North Carolina

Division of Mental Health,

Developmental Disabilities and Substance Use Services

State-Funded Enhanced Mental Health and Substance Use Service, Intensive In-Home Services (State-Funded)

Date Amended – October 1st, 2024

Contents

1.0 Intensive In-Home Services (State-Funded)

1.1 Service Definition and Required Components

The Intensive In-Home (IIH) service is a team approach designed to address the identified needs of children and adolescents who, due to serious and chronic symptoms of an emotional, behavioral, or substance use disorder, are unable to remain stable in the community without intensive interventions. This service may only be provided to individuals through age 17. This medically necessary service directly addresses the individual's mental health or substance use disorder diagnostic and clinical needs. The needs are evidenced by the presence of a diagnosable mental, behavioral, or emotional disturbance (as defined by DSM-5 or any subsequent editions of this reference material), with documentation of symptoms and effects reflected in the Comprehensive Clinical Assessment and the PCP. This team provides a variety of clinical rehabilitative interventions available 24 hours per day, 7 days per week, 365 days per year.

This is a time-limited, intensive child and family intervention based on the clinical needs of the individual. The service is intended to accomplish the following:

- reduce presenting psychiatric or substance use disorder symptoms,
- provide first responder intervention to diffuse current crisis,
- ensure linkage to community services and resources, and
- prevent out of home placement for the individual.

IIH services are authorized for one individual child in the family. The parent or caregiver must be an active participant in the treatment. The team provides individualized services that are developed in full partnership with the family. Effective engagement, including cultural sensitivity, is essential in providing services in the family's living environment. Services are generally more intensive at the beginning of treatment and decrease over time as the individual's skills develop.

This team service includes a variety of interventions that are available 24 hours per day, 7 days per week, 365 days per year. Services are delivered by the IIH staff who maintain contact and intervene as one organizational unit. IIH services are provided through a team approach; however, discrete interventions may be delivered by any one or more team members as clinically indicated. Not all team members are required to provide direct intervention to each individual on the caseload. The Team Leader must provide direct clinical interventions with each individual. The team approach involves structured, scheduled therapeutic interventions to provide support and guidance across multiple functional domains including emotional, medical and health. This service is not delivered in a group setting.

IIH services are delivered to children and adolescents, primarily in their living environments, with a family focus and IIH services include, but are not limited to, the following interventions as clinically indicated:

a. individual and family therapy
b. substance use disorder treatment interventions

c. developing and implementing a home-based behavioral support plan with the individual and his or her caregivers
d. psychoeducation imparts information about the individual's diagnosis, condition, and treatment to the individual, family, caregivers, or other persons involved with the individual's care
e. intensive case management, which includes the following:
    1. assessment
    2. planning
    3. linkage and referral to paid and natural supports
    4. monitoring and follow up
f. arrangements for psychological and psychiatric evaluations
g. crisis management

The IIH Team shall provide "first responder" crisis response, as indicated in the PCP, 24 hours a day, 7 days a week, 365 days a year to individuals receiving this service.

In partnership with the individual, the individual's family, and the legally responsible person, as appropriate, the Licensed Professional or QP is responsible for convening the Child and Family Team, which is the vehicle for the person-centered planning process. The Licensed Professional or QP is responsible for monitoring and documenting the status of the individual's progress and the effectiveness of the strategies and interventions outlined in the PCP. The Licensed Professional or QP consults with identified medical (such as primary care and psychiatric) and non-medical providers (e.g., the county department of social services [DSS], school, the Department of Juvenile Justice and Delinquency Prevention [DJJDP]), engages community and natural supports, and includes their input in the person-centered planning process.

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

1.2 Provider Requirements

IIH services shall be delivered by practitioners employed by mental health, substance use disorder, or intellectual or developmental disability provider organizations that:

a. are currently certified as a Critical Access Behavioral Healthcare Agency (CABHA)
b. meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DHM/DD/SUS;
c. meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Use Services (DMHDDSUS); and
d. fulfill the requirements of 10A NCAC 27G.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being

credentialed by the LME-MCO. As part of the endorsement, the provider must notify the LME-MCO of the therapies, practices, or models that the provider has chosen to implement. Additionally, within one year of enrollment as a provider with the LME-MCO, the organization shall achieve national accreditation with at least one of the designated accrediting agencies. (Providers who were enrolled prior to July 1, 2008, shall have achieved national accreditation within three years of their enrollment date.) The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements.

The organization is responsible for obtaining prior authorization from the LME-MCO for medically necessary services identified in the PCP.

1.3 Staffing Requirements

All treatment shall be focused on, and for the benefit of, the eligible individual receiving IIH services. The service model requires that IIH staff provide 24-hour-a-day coverage, 7 days a week, 365 days a year. This service model is delivered by an IIH team comprised of one full- time equivalent (FTE) team leader and at least two additional full-time equivalent positions as follows:

a. One FTE team leader who is a Licensed Professional who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals). An associate level professional actively seeking licensure may serve as the team leader conditional upon being fully licensed within 30 months from the date of hire. **AND**
b. One FTE QP who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals).
AND
c. One FTE QP or AP who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals).

For IIH services focused on substance use disorder interventions, the team shall include at least one Certified Clinical Supervisor (CCS), Licensed or associate level Licensed Clinical Addiction Specialist (LCAS), Certified Substance Abuse Counselor (CSAC) or Certified Alcohol and Drug Counselor (CADC) as a member of the IIH team.

All staff providing Intensive In-Home services to children and families must have a minimum of one (1) year of documented experience with this population.

No IIH Team member who is actively fulfilling an IIH Team role may contribute to the staffing ratio required for another service during that time. When fulfilling the responsibilities of IIH services, the staff member shall be fully available to respond in the community.

The team-to-family ratio shall not exceed 1:12 for

each IIH team.

The team leader is responsible for the following:

a. providing individual and family therapy for each individual served by the team;
b. designating the appropriate team staff such that specialized clinical expertise is applied as clinically indicated for each individual;
c. providing and coordinating the assessment and reassessment of the individual's clinical needs;
d. providing clinical expertise and guidance to the IIH team members in the team's interventions with the individual; and
e. providing the clinical supervision of all members of the team for the provision of this service. An individual supervision plan is required for all IIH team members exclusive of the Team Leader.

The Licensed Professional or Qualified Professional has responsibility for the following:

a. coordinating and overseeing the initial and ongoing assessment activities;
b. convening the Child and Family Team for person-centered planning;
c. completing the initial development and ongoing revision of the PCP and ensuring its implementation;
d. consulting with identified medical (for example, primary care and psychiatric) and non- medical (for example, DSS, school, DJJDP) providers, engaging community and natural supports, and including their input in the person-centered planning process;
e. ensuring linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations;
f. providing and coordinating behavioral health services and other interventions for the individual or other family members with other licensed professionals and Child and Family Team members; and
g. monitoring and documenting the status of the individual's progress and the effectiveness of the strategies and interventions outlined in the PCP.

All IIH staff have responsibility for the following under the direction of the team leader:

a. Participating in the person-centered planning process;
b. Assisting with implementing a home-based behavioral support plan with the individual and his or her caregivers as indicated in the PCP;
c. Providing psychoeducation as indicated in the PCP;
d. Assisting the team leader in monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and progress toward goals identified in the PCP
e. Assisting with crisis interventions; and
f. Assisting the team leader in consulting with identified providers, engaging community and natural supports, and including their input in the person-centered planning process.

All members of the IIH services team shall be supervised by the team leader. Persons who meet the requirements specified for QP or AP status according to 10A NCAC 27G .0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver IIH services.

Family members or legally responsible persons of the individual receiving Intensive

In-Home services may not provide these services for reimbursement.

NOTE: Supervision of IIH staff is covered as an indirect cost and therefore should not be billed as an IIH service.

1.3.1 Staff Training

The following are the requirements for training staff in IIH.

All IIH Team Staff

a. Within 30 days of hire to provide IIH services, all staff shall complete the following training requirements:
    1. 3 hours of training in the IIH service definition required components;
    2. 3 hours of crisis response training; and
    3. 3 hours of PCP Instructional Elements (required for only IIH Team Leaders and IIH QP staff responsible for PCP) training;

    AND

b. Within 90 days of hire to provide this service, or by June 30, 2011 for staff who were currently working as an IIH Team member as of January 1,2011, all IIH staff shall complete the following training requirements:

    IIH staff must complete 24 hours* of training (a minimum of 3 days) in one of the designated therapies, practices or models below specific to the population(s) to be served by each IIH Team. The designated therapies, practices or models are as follows:
    1. Cognitive Behavior Therapy;
    2. Trauma-Focused Therapy (For Example: Seeking Safety, Trauma Focused CBT, Real Life Heroes); or
    3. Family Therapy (For Example: Brief Strategic Family Therapy, Multidimensional Family Therapy, Family Behavior Therapy, Child Parent Psychotherapy, or Family Centered Treatment).

        A. Practices or models must be treatment focused, not prevention focused.
        B. Each practice or model chosen must specifically address the treatment needs of the population to be served by each IIH.
        C. Cognitive Behavior Therapy training must be delivered by a licensed professional.
        D. Trauma-focused therapy and family therapy training must be delivered by a trainer who meets the qualifications of the developer of the specific therapy, practice or model and meets the training standard of the specific therapy, practice or model. If no specific trainer qualifications are specified by the model then the training must be delivered by a licensed professional.

* Licensed Professionals (LP) who have documented evidence of post graduate training in the chosen qualifying practice (identified in the DMA Clinical Coverage Policy 8A March 20, 2006) dated no earlier than March 20, 2006, may count those training hours toward the 24- hour requirement. It is the responsibility of the LP to have clearly documented evidence of the hours and type of training received.

Licensed (or associate level Licensed Professionals, under supervision) staff shall

be trained in and provide the aspects of these practice(s) or model(s) that require licensure, such as individual therapy or other therapeutic interventions falling within the scope of practice of Licensed Professionals. It is expected that Licensed (or associate level Licensed Professionals, under supervision) staff will practice within their scope of practice.

Non-licensed staff [QPs and APs] shall be trained in and provide only the aspects of these practice(s) or model(s) that do not require licensure and are within the scope of their education, training, and expertise. Non-licensed staff will practice under supervision according to the service definition. It is the responsibility of the Licensed (or associate level Licensed Professional, under supervision) supervisor and the CABHA Clinical Director to ensure that the non-licensed staff practice within the scope of their education, training, and expertise and are not providing any services that require licensure.

All follow up training, clinical supervision, or ongoing continuing education requirements for fidelity of the clinical model or EBP(s) must be followed.
AND

c. On an annual basis, follow up training and ongoing continuing education for fidelity to the chosen modality (Cognitive Behavioral Therapy, Trauma Focused Therapy, Family Therapy) is required. If no requirements have been designated by the developers of that modality, a minimum of 10 hours of continuing education in components of the selected modality must be completed annually.

IIH Team Leaders

a. In addition to the training required for all IIH staff, IIH Team Leaders, within 90 days of hire to provide this service, or by March 31, 2011, for staff who were currently working as an IIH Team member as of January 1, 2011, shall complete the following training requirements:
    1. 13 hours of Introductory Motivational Interviewing (MI) training by a MINT Trainer** (mandatory 2-day training).
    2. 11 hours of Introduction to System of Care Training
    3. 12 hours of Person-Centered Thinking (PCT) training from a Learning Community for Person Centered Practices certified PCT trainer.
        A. All new hires to IIH must complete the full 12-hour training.
        B. Staff who previously worked in IIH for another agency and had six (6) hours of PCT training under the old requirement will have to meet the 12-hour
        C. requirement when moving to a new company.
        D. The 12-hour PCT training will be portable if an employee change jobs any time after completing the 12-hour requirement, as long as there is documentation of such training in the new employer's personnel records.
        E. Staff who previously worked in IIH within the same agency and had six (6) hours of PCT training under the old requirement may complete the additional six (6) hour PCT or Recovery training curriculum when available as an alternative to the full
        12-hour training; if not, then the full 12 hour training must be completed.

AND

b. Within 90 days of hire to provide this service, or by June 30, 2011, for staff who were currently working as an IIH Team member as of January 1,2011, all IIH Team Leaders shall complete all supervisory level training required by the

developer of the designated therapy, practice or model. If no specific supervisory level training exists for the designated therapy, practice, or model, then all IIH Team Leaders must complete a minimum of 12 hours of clinical supervision training.

All Non-Supervisory IIH Staff (QPs and APs)

In addition to the training required for all IIH staff, non-supervisory IIH staff, within 90 days of hire to provide this service, or by June 30, 2011, for staff who were currently working as an IIH team member as of January 1, 2011, shall complete the following training requirements:

a. 13 hours of Introductory Motivational Interviewing (MI) training by a MINT Trainer** (mandatory 2-day training);
b. 11 hours of Introduction to System of Care Training; and
c. 12 hours of Person-Centered Thinking training from a Learning Community for Person Centered Practices certified PCT trainer.

1. All new hires to IIH must complete the full 12-hour training.
2. Staff who previously worked in IIH for another agency and had six (6) hours of PCT training under the old requirement will have to meet the 12-hour requirement when moving to a new company.
3. The 12-hour PCT training will be portable if an employee change jobs any time after completing the 12-hour requirement, as long as there is documentation of such training in the new employer's personnel records.
4. Staff who previously worked in IIH within the same agency and had six (6) hours of PCT training under the old requirement may complete the additional six (6) hour PCT or Recovery training curriculum when available as an alternative to the full 12-hour training; if not, then the full 12-hour training must be completed.

**NOTE: Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer (www.motivationalinterview.org).

Motivational Interviewing and all selected therapies, practices and models must be designated in the provider's program description. All staff shall be trained in Motivational Interviewing as well as the other practice(s) or model(s) identified above and chosen by the provider. All training shall be specific to the role of each staff member and specific to the population served.

The following table summarizes the training requirements for the IIH service.

Time Frame	Training Required	Who	Total Minimum Hours Required
Within **30 days** of hire to provide service	■ 3 hours IIH service definition required components ■ 3 hours of crisis response	■ All Staff	6 hours
	■ 3 hours of PCP Instructional Elements	■ IIH Team Leaders ■ QPs responsible for PCP	3 hours
Within **90 days** of hire to provide this service, **or** by **March 31, 2011** for staff members of existing providers	■ 13 hours of Introductory Motivational Interviewing* (MI) (mandatory 2-day training) ■ 12 hours of Person Centered Thinking ■ 11 hours Introduction to SOC	■ IIH Team Leaders	36 hours
Within **90 days** of hire to provide this service, **or** by **June 30, 2011** for staff members of existing providers	■ 13 hours of Introductory Motivational Interviewing* (MI) (mandatory 2-day training) ■ 12 hours of Person Centered Thinking ■ 11 hours Introduction to SOC	■ All Non-Supervisory IIH Team Staff	36 hours
	■ To ensure the core fundamental elements of training specific to the modality** selected by the agency for the provision of services are implemented a minimum of 24 hours of the selected modality must be completed.	■ All IIH Staff	24 hours
	■ All supervisory level training required by the developer of the designated therapy, practice or model with a minimum of 12 hours must be completed.	■ IIH Team Leaders	12 hours
Annually	■ Follow up training and ongoing continuing education required for fidelity to chosen modality** (If no requirements are designated by developers of that modality, a minimum of 10 hours of continuing education in components of the selected modality must be completed.).	■ All IIH Staff	10 hours**

* Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer.

**Modalities must be ONE of the following: Cognitive Behavioral Therapy, Trauma Focused Therapy, and Family Therapy.

Total Hours of Training for the IIH Staff:

a. IIH Staff other than Team Leader and QPs responsible for PCPs – 42 hours plus the required hours of training for the selected model;
b. QPs responsible for the PCP – 45 hours plus the required hours of training for the selected model;
c. Team Leader – 45 hours plus the required hours of training for the selected model as well as the supervisory training requirement;
AND
d. Annually, all IIH staff must have a minimum of 10 hours of training (more if fidelity to the model requires it).

1.4 Service Type and Setting

IIH is a direct and indirect, periodic, rehabilitative service in which the team members provide medically necessary services and interventions that address the diagnostic and clinical needs of the individual. Additionally, the team provides interventions with the family and caregivers on behalf of and directed for the benefit of the individual as well as plans, links, and monitors services on behalf of the individual. This service is provided in any location. IIH providers shall deliver services in various environments, such as homes, schools, court, homeless shelters, libraries, street locations, and other community settings.

The IIH Team shall provide “first responder” crisis response, as indicated in the PCP, 24 hours a day, 7 days a week, 365 days a year to individuals receiving this service.

IIH also includes telephone time with the individual and his or her family or caregivers, as well as collateral contact with persons who assist the individual in meeting his or her rehabilitation goals specified in the PCP. IIH includes participation and ongoing clinical involvement with the Child and Family Team and meetings for the planning, development, implementation, and revision of the PCP.

1.5 Program Requirements

All aspects of the delivery of this service occurring per date of service will equal one per diem event of a two-hour minimum. It is the expectation that service frequency will decrease over time: at least 12 in-person contacts per individual are required in the first month, and at least 6 face-to face contacts per individual per month are required in the second and third months of IIH services. The IIH service varies in intensity to meet the changing needs of individuals, families, and caregivers; to assist them in the home and community settings; and to provide a sufficient level of service as an alternative to the individual’s need for a higher level of care.

The IIH team works together as an organized, coordinated unit under the direct supervision of the Team Leader. The team meets at least weekly to ensure that the planned interventions are implemented by the appropriate staff members and to discuss the individual's progress toward goals as identified in the PCP.

This service is billed per diem, with a 2-hour minimum. That is, when the total contact time per date of service meets or exceeds 2 hours, it is a billable event. Based on the percentages listed below, the 2 hours may include:

a. direct clinical interventions as identified in the PCP; or
b. case management interventions (in-person, telephone time, and collateral contacts).

Services are delivered in-person with the individual, family, and caregivers and in locations outside the agency's facility. Each provider agency will assess and document at least annually the aggregate services delivered at each site, using both of the following quality assurance benchmarks:

a. at least 60% of the contacts shall occur in-person with the individual, family, and caregivers. The remaining units may be either telephone or collateral contacts; and
b. at least 60% of staff time shall be spent working outside of the agency's facility, with or on behalf of the individual.

At any point while the individual is receiving IIH services, IIH staff shall link him or her to an alternative service when clinically indicated and functionally appropriate for the needs of the individual and family as determined by the Child and Family Team. A full service note is required to document the activities that led to the referral.

It is incumbent upon the IIH provider agency as a professional entity to research and implement evidence-based practices appropriate to this service definition.

1.6 Utilization Management

Services are based upon a finding of medical necessity, shall be directly related to the individual's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in his or her PCP. Medical necessity is determined by North Carolina community practice standards as verified by the LME-MCO.

Medically necessary services are authorized in the most cost-efficient mode, as long as the treatment that is made available is similarly efficacious to services requested by the individual's physician, therapist, or other licensed practitioner. Typically, a medically necessary service shall be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined in this policy.

No more than one individual in the home may receive IIH services during any active authorization period.

Prior authorization by the LME-MCO is required.

The LME-MCO will evaluate the request to determine if medical necessity supports more or less intensive services.

The LME-MCO may cover up to 60 days for the initial authorization period based on the medical necessity documented in the individual's PCP, the authorization request form, and supporting documentation. Submit the reauthorization request before the initial authorization expires. The LME-MCO may cover up to 60 days for reauthorization based on the medical necessity documented in the required PCP, the authorization request form, and supporting documentation. If continued IIH services are needed at the end of the initial authorization period, submit the PCP and a new request for authorization reflecting the appropriate level of care and service to the LME-MCO. This should occur before the authorization expires.

This service is billed per diem, with a 2-hour minimum. That is, when the total contact time per date meets or exceeds 2 hours, it is a billable event. The 2 hours may include both direct and indirect interventions (in-person, telephone time, and collateral contacts), based on the percentages listed in Program Requirements.

1.7 Eligibility Criteria

An individual is eligible for this service when all of the following criteria are met:

a. there is a mental health and/or substance use disorder diagnosis (as defined by the DSM-5 or any subsequent editions of this reference material), other than a sole diagnosis of intellectual or developmental disability;
b. based on the current comprehensive clinical assessment, this service was indicated and outpatient treatment services were considered or previously attempted, but were found to be inappropriate or not effective;
c. the individual has current or past history of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk taking behavior (running away, sexual aggression, sexually reactive behavior, or substance use);
d. the individual's symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of his or her mental health or substance use disorder condition, requiring intensive, coordinated clinical interventions;
e. the individual is at imminent risk of out-of-home placement based on his or her current mental health or substance use disorder clinical symptomatology, or is currently in an out-of-home placement and a return home is imminent; and
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).

1.8 Continued Service Criteria

The individual is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's PCP; or the individual continues to be at risk for out- of-home placement, based on current clinical assessment, history, and the tenuous nature of the functional gains.

AND

One of the following applies:

a. The individual has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms;
b. The individual is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;
c. The individual is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the individual's premorbid level of functioning, are possible; or
d. The individual fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The individual's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations should be revised based on the findings. This includes consideration of alternative or additional services.

1.9 Discharge Criteria

The individual meets the criteria for discharge if any one of the following applies:

a. The individual has achieved goals and is no longer in need of IIH services;
b. The individual's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;
c. The individual is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
d. The individual or legally responsible person no longer wishes to receive IIH services; or
e. The individual, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

In addition, a completed LME-MCO Consumer Admission and Discharge Form shall be submitted to the LME-MCO.

NOTE: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person, or both about the

individual's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules 10A NCAC 27I .0601-.0609.

1.10 Expected Outcomes

The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the individual's PCP.

Expected clinical outcomes include, but are not limited to, the following:

a. Decrease in the frequency or intensity of crisis episodes;
b. Reduction in symptomatology;
c. Engagement in the recovery process by the individual, and family or caregivers;
d. Improved functioning in the home, school and community settings;
e. Ability of the individual and family or caregiver to better identify and manage triggers, cues, and symptoms;
f. Sustained improvement in developmentally appropriate functioning in specified life domains;
g. Increased utilization of coping skills and social skills that mitigate life stresses resulting from the individual's diagnostic and clinical needs;
h. Reduction of symptoms and behaviors that interfere with the individual's daily living, such as negative effects of the substance use disorder, psychiatric symptoms, or both;
i. Decrease in delinquent behaviors when present; and
j. Increased use of available natural and social supports by the individual and family or caregivers.

1.11 Documentation Requirements

Refer to the DMH/DD/SAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

For this service, one of the documentation requirements is a full service note for each contact or intervention (such as family counseling, individual counseling, case management, crisis response) for each date of service, written and signed by the person(s) who provided the service, that includes the following:

a. Individual's name;
b. Service Record Number;
c. Service provided (for example, IIH services);
d. Date of service;
e. Place of service
f. Type of contact (in-person, telephone call, collateral);
g. Purpose of the contact;
h. Description of the provider's interventions;
i. Amount of time spent performing the intervention;
j. Description of the effectiveness of the interventions in meeting the individual's specified goals as outlined in the PCP; and
k. Signature and credentials of the staff member(s) providing the service.

A documented discharge plan shall be discussed with the individual and

included in the service record.

In addition, a completed LME-MCO Consumer Admission and Discharge Form shall be submitted to the LME-MCO.

1.12 Service Exclusions

An individual may receive IIH services from only one IIH service provider organization during any active authorization period for this service.

The following are not billable under this service:

a. Transportation time (this is factored in the rate);
b. Any habilitation activities;
c. Any social or recreational activities (or the supervision thereof); or
d. Clinical and administrative supervision of staff, including team meetings (this is factored in the rate).

Service delivery to individuals other than the child or adolescent receiving the service may be covered only when the activity is directed exclusively toward the benefit of that child or adolescent.

IIH services may not be provided during the same authorization period as the following services:

a. Multisystemic Therapy;
b. Day Treatment;
c. individual, group and family therapy;
d. Substance Abuse Intensive Outpatient Program;
e. child residential treatment services Level II Program Type through Level IV;
f. Psychiatric Residential Treatment Facility (PRTF); or
g. substance use disorder residential services.

1.13 Entrance Process

The process for an individual to enter this service includes a comprehensive clinical assessment that demonstrates medical necessity shall be completed prior to provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning**,** and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and included in the PCP.

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Prior authorization is required on the first day of this service.

Prior authorization by the LME-MCO is required. To request the initial authorization, submit the PCP with signatures, the required authorization request form, and any additional documentation required to the LME-MCO. In addition,

submit a completed LME-MCO Consumer Admission and Discharge Form to the LME-MCO.

The LME-MCO may cover up to 60 days for the initial authorization period, based on medical necessity.

After the initial authorization has been obtained, the team leader will convene the Child and Family Team, in partnership with the individual and his or her family, for the purpose of further developing the PCP.

Refer to https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitionsfor the related coverage policies listed below:

State-Funded Assertive Community Treatment (ACT) Program
State-Funded Diagnostic Assessment
State-Funded Inpatient Behavioral Health Services
State-Funded Opioid Treatment Service
State-Funded Telehealth and Virtual Communications

Note: Information in **Sections 1.0** through **8.0** of this policy supersedes information found in the attachments.

2.0 Description of the Service

This document describes policies and procedures that state-funded providers shall follow to receive reimbursement for covered enhanced benefit behavioral health services provided to individuals who meet the eligibility criteria for a State-Funded Benefit Plan. It sets forth the basic requirements for qualified providers to bill state-funded mental health and substance use services through the Local Management Entity-Managed Care Organization (LME-MCO), including services for individuals with intellectual or developmental disabilities (I/DD), as appropriate.

The following resources, and the rules, manuals, and statutes referenced in them, give the Division of Mental Health, Developmental Disabilities and Substance Use Services (DMH/DD/SAS) the authority to set the requirements included in this policy:

a. *Rules for Mental Health, Developmental Disabilities and Substance Use; Facilities and Services,* Administrative Publication System Manuals, APSM 30-1;
b. DMH/DD/SAS *Records Management and Documentation Manual,* APSM 45-2;
c. DMH/DD/SAS *Person-Centered Planning Instruction Manual;*
d. *N.C. Mental Health, Developmental Disabilities, and Substance Abuse Laws, 2001* (G.S. 122-C); and
e. *DMH/DD/SAS NC Tracks Benefit Plan (Client Eligibility Criteria)*

3.0 Eligibility Requirements

An eligible individual shall be enrolled with the LME-MCO on or prior to the date of service, meet the criteria for a state-funded Benefit Plan that covers this service and shall meet the criteria in Section 3.0 of this policy.

Individuals may be ineligible for a state-funded service due to coverage by other payors that would make them ineligible for the same or similar service funded by the state (e.g. individual is eligible for the same service covered by Medicaid, Health Choice or other third party payor).

4.0 When State-Funded Services Are Covered

4.1 General Criteria

State funds shall cover services related to this policy are covered when they are medically necessary and when:

a. the service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the individual's needs;
b. the service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the service is furnished in a manner not primarily intended for the convenience of the individual, the individual's caregiver, or the provider.

4.1.1 Telehealth Services

As outlined in Attachments A and D, select services within this clinical coverage policy may be provided via telehealth and telephonically. Services delivered via telehealth and telephonically must follow the requirements and guidance set forth in the *State-Funded Telehealth, Virtual Patient Communications, and Remote Patient Monitoring* service definition policy.

4.2 Specific Criteria Covered By State Funds

All state-funded services are based upon a finding of medical necessity, which is determined by generally accepted North Carolina community practice standards as verified by Local Management Entity-Managed Care Organization. There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the individual.

a. **Preventive** means to anticipate the development of a disease or condition and preclude its occurrence.
b. **Diagnostic** means to examine specific symptoms and facts to understand or explain a condition.
c. **Therapeutic** means to treat and cure disease or disorders; it may also serve to preserve health.
d. **Rehabilitative** means to restore that which one has lost, to a normal or optimum state of health.

Refer to **Section 1,** for service-specific medical necessity criteria. Service definitions are also located at: http://www.ncdhhs.gov/mhddsas/providers/servicedefs/index.htm.

5.0 When State-Funded Services Are Not Covered

Services related to this policy are not covered when:
a. the individual does not meet the requirements listed in the DMH/DD/SAS NC Tracks Benefit Plan client eligibility criteria;
b. the individual does not meet the medical necessity criteria listed in **Section 3.0;**
c. the service duplicates another provider's service; or
d. the service is experimental, investigational, or part of a clinical trial.

6.0 Requirements for and Limitations on Coverage

6.1 Prior Approval

Prior approval is required on or before the first day of service for all state-funded services, with the following exceptions as identified in the service definitions found in **Section 1**.

a. Mobile Crisis Management;
c. Substance Abuse Intensive Outpatient Program (SAIOP); and
d. Substance Abuse Comprehensive Outpatient Treatment (SACOT)

6.2 Prior Approval Requirements

6 .2.1 General

The provider(s) shall submit to Local Management Entity-Managed Care Organization the following:
a. the prior approval request; and
b. all supporting documentation that demonstrates that the individual has met the specific criteria in **Subsection 3.2** of this policy, specific to the service being requested.

6.2.2 Specific

Utilization management of state-funded services is a part of the assurance of medical necessity for the service. Authorization, which is an aspect of utilization management, validates approval by the Local Management Entity-Managed Care Organization to provide a medically necessary service to eligible individuals.

6.3 Utilization Management and Authorization of Covered Services

Refer to **Section 1**the specific service definition for utilization management and authorization requirements.

Utilization management must be performed by the Management Entity-Managed Care Organization (LME-MCO).

6.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of each individual's needs. For state-funded services, a service order is recommended unless otherwise indicated in the specific service definition policy in **Section 1**. Providers shall coordinate with the LME- MCO regarding their requirements for service orders.

6.5 Clinical or Professional Supervision

State-funded services are provided to individuals by agencies that are enrolled in a Local Management Entity-Managed Care Organization's provider network and that employ Licensed Professionals (LPs), Qualified Professionals (QPs), Associate Professionals (APs), and Paraprofessionals. Clinical or professional supervision must be provided according to the supervision and staffing requirements outlined in each service definition. Medically necessary services delivered by APs are delivered under the supervision and direction of the LP or QP. Medically necessary services delivered by Paraprofessionals are delivered under the supervision and direction of the LP, QP or, when the service definition does not specify a more stringent supervision requirement, an AP. Supervision shall be provided at the frequency and for the duration indicated in the individualized supervision plan created for each AP and Paraprofessional upon hire. Each supervision plan must be reviewed annually.

The Licensed Professional or Qualified Professional personally works with individual's families, and team members to develop an individualized PCP. The LP or QP meets with the individuals' receiving services throughout the course of treatment to monitor the services being delivered and to review the need for continued services. The supervising professional assumes professional responsibility for the services provided by staff who do not meet QP status and spends as much time as necessary directly supervising the staff member providing the service to ensure that the goals outlined on each PCP are being implemented and that individuals are receiving services in a safe and efficient manner in accordance with accepted standards of practice.

The terms of employment with the state-funded provider agency must specify that each supervising professional is to provide adequate supervision for the APs, Paraprofessionals, and other staff in the agency who are assigned to him or her. The provider agency shall ensure that supervisory ratios meet any requirements that are specified in the service definition, are reasonable and ethical, and provide adequate opportunity for the supervising professional to effectively supervise the staff member(s) assigned. Documentation must be kept on file to support the supervision provided to AP and Paraprofessional staff in the delivery of medically necessary services.

6.6 Person Centered Plans

Most state-funded services covered by this policy require a PCP. Refer to the service definitions in **Section 1,** the DMH/DD/SAS *Person-Centered Planning Instruction Manual,* and the DMH/DD/SAS *Records Management and Documentation Manual* for specific information.

The primary reference document for person-centered planning and PCPs is the DMH/DD/SAS *Person-Centered Planning Instruction Manual*. The guidance offered throughout **Subsection 5.7** is derived from it.

6.6.2 Person-Centered Planning

Person-centered planning is a process of determining real-life outcomes with individuals and developing strategies to achieve those outcomes. The process supports strengths, rehabilitation, and recovery, and applies

to everyone supported and served in the system. Person-centered planning provides for the individual with the disability to assume an informed and in-command role for life planning and for treatment, service, and support options. The individual with a disability, the legally responsible person, or both direct the process and share authority and responsibility with system professionals for decisions made.

For all individuals receiving services, it is important to include people who are important in the person's life, such as family members, the legally responsible person, professionals, friends and others identified by the

individual (for example, employers, teachers, and faith leaders). These individuals can be essential to the planning process and help drive its success. Person-centered planning uses a blend of paid, unpaid, natural and public specialty resources uniquely tailored to the individual or family needs and desires. It is important for the person-centered planning process to explore and use all these resources.

Before most services may be billed, a written PCP for the delivery of medically necessary services must be in place. The PCP must be completed at the time the individual is admitted to a service. Information gathered from discussions with the person or family receiving services and others identified by them, along with recommendations and other information obtained from the comprehensive clinical assessment, together provide the foundation for the development of the PCP. Refer to **Attachment B** for effective PCP goal writing guidelines.

If limited information is available at admission, staff should document on the PCP whatever is known and update it when additional information becomes available.

6.7.2 Person Centered Plan Reviews and Annual Rewriting

All PCPs must be updated as needed and must be rewritten at least annually.

At a minimum, the PCP must be reviewed by the responsible professional based upon the following:

a. Target date or expiration of each goal
    - Each goal on the PCP must be reviewed separately, based on the target date associated with it. Short-range goals in the PCP may never exceed 12 months from the Date of Plan.
b. Change in the individual's needs
c. Change in service provider
d. Addition of a new service.

Refer to the *Person-Centered Planning Instruction Manual* and the *Records Management and Documentation Manual* for more detailed information.

For individuals who receive psychosocial rehabilitation services, the PCP shall be reviewed every six months.

6.7 Documentation Requirements

The service record documents the nature and course of an individual's progress in treatment. To bill for state-funded services, providers shall ensure that their documentation is consistent with the requirements contained in this policy, including the service definitions in **Section 1** and the DMH/DD/SAS *Records Management and Documentation Manual*.

6.8.2 Responsibility for Documentation

The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by the Local Management Entity-Managed Care Organization:

a. The staff person who provides the service must sign the written entry. The signature must include credentials (professionals) or a job title (paraprofessionals).
b. A QP is not required to countersign service notes written by a staff person who does not have QP status.

6.8.3 Contents of a Service Note

Service notes unless otherwise noted in the service definition, must include the following. More than one intervention, activity, or goal may be reported in one service note, if applicable.

a. **Date** of service provision
b. **Name of service** provided (for example, Mobile Crisis Management)
c. **Type of contact** (in person, telehealth, phone call, collateral)
d. **Place of service,** when required by service definition
e. **Purpose** of the contact as it relates to the goal(s) in the PCP
f. **Description of the intervention** provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated. For case management–type services, a description of the case management activity fulfills this requirement.
g. **Duration** of service: Amount of time spent performing the intervention
h. **Assessment of the effectiveness** of the intervention and the individual's progress toward the individual's goal. For case management functions within an enhanced service in this policy, a description of the result or outcome of the case management activity fulfills this requirement.
i. **Signature** and credentials or job title of the staff member who provided the service, as described in **Subsection 5.8.1**
j. **Each service note page must** be identified with the individual's name, service record number, and record number.

6.8.4 Other Service Documentation Requirements

Frequency, format, and any other service-specific documentation requirements can be found in the service definitions in **Section 1** or the DMH/ DD/SAS *Records Management and Documentation Manual*. Services that are billed to the Local Management Entity-Managed Care

Organization must comply with the documentation requirements outlined in the DMH/DD/SAS *Records Management and Documentation Manual,* state reimbursement guidelines, and all service-related documentation must relate to goals in the individual's PCP. Refer to **Attachment C** for additional documentation Best Practice guidelines.

7 Providers Eligible to Bill for State-Funded Services

To be eligible to bill for services under this policy, providers shall:

a. meet Local Management Entity-Managed Care Organization requirements for participation;
b. be currently enrolled in the LME-MCO's provider network; and
c. bill only for services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.2 Provider Qualifications

Qualified provider agencies must be credentialed by the LME-MCOs and enrolled in an LME-MCO's provider network for each service they wish to provide. The credentialing process includes a service-specific checklist and adherence to the following:

a. Rules for Mental Health, Developmental Disability, and Substance Use Facilities and Services
b. Confidentiality Rules
c. Client Rights Rules in Community MH/DD/SU Services
d. *Records Management and Documentation Manual*
e. DMH/DD/SUS Communication Bulletins
f. Implementation Updates to rules, revisions, and policy guidance
g. *Person-Centered Planning Instruction Manual*
h. DMH/DD/SUS NC Tracks Benefit Plan Criteria

Except for Substance Abuse Halfway House services, providers shall be nationally accredited by one of the accrediting bodies approved by the N.C. Department of Health and Human Services (DHHS) within one year of enrollment in the LME-MCO provider network. Staff members providing services shall have all required training as specified in each service definition. Employees and contractors shall meet the requirements specified (10A NCAC 27G .0104) for QP, AP, or Paraprofessional status and shall have the knowledge, skills and abilities required by the population and age to be served.

Competencies are documented along with supervision requirements to maintain that competency. This applies to QPs and APs (10A NCAC 27G .0203) and to Paraprofessionals (10A NCAC 27G .0204).

Some services distinguish between the professionals and paraprofessionals who may provide a particular service. Refer to **Section 1** for service-specific requirements.

7.3 Provider Certifications

None Apply.

7.4 Staff Definitions

7.4.2 North Carolina General Statutes Requirements

7.4.2.1 Licensed/Certified Professionals Providing State-Funded Services Under This Policy

Staff members with the following classifications must be licensed or certified, as appropriate, in accordance with North Carolina General Statutes and shall practice within the scope of practice defined by the applicable practice board.

7.4.2.1.1 Licensed Professional Counselor or Licensed Clinical Mental Health Counselor
7.4.2.1.2 Licensed Professional Counselor Associate or Licensed Clinical Mental Health Counselor Associate
7.4.2.1.3 Licensed Clinical Addiction Specialist
7.4.2.1.4 Licensed Clinical Addiction Specialist Associate
7.4.2.1.5 Certified Clinical Supervisor
7.4.2.1.6 Licensed Marriage and Family Therapist
7.4.2.1.7 Licensed Marriage and Family Therapist Associate
7.4.2.1.8 Licensed Clinical Social Worker
7.4.2.1.9 Licensed Clinical Social Worker Associate
7.4.2.1.10 Doctor of Osteopathy
7.4.2.1.11 Licensed Psychologist
7.4.2.1.12 Licensed Psychological Associate
7.4.2.1.13 Nurse Practitioner
7.4.2.1.14 Licensed Physician
7.4.2.1.15 Certified Clinical Nurse Specialist (only if certified as an advanced practice psychiatric clinical nurse specialist)
7.4.2.1.16 Certified Substance Abuse Counselor or Certified Alcohol and Drug Counselor and
7.4.2.1.17 Physician Assistant

Note: To comply with NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC); and certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.

7.4.3 North Carolina Administrative Code Staff Requirements

The following staff members may provide services according to 10A NCAC 27G .0104 - Staff Definitions:

a. Qualified Professional (QP)
b. Associate Professional (AP)
c. Paraprofessional

8 Additional Requirements

8.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 and record retention requirements; and

b. All DMH/DD/SAS clinical service definition policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by DHHS, its divisions or its fiscal agent.

8.2 Audits and Compliance Reviews

Local Management Entities-Managed Care Organizations are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance use services at the community level. An LME-MCO shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for individuals eligible for state funded services within available resources, per NC GS § 122C-115.4(a).

The area authority or county program shall monitor the provision of mental health, developmental disabilities, or substance use services for compliance with law, which monitoring, and management shall not supersede or duplicate the regulatory authority or functions of agencies of the Department, per NC GS § 122C-111.

DMH/DD/SUS conducts annual monitoring of a sample of mental health and substance use disorder services funded with SUPTRS, CMHBG and state funds. The purpose of the monitoring is to ensure that these services are provided to individuals in accordance with federal & state regulations and requirements. The LME- MCO shall also conduct compliance reviews and monitor provider organizations under the authority of DMH/DD/SAS to ensure compliance with state funds and federal block grant regulations and requirements.

8.3 Authority

The following resources, and the rules, manuals, and statutes referenced in them, give the Division of Mental Health, Developmental Disabilities and Substance Use Services (DMHDDSUS) the authority to set the requirements included in this policy:

8.3.1 Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, Administrative Publication System Manuals (APSM)30-1

8.3.2 DMHDDSUS Records Management and Documentation Manual, APSM 45-2

8.3.3 DMHDDSUS Person-Centered Planning Instruction Manual

8.3.4 N.C. Mental Health, Developmental Disabilities, and Substance Abuse Laws, 2001 (G.S. 122-C)

Attachment A: Claims-Related Information

Reimbursement requires compliance with all DMH/DD/SAS NC Tracks Benefit Plan guidelines, including obtaining appropriate referrals for individuals meeting NC Tracks Benefit Plan eligibility criteria.

A. Claim Type

Professional (837P transaction).

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Providers shall bill the ICD-10-CM diagnosis code(s) (or its successors) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

A qualified provider who renders services to an individual eligible for state-funded services shall bill all other third-party payors, including Medicaid, NC Health Choice, and Medicare, before submitting a claim for state fund reimbursement.

Claims submitted to NC Tracks have coding requirements that are specific to DMH/DD/SAS billing policy. Specifically, diagnosis coding is required on all claims to NC Tracks. NC Tracks recognizes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes or its successors, as directed by DMH/DD/SAS. NC Tracks does not recognize any diagnosis codes in any versions of the Diagnostic and Statistical Manual of Mental Disorders.

Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

Intensive In-Home Services

HCPCS Code	Billing Unit	Telehealth Eligible
H2022	1 unit =1 day	No

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Providers shall follow applicable modifier guidelines. Refer to **Section C** above.

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication.

E. Billing Units

The provider shall report the appropriate procedure code(s) used which determines the billing unit(s).

F. Place of Service

Places of service will vary depending on the specific service rendered. They include the following: community settings such as home, school, shelters, work locations, and hospital emergency rooms; licensed substance use disorder services settings; and licensed crisis settings.

Telehealth claims should be filed with the provider's usual place of service code(s) and not place of service 02 (Telehealth).

G. Reimbursement

Providers shall bill their usual and customary charges based on DMH/DD/SAS reimbursement policy.

Note: DMH/DD/SAS will not reimburse for conversion therapy

Attachment B: Goal Writing

"A usefully stated objective *[goal]* is one that succeeds in communicating an intended result." *[Mager, Preparing Instructional Objectives].*

A strong, well-written goal will communicate three pieces of information: what the person will do (behavior); under what conditions the performance will occur (condition); and the acceptable level of performance (criteria).

What the Person Will Do refers to the **behavior, performance, or action** of the person for whom the goal is written. In services for people with disabilities, especially in the context of person-centered services, behavioral objectives or goals should be stated in positive, affirmative language.

Under What Conditions the Performance Will Occur is the part of the goal that describes the **action of the staff person** or **staff intervention**. Specifically address what assistance the staff person will provide, or what the staff person will do (if anything) to see that the behavior, performance, or action of the individual occurs. Here are some examples of conditions and interventions:

- With assistance from a staff person…
- When asked…
- With suggestions from a team member…
- With physical assistance…
- Given that Ellen has received instruction…
- Given that Jeremy has the phone book in front of him…
- Without any verbal suggestions…
- Given that a staff person has shown Jose where the detergent is…
- With no suggestions or demonstrations…

Acceptable Level of Performance refers to **criteria**. This means the goal must include a description of how "achievement" will be defined. In writing this part of the goal, always consider how the person or the people who know the person well define success. Performance may be overt, which can be observed directly, or it may be covert, which means it cannot be observed directly, but is mental, invisible, cognitive, or internal. *[Mager, Preparing Instructional Objectives].*

Measurable Goals are most easily written by using words that are open to ***fewer interpretations***, rather than words that are open to *many interpretations*. Consider the following examples:

a. Words open to many interpretations (TRY *NOT* TO USE THESE WORDS) are:

- to know
- to understand
- to really understand
- to appreciate
- to fully appreciate
- to grasp the significance of
- to enjoy
- to believe
- to have faith in
- to internalize

b. Words open to fewer interpretations (USE THESE *TYPES* OF WORDS) are:

- to write
- to recite
- to identify
- to sort
- to solve
- to construct
- to build
- to compare
- to contrast
- to smile

c. Here are some examples of goals that are written using positive language and that include the elements above:

- With staff assistance ***[condition],*** Marsha will choose her clothing, based on the weather ***[performance],*** five out of seven days for the next three months ***[criteria].***
- Adam will identify places he can go in his free time ***[performance],*** without any suggestions from staff ***[condition],*** each Saturday morning for the next three months ***[criteria].***
- With gentle, verbal encouragement from staff ***[condition],*** Charles will not scream while eating ***[performance],*** two out of three meals, for five minutes each time, for the next two months ***[criteria].***
- Given that Rosa has received instructions ***[condition],*** she will call her therapist to make her own appointments ***[performance],*** as needed during the next four months ***[criteria].***
- With suggestions from a support team member ***[condition],*** Henry will write a letter to his father ***[performance],*** once a month for the next six months ***[criteria].***

Attachment C: Documentation—Best Practice Guidelines

Services that are billed for state funds must comply with DMH/DD/SAS NC Tracks Benefit Plan reimbursement guidelines and relate to goals in the individual's PCP. All service-related documentation must meet the requirements outlined in the *Records Management and Documentation Manual* and the *Person-Centered Planning Instruction Manual*. To assist in assuring that these guidelines are met, documentation shall be:

a. **Accurate** — describing the facts as observed or reported;

b. **Timely** — recording significant information at the time of the event, to avoid inaccurate or incomplete information;

c. **Objective** — recording facts and avoiding drawing conclusions. Professional opinion must be phrased to clearly indicate that it is the view of the recorder;

d. **Specific, concise, and descriptive** — recording in detail rather than in general terms, being brief and meaningful without sacrificing essential facts, and thoroughly describing observation and other pertinent information;

e. **Consistent** — explaining any contradictions and giving the reasons for the contradictions;

f. **Comprehensive, logical, and reflective of thought processes** — recording significant information relative to an individual's condition and course of treatment or rehabilitation. Document pertinent findings, services rendered, changes in the individual's condition, and response to treatment or rehabilitation, as appropriate. Include justification for initial services as well as continued treatment or rehabilitation needs. Document reasons for any atypical treatment or rehabilitation utilized.

g. **Clear** — recording meaningful information, particularly for other staff involved in the care or treatment of the individual. **Write in non-technical terms** to the extent possible.