

Intensive Family Intervention

Service Definition

A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification, or preventing the utilization of out of home therapeutic venues (i.e., psychiatric hospital, psychiatric residential treatment facilities, or residential treatment services) for the identified youth. Services are delivered utilizing a team approach and are provided primarily to youth in their living arrangement and within the family system. Services promote a family-based focus in order to:

- Defuse the current behavioral health crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence.
- Ensure linkages to needed psychiatric, psychological, medical, nursing, educational, and other community resources, including appropriate aftercare upon discharge (i.e., medication, outpatient appointments, etc.); and
- Improve the individual child's/adolescent's ability to self-recognize and self-managed behavioral health issues, as well as the parents'/responsible caregivers' capacity to care for their children.

Services should include crisis intervention, intensive supporting resources management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive, individualized assessment and are directed towards the identified youth and his or her behavioral health needs/strengths and goals as identified in the Individualized Resiliency Plan.

Services shall also include resource coordination/acquisition to achieve the youth's and their family's' goals and aspirations of self-sufficiency, resiliency, permanency, and community integration.

Admission Criteria

1. Youth has a diagnosis and duration of symptoms which classify the illness as SED (youth with SED have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet DSM diagnostic criteria and results in a functional impairment which substantially interferes with or limits the child's role or functioning in the family, school, or community activities) and/or is diagnosed with a Substance Related Disorder; and one or more of the following:
2. Youth has received documented services through other services such as Non-Intensive Outpatient Services and exhausted these less intensive out-patient resources. Treatment at a lower intensity has been attempted or given serious consideration, but the risk factors for out-of-home placement are compelling (see item G.1. below); The less intensive services previously provided must be documented in the clinical record (even if it via by self-report of the youth and family); or
3. Youth and/or family has insufficient or severely limited resources or skills necessary to cope with an immediate behavioral health crisis; or
4. Youth and/or family behavioral health issues are unmanageable in traditional outpatient treatment and require intensive, coordinated clinical and supportive intervention; or

5. Because of behavioral health issues, the youth is at immediate risk of out-of-home placement;
or
6. Because of behavioral health issues, the youth is at immediate risk of legal system intervention or is currently involved with DJJ for behaviors/issues related to SED and/or the Substance-related disorder

Continuing Stay Criteria

Same as above

Discharge Criteria

1. An adequate continuing care plan has been established; and one or more of the following:
2. Youth no longer meets the admission criteria; or
3. Goals of the Individualized Resiliency Plan have been substantially met; or
4. Individual and family request discharge, and the individual is not imminently dangerous; or
5. Transfer to another service is warranted by change in the individual's condition; or
6. Individual requires services not available within this service.

Service Exclusions

1. Not offered in conjunction with Individual Counseling, Family Counseling/Training, Crisis Intervention Services, and/or Crisis Stabilization Unit, PRTF, or inpatient hospitalization.
2. Community Support may be used for transition/continuity of care.
3. This service may not be provided to youth who reside in a congregate setting in which the caregivers are paid (such as group homes, or any other living environment that is not comprised of family, guardians, or other more permanent caregivers). A short-term exception would be if the youth were preparing for transition back to a single-family unit, the family member is present during the intervention, and the service is directed to supporting the unification/reunification of the youth and his/her identified family/caregiver and takes place in that home and community.
4. The absence of empirical evidence for conversion therapy prohibits the use of this intervention and it is not reimbursed by DBHDD.
5. The billable activities of IFI do not include:
 - Transportation.
 - Observation/Monitoring.
 - Tutoring/Homework Completion; and
 - Diversionary Activities (i.e., activities without therapeutic value).

Clinical Exclusions

1. Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/substance use disorder episode overlaying the diagnosis: Autism Spectrum Disorders including Asperger's Disorder, Intellectual/Developmental Disabilities, Neurocognitive Disorder; or Traumatic Brain Injury.
2. Youth can effectively and safely be treated at a lower intensity of service. This service may not be used in lieu of family preservation and post-adoption services for youth who do not meet the admission criteria for IFI.

Required Components

1. The organization has procedures/protocols for emergency/crisis situations that describe methods for intervention when youth require psychiatric hospitalization.
2. Each IFI provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities.
3. The organization must have an Intensive Family Intervention Organizational Plan that addresses the description of:
 - Particular evidence-based family preservation, resource coordination, crisis intervention and wraparound service models utilized (MST, DBT, MDFT, etc.), types of intervention practiced. The organization must show documentation that each staff member is trained in the model for in-home treatment (i.e., certification, ongoing supervision provided by the training entity, documentation of annual training in the model).
 - The organization must have demonstrable evidence that they are working towards fidelity to the model that they have chosen (via internal Quality Assurance documentation, staff training documentation, etc.). There should not be an eclectic approach to utilizing models. Fidelity to the chosen model is the expectation for each IFI team. If an agency chooses to develop a plan which incorporates more than one evidenced-based model within the organization, there must be a particular evidenced-based model chosen for each IFI team (e.g., an agency administers 3 teams, 2 which will adhere to one model, one to another model). Documentation of training for each staff person on the evidenced-based in-home model they will be utilizing in the provision of services should exist in their personnel files. Some models do not have the stringent staffing requirements that this service requires. The expectation is that staffing patterns in accordance with the specific model used are in compliance with staffing requirements noted in this service definition.
 - Hours of operation, the staff assigned, and types of services provided to individuals, families, parents, and/or guardians.
 - How the plan for services is modified or adjusted to meet the needs specified in each Individualized Resiliency Plan; and
4. At least 60% of service units must be provided face-to-face with youth and their families and 80% of all face-to-face service units must be delivered in non-clinic settings over the authorization period.
5. At least 50% of IFI face-to-face units must include the identified youth. However, when the child is not included in the face-to-face contacts, the focus of the contacts must remain on the child and their goals as identified on their IRP.
6. Documentation of how the team works with the family and other agencies/support systems (such as LIPTs, provider agencies, etc.) to build a clinically oriented transition and discharge plan is required and should be documented in the clinical record of the individual.
7. IFI is an individual intervention and may not be provided or billed for more than 1 youth at the same time (including siblings); however, youth participating in an IFI program may receive group skills training and/or group counseling in keeping with his/her individual recovery plan. Siblings who are each authorized to receive IFI must receive individualized services, but family interventions can be done jointly, with only one bill being submitted to the payer (For example, Sibling 1 and Sibling 2 are being seen for 2 units with the parents. Sibling 1 and Sibling 2 each

have the documentation in both records, but only one claim for 2 units of reimbursement may be submitted to the payer source).

8. IFI is intended to be provided to youth/families in their living arrangement. Services provided in school settings are allowable up to 3 hours/week as a general rule and the clinical record shall include documentation of partnership with the school. Exceptions to this 3 hours/week should be documented to include approval by the IFI Team Leader of clinical need (CANS scores, recent discharge from inpatient hospitalization, PRTF, CSU, etc.). The record should indicate why a specific intervention took place in the school during school hours instead of after school in the home or community. Youth receiving this service must never be taken out of the classroom for the convenience of the service provider. IFI should not supplant what schools must provide for support of a child based on the IEP.

Staffing Requirements

1. Intensive Family Intervention is provided by a team consisting of the family and the following practitioners:
 - a. One fulltime Team Leader who is licensed (and/or certified as a CAC-II, GCADC-II or -III, CAADC, or MAC if the target population is solely diagnosed with substance related disorders) by the State of Georgia under the Practice Acts and has at least 3 years of experience working with children with severe emotional disturbances. AMFT, LMSW, APC staff do not qualify for this position. The team leader must be actively engaged in the provision of the IFI service in the following manner:
 - i. Convene, at least weekly, team meetings that serve as the way to staff a child with the team, perform case reviews, team planning, and to provide for the team supervision and coordination of treatment/supports between and among team members. When a specific plan for a specific youth results from this meeting, there shall be an administrative note made in the youth's clinical record. In addition, there should exist a log of meeting minutes from this weekly team meeting that documents team supervision. There should be two documentation processes for these meetings; one child specific in the clinical record, and the other a log of meeting minutes for each team meeting that summarizes the team supervision process. This supervision and team meeting process is not a separately-billable activity, but the cost is accounted for within the rate methodology and supports the team approach to treatment. Weekly time for group supervision and case review is scheduled and protected.
 - ii. Meet at least twice a month with families face-to-face or more often as clinically indicated.
 - iii. Provide weekly, individual, clinical supervision to each IFI team member (outside of the weekly team meeting) for all services provided by that member of the IFI team. The individual supervision process is to be one-on-one supervision, documented in a log, with appropriate precautions for individual confidentiality and indicating date/time of supervision, issues addressed, and placed in the personnel file for the identified IFI team staff.
 - iv. Be dedicated to a single IFI team ("Dedicated" means that the team leader works with only one team at least 32 hours/week [up to 40 hours/week] and is a full-time

employee of the agency [not a subcontractor/1099 employee]). The Team Leader is available 24/7 to IFI staff for emergency consultation/supervision.

- b. Two to three fulltime equivalent paraprofessionals who work under the supervision of the Team Leader.
 - c. The team may also include an additional mental health professional, addiction professional or paraprofessional. The additional staff may be used .25 FTE between 4 teams.
2. To facilitate access for those families who require it, the specialty IFI providers must have access to psychiatric and psychological services, as provided by a Physician, Psychiatrist, or a Licensed Psychologist (via contract or referral agreement). These contracts/agreements must be kept in the agency's administrative files and be available for review.
3. Practitioners providing this service are expected to maintain knowledge/skills regarding current research trends in best/evidence-based practices. Some examples of best/evidence-based practice are multi-systemic therapy, multidimensional family therapy, dialectic behavioral therapy, and others as appropriate to the child, family, and issues to be addressed. Their personnel files must indicate documentation of training and/or certification in the evidenced-based model chosen by the organization. There shall be training documentation indicating the evidenced-based in-home practice model each particular staff person will be utilizing in the provision of services.
4. The IFI Team's family-to-staff ratio must not exceed 12 families for teams with two paraprofessionals, and 16 families for teams with three paraprofessionals (which is the maximum limit which shall not be exceeded at any given time). The staff-to-family ratio takes into consideration evening and weekend hours, needs of special populations, and geographic areas to be covered.
5. Documentation must demonstrate that at least 2 team members (one of whom must be licensed/credentialed) are providing IFI services in the support of each individual served by the team in each month of service. One of these team members must be appropriately licensed/credentialed to provide the professional counseling and treatment modalities/interventions needed by the individual and must provide these modalities/interventions as clinically appropriate according to the needs of the youth.
6. It is critical that IFI team members are fully engaged participants in the supports of the served individuals. No more than 50% of staff can be "contracted"/1099 team members. Team members must work for only one IFI organization at a time and cannot be providing this service when they are a member of another team because they cannot be available as directed by families need or for individual crises while providing on-call services for another program.
7. When a team is newly starting, there may be a period when the team does not have a "critical mass" of individuals to serve. During this time, a short-term waiver may be granted to the agency's team by the DBHDD for the counties served. The waiver request may address the part-time nature of a team leader and the paraprofessionals serving less than individual-load capacity. For example, a team may only start by serving 4-6 families (versus full capacity 12-16 families) and therefore could request to have the team leader serve ½ time and a single paraprofessional. A waiver of this nature will not be granted for any time greater than 6 months. The waiver request to DBHDD must include:
 - a. The agency's plan for building individual capacity (not to exceed 6 months).

- b. The agency's corresponding plan for building staff capacity which shall be directly correlated to the item above. DBHDD has the authority to approve these short-term waivers and must copy BHO on its approval and/or denial of these waiver requests. No extension on these waivers will be granted.
8. It is understood that there may be periodic turn-over in the Team Leader position; however, the service fails to meet model-integrity in the absence of a licensed/credentialed professional to provide supervision, therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination. Understanding this scenario, an IFI team who loses a Team Leader must provide the critical functions articulated via one of the following means:
 - a. Documentation that there is a temporary contract for Team Leader who meets the Team Leader qualifications; or
 - b. Documentation that there is another fully licensed/credentialed professional who meets the Team Leader qualifications and is currently on the team providing the Team Leader functions temporarily (this would reduce the team staff to either 2 or 3 members based on the numbers of families served by the team); or
 - c. Documentation that there is another fully licensed/credentialed professional who meets the Team Leader qualifications and is currently employed by the agency providing the Team Leader functions temporarily (this professional would devote a minimum of 15-20 hours/week to supervision, therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination); or
 - d. Documentation that there is an associate-licensed professional who could work full-time dedicated to therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination with a fully licensed/credentialed professional supporting the team for 5 hours/week for clinical supervision.

For this to be allowed, the agency must be able to provide documentation that recruitment is underway. Aggressive recruitment shall be evidenced by documentation in administrative files of position advertising. In the event that a position cannot be filled within 60 days OR in the event that there is no ability to provide the coverage articulated in this item (B.8.), there shall be notification to the State DBHDD Office and the associated Regional Field Office of the intent to cease billing for the IFI service.

9. IFI providers may not share contracted team members with other IFI agencies. Staff may not work part-time for one agency and part-time with another agency due to the need for staff availability in accord with the specific needs, requirements, and requests of the families served. Team members must be dedicated to each specific team to ensure intensity, consistency, and continuity for the individuals served.

Clinical Operations

1. In-home services include consultation with the individual, parents, or other caregivers regarding medications, behavior management skills, and dealing with the responses of the individual, other caregivers, and family members, and coordinating with other child-serving treatment providers.
2. Individuals receiving this service must have a qualifying and verified diagnosis present in the medical record prior to the initiation of services.

3. The Individualized Resiliency Plan must be individualized, strengths-based, and not developed from a template used for other individuals and their families. Team services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence.
4. IFI must be provided through a team approach (as evidenced in documentation) and flexible services designed to address concrete therapeutic and environmental issues in order to stabilize a situation quickly. Services are family-driven, child focused, and focus on developing resiliency in the child. They are active and rehabilitative, and delivered primarily in the home or other locations in the community. Services are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the individual's functioning (with the family's needs for intensity and time of day as a driver for service delivery).
5. Service delivery must be preceded by a thorough assessment of the child and the family in order to develop an appropriate and effective IRP. This assessment must be clearly documented in the clinical record.
6. IFI services provided to children and youth must be coordinated with the family and significant others and with other systems of care such as the school system, the juvenile justice system, and children's protective services when appropriate to treatment and educational needs.
7. The organization must have policies that govern the provision of services in natural settings and can document that it respects the youth's and/or family's right to privacy and confidentiality when services are provided in these settings.
8. When a projected discharge date for the service has been set, the youth may begin to receive more intensified Community Support services two weeks prior to IFI discharge for continuity of care purposes only.
9. When there is a crisis situation identified or there is potential risk of youth harm to self or others, there must be documentation that a licensed/credentialed practitioner is involved in that crisis resolution.
10. The IFI organization will be expected to develop and demonstrate comprehensive crisis protocols and policies and must adhere to all safety planning criteria as specified below. Safety planning with the family must be evident at the beginning of treatment and must include evidence that safety needs are assessed for all youth and families. The family shall be a full participant in the safety planning, and all crisis stabilization steps will be clearly identified. All parties involved, including community partners, will need to know the plan and who is responsible for supporting its implementation. When aggression is an issue within the family, a written safety plan must be developed and signed by the parents/caregivers, staff, youth, and other agency staff involved in the plan. Safety plans should also include natural supports and should not rely exclusively on professional resources. This plan must be given to the family, other agency staff, the youth, and a copy kept in the individual's record.
11. Service delivery should be organized in a way such that there is a high frequency of services delivered at the onset of support and treatment and a tapering off as the youth moves toward discharge. As it applies to the specific youth, this shall be documented in the record.

Service Accessibility

1. Services must be available 24 hours a day, 7 days a week, through on-call arrangements with practitioners skilled in crisis intervention. A team response is preferable when a family requires face-to-face crisis intervention.
2. Due to the intensity of the service, providers must offer a minimum of 3 contacts per week with the youth/family except during periods where service intensity is being tapered toward the goal of transition to another service or discharge.
3. Intensive Family Intervention may not be provided in an Institution for Mental Diseases (IMD, e.g., state, or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
4. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility.
5. Services provided for over 6 hours on any given day must be supported with rigorous reasons in the documentation. Anything over 6 hours would need to relate to a crisis situation and the support administrative documentation should spell out the reasons for extended hours and be signed by the Team Leader.
6. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:
 - a. the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or
 - b. the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.
7. Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.

Documentation Requirements

1. If admission criteria #2 is utilized to establish admission, notation of other services provision intensity/failure should be documented in the record (even if it is self-reported by the youth/family).
2. As the team, youth, and family work toward discharge, documentation must indicate planning with the youth/family for the supports and treatment needed postdischarge from the IFI service. Referrals to subsequent services should be a part of this documentation

Billing & Reporting Requirements

When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.