identification of new or continuing services and supports.  This plan is discussed as part of a graduation meeting with the youth and family and their chosen team members.  A method of continuing care coordination must be identified to ensure continuity of service delivery.  Any new service providers should be engaged prior to the graduation meeting and invited to participate in order to promote continuity of care.

There is no set limit on the time that a youth and family can receive In Home Therapy so long as the youth continues to meet the Medical Necessity criteria, is under 21, has MassHealth insurance, and consents to participate in service.

A copy of the complete[**IHT Practice Guidelines**](http://www.rosied.org/resources/Documents/practice-guidelines-iht.pdf)is available for download in the*Rosie D*implementation library.