Integrated Care; Health Homes

DEFINITION

Integrated care is the systematic coordination of behavioral and physical health care in order to improve an individual's overall health. Integrated care programs are person- or family-centered, quality driven, trauma-informed, designed to treat the whole person, and promote recovery and wellness.

Behavioral health providers can offer integrated care by fully integrating primary care into their existing program, establishing written agreements with a primary care provider that is located on-site, or establishing written agreements with a primary care provider that is located in the community.

One specific model for providing integrated care is the Medicaid health home, which was established by the Patient Protection and Affordable Care Act (ACA) to coordinate health care for adults and children with chronic conditions. The health home is a central point of contact responsible for facilitating access to and systematically coordinating an individual's behavioral, medical, and oral health care, while making linkages to needed community and social support services.

Health home services that are eligible for federal reimbursement as authorized by the ACA include:

a. comprehensive care management;
b. care coordination and health promotion;
c. comprehensive transitional care, including appropriate follow-up from inpatient to other settings;
d. individual and family support;
e. referral to community and social support services, as applicable; and
f. the use of health information technology (HIT) to link services.

It should be noted that health homes and integrated care providers do not need to provide the full array of behavioral health, medical and oral health, or community and social support services. However, they must ensure that each individual has access to coordinated health care and community and social support services either directly or by referral to a partnering provider.

Finally, throughout the ICHH standards, the involvement of the person's family has been emphasized due to the significant impact family engagement can have on resilience and recovery. However, the level of family involvement will vary given the age and expressed wishes of the person and as permitted by law.

Due to the importance of family involvement in achieving positive outcomes for children, all aspects of service delivery should be family-driven when working with this population, accounting for the dynamics of the family as well as the needs of the child. Family should be defined in partnership with the child and can include the child's birth, foster, adoptive, or kinship

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

caregivers as appropriate.

Research Note: *In order to qualify for health home services under the ACA, Medicaid eligible individuals must have*

a. *two chronic conditions;*
b. *one chronic condition and be at risk for a second; or*
c. *one serious and persistent mental health condition.*

Chronic conditions include, but are not limited to, substance use disorders, mental health conditions, asthma, diabetes, heart disease, and having a Body Mass Index (BMI) over 25.

Note: *Please see ICHH Reference List for a list of resources that informed the development of these standards.*

Table of Evidence

Self-Study Evidence

- Provide an overview of the different programs being accredited under this section. The overview should describe:
  a. eligibility criteria;
  b. any unique or special services provided to specific populations; and
  c. major funding streams.
- If elements of the service (e.g., health promotion activities) are provided by contract with outside programs or through participation in a formal, coordinated service delivery system, provide a list that identifies the providers and the service components for which they are responsible. Do not include services provided by referral.
- Provide any other information you would like the peer review team to know about these programs.
- A demographic profile of persons and families served by the programs being reviewed under this service section with percentages representing the following:
  a. racial and ethnic characteristics;
  b. gender/gender identity;
  c. age;
  d. major religious groups; and
  e. major language groups
- As applicable, a list of groups or classes including, for each group or class:
  a. the type of activity/group;
  b. whether the activity/group is short-term or ongoing;

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c. how often the activity/group is offered;
d. the average number of participants per session of the activity/group, in the last month; and
e. the total number of participants in the activity/group, in the last month

- A list of any programs that were opened, merged with other programs or services, or closed
- A list or description of program outcomes and outputs being measured

On-Site Evidence

No On-Site Evidence

On-Site Activities

No On-Site Activities

Purpose

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Integrated Care; Health Homes

ICHH 1: Administrative Practices

The organization's administrative practices support:

a. program quality and the achievement of positive outcomes; and
b. effective health care integration.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

Rating Indicators

1) All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted, however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations (HR 6.02) and training (TS 2.03); or
- Active client participation occurs to a considerable extent.

3) Practice requires significant improvement, as noted in the ratings for the Practice standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- A number of client records are missing important information Â or
- Client participation is inconsistent; or
- One of the Fundamental Practice Standards received a rating of 3 or 4.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing; or Â

- Two or more Fundamental Practice Standards received a rating of 3 or 4.

Table of Evidence

Self-Study Evidence

- Service Philosophy
- Include program outcomes and outputs in the Narrative
- A description of mechanisms for linking behavioral health and primary care services

On-Site Evidence

- Copies of informational materials provided to clients and other stakeholders

On-Site Activities

- Interview:
  a. Program director
  b. Relevant personnel
  c. Persons served
- Review case records
- Observe health information technologies

ICHH 1.01

The organization is guided by a service philosophy that:

a. sets forth a logical approach for how program activities and interventions will meet the needs of persons served;
b. guides the development and implementation of the program based on program goals and the best available evidence of service effectiveness; and
c. establishes a holistic, person- or family-centered, resilience and recovery-focused approach to service delivery.

Interpretation: *A practice model, or similar tool, guides program development and implementation by linking the organization's service philosophy and mission with the strategies, practices, and tools needed to integrate these into daily work. A practice model can also help staff think systematically about how the program can make a measureable difference by drawing a clear connection between the service population's needs,*

Purpose

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available resources, program activities and interventions, program outputs, and desired outcomes.

Purpose

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ICHH 1.02

Tracking the impact of integrated services on client outcomes is incorporated into the organization-wide performance and quality improvement program and reflects applicable regulatory requirements.

Interpretation: *Recommended quality measures for integrated programs serving adults include, but are not limited to:*

a. *body mass index;*
b. *screening for clinical depression;*
c. *hospital admissions and readmissions;*
d. *emergency room visits;*
e. *skilled nursing facility admissions;*
f. *initiation and engagement of alcohol and other drug use treatment;*
g. *tobacco use;*
h. *appointment attendance; and*
i. *measures related to chronic medical conditions such as hypertension, diabetes, and asthma.*

Recommended quality measures for integrated programs serving children include, but are not limited to:

a. *body mass index;*
b. *immunization status;*
c. *well-child visits;*
d. *school attendance;*
e. *placement disruptions in child welfare;*
f. *juvenile justice recidivism;*
g. *residential placements;*
h. *hospital admissions and readmissions;*
i. *measures related to chronic conditions such as asthma, diabetes, and ADHD; and*
j. *other clinical and functional outcomes found on standardized, child-oriented tools such as the Child and Adolescent Needs and Strengths (CANS).*

ICHH 1.03

The organization has developed clear mechanisms for linking behavioral

health and primary care services through:

a. shared access to the person's health information consistent with applicable privacy regulations;
b. documentation techniques that utilize common terms and concepts to facilitate clear and effective communication; and
c. systems for tracking referrals and needed follow-up.

Related: CR 2

(FP) ICHH 1.04

Persons served are informed of:

a. how information will be shared both internally and externally among collaborating providers;
b. their right to refuse integrated services; and
c. what will happen if services are refused.

Related: CR 1.07, CR 2

(FP) ICHH 1.05

The organization clearly defines for its stakeholders:

a. the scope of services offered directly by the organization; and
b. the nature of the relationship that exists between providers when direct services are provided through contract or other agreement between separate legal entities.

ICHH 1.06

The organization uses health information technologies to:

a. link services;
b. organize, track, and analyze critical program information; and
c. satisfy applicable reporting requirements.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

ICHH 2: Assessment

The person and his or her family participate in a comprehensive, strengths-based, individualized assessment to identify service needs and goals.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

Rating Indicators

1) All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice standards; e.g.,Â

- Minor inconsistencies and not yet fully developed practices are noted, however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations (HR 6.02) and training (TS 2.05); or
- Active client participation occurs to a considerable extent; or
- Diagnostic tests are consistently and appropriately used, but interviews with staff indicate a need for more training (TS 2.08).

3) Practice requires significant improvement, as noted in the ratings for the Practice standards. Â Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Assessment and reassessment timeframes are often missed; or
- Assessment are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm and this is not being addressed in supervision or training; or
- Staff are not competent to administer diagnostic tests , or tests are not being used when clinically indicated; or
- Client participation is inconsistent; or
- Assessments are done by referral source and no documentation and/or summary of required information present in case record; or
- One of the Fundamental Practice Standards received a rating of 3 or 4.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice standards; e.g.,

- There are no written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing; or Â
- Two or more Fundamental Practice Standards received a rating of 3 or 4.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

Table of Evidence

Self-Study Evidence

- Assessment procedures
- Assessment tool
- Procedures for making referrals for specialized screenings, assessments, or tests when needed

On-Site Evidence

- Job descriptions of personnel responsible for conducting assessments
- Assessment training curricula
- Documentation of training

On-Site Activities

- Interview:
  a. Program director
  b. Relevant personnel
  c. Persons served
- Review case records

ICHH 2.01

Personnel who conduct assessments are:

a. appropriately qualified by training, skill and experience; and
b. licensed or certified when required by law.

Interpretation: *For example, medical screenings that are done as part of the assessment should be conducted or reviewed by a medical professional such as a nurse.*

ICHH 2.02

Assessments are conducted within established timeframes using a standardized assessment tool to identify:

a. the person's behavioral health, physical health, and community and social support service needs and goals;
b. history of trauma;
c. individual and family strengths, risks, and protective factors;
d. natural supports and helping networks; and
e. the impact of the individual's health care needs on the family unit.

Interpretation: *Basic needs such as food, clothing, and shelter should be considered when identifying the person's service needs. For organizations serving children, the assessments should take into account systems involvement including education, child welfare and juvenile justice.*

Note: *Organizations should review state Medicaid plans or other third party reimbursement requirements to ensure they are meeting required timeframes for conducting assessments. Organizations serving children in the child welfare system should also be aware of any assessment timeframe requirements applicable to that population.*

Note: *See ICHH 3.03 for more information on keeping the assessment up-to-date as part of the case review process.*

ICHH 2.03

The assessment incorporates applicable information from a variety of sources, which include, but are not limited to:

a. the person;
b. the person's family;
c. medical and/or clinical case records;
d. the results of screening tools;
e. content of assessments completed by partnering or referring providers;
f. other providers; and
g. members of the care planning team.

Interpretation: *Information received through assessments completed by partnering or referring providers should be reviewed to identify:*

a. *gaps in information;*
b. *out-of-date information; and*
c. *information that can be used to minimize duplication of effort.*

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

ICHH 2.04

Assessments are conducted in a culturally responsive manner to identify resources that can increase service participation, support the achievement of agreed upon goals, and promote recovery and resilience.

Interpretation: *Culturally responsive assessments can include attention to geographic location, language of choice, and the person's religious, racial, ethnic, and cultural background. Other important factors that contribute to a responsive assessment include attention to age, gender identity, sexual orientation, immigration status, and developmental level.*

(FP) ICHH 2.05

Assessment procedures include mechanisms to identify and respond to individuals or families in crisis including:

a. giving priority to urgent needs and emergency situations;
b. expedited care planning;
c. connecting the individual to more intensive services as needed;
d. facilitating the development of a safety and/or crisis plan; and
e. contacting emergency responders as appropriate.

ICHH 2.06

The organization promptly provides or makes arrangements for specialized screenings, assessments, or tests as needed based on information collected during initial and ongoing assessments.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

ICHH 3: Care Planning and Monitoring

The person and his or her family participate in the development and ongoing monitoring of a care plan that is the basis for delivery of needed services.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

Rating Indicators

1) All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice standards; e.g.,Â

- Minor inconsistencies and not yet fully developed practices are noted, however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations (HR 6.02) and training (TS 2.03); or
- In a few instances client or staff signatures are missing and/or not dated; or
- Active client participation occurs to a considerable extent.

3) Practice requires significant improvement, as noted in the ratings for the Practice standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- In a number of instances client or staff signatures are missing and/or not dated (RPM 7.04); or
- Quarterly reviews are not being done consistently; or
- Level of care for some clients is inappropriate; or
- Service planning is often done without full client participation; or
- Appropriate family involvement is not documented; or
- Documentation is routinely incomplete and/or missing; or
- Assessments are done by referral source and no documentation and/or summary of required information present in case record; or

- One of the Fundamental Practice Standards received a rating of 3 or 4.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing; or Â
- Two or more Fundamental Practice Standards received a rating of 3 or 4.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

Table of Evidence

Self-Study Evidence

- Care planning and monitoring procedures

On-Site Evidence

No On-Site Evidence

On-Site Activities

- Interview:
  a. Program director
  b. Relevant personnel
  c. Persons served
- Review case records

ICHH 3.01

A care plan is developed:

a. within established timeframes; and
b. with the full participation of the individual and his or her family.

Interpretation: *Care planning is conducted such that individuals and families retain as much personal responsibility and self-determination as possible or desired. Individuals with limited ability in making independent choices can receive help with making decisions for themselves and gradually assume more responsibility for making decisions independently. When the person receiving services is a minor, or an adult under the care of a guardian, the organization should follow applicable state laws or regulations requiring the involvement or consent of the person's legal*

guardian.

Interpretation: *Generally, care plans should be developed following completion of all necessary assessments and reviewed with the person at their next visit.*

Note: *The organization should review state Medicaid plans or other third party reimbursement requirements to ensure they are meeting required timeframes for completing care plans.*

ICHH 3.02

The care plan is based on the assessment and includes:

a. the person's behavioral health, physical health, and community and social support service needs and goals;
b. steps for working toward achievement of desired goals including timeframes where appropriate;
c. services and supports to be provided, and by whom;
d. supports and/or services to improve family functioning;
e. strategies for building on individual and family strengths and natural supports;
f. agreed upon timelines for conducting regular case reviews; and
g. documentation of the individual's or family's involvement in care planning.

Interpretation: *The care plan should address any unmet basic needs, such as housing, as these needs can limit engagement and successful achievement of service goals.*

Note: *Regarding element g, the organization should review state regulations governing the documentation of the individual's or family's involvement to ensure documentation meets all applicable requirements.*

ICHH 3.03

The care coordinator and the care planning team actively review the case according to established timelines to assess:

a. continued accuracy of the assessment;
b. care plan implementation;
c. the person's continued engagement in his or her treatment;
d. the person's progress toward achieving goals and desired outcomes; and
e. the continuing appropriateness of agreed upon service goals.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

Interpretation: *Timeframes for the review should be defined by the person and the care coordinator and take into consideration the issues and needs of the person and the frequency and intensity of services provided. Traumatic events or other significant life changes such as changes in housing, disclosure of abuse, hospitalization, or contact with the criminal justice system should trigger an immediate review of the case.*

ICHH 3.04

The care coordinator and the individual or family regularly review progress toward achievement of agreed upon goals and make revisions to service goals and plans as needed.

Interpretation: *The individual's or family's involvement in updating the plan should be documented.*

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

ICHH 4: Care Coordination

All aspects of the person's treatment are managed in accordance with the care plan to ensure access to and coordination of needed behavioral health care, physical health care, and community and social support services.

Interpretation: *This includes coordination of any services provided directly by the organization as well as those provided through linkages to community providers.*

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

Rating Indicators

1) All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted, however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations (HR 6.02) and training (TS 2.03); or
- Active client participation occurs to a considerable extent.

3) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing; or Â
- Two or more Fundamental Practice Standards received a rating of 3 or 4.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or

- Documentation is routinely incomplete and/or missing; or Â
- Two or more Fundamental Practice Standards received a rating of 3 or 4.

Table of Evidence

Self-Study Evidence

- Description of care coordination services
- Care coordination procedures
- Care transition procedures
- Procedures / mechanisms for tracking medication reconciliation and adherence

On-Site Evidence

- Copy of agreement with and/or job description and resume for each member of the care planning team, including a physician and psychiatrist for consultation
- Copies of agreements with community providers, as applicable
- Up-to-date referral list

On-Site Activities

- Interview:
  a. Program director
  b. Care planning team members
  c. Persons served
- Review case records

ICHH 4.01

All individuals and their families receive:

a. direct provision of, or linkages to needed services and supports, as outlined in the care plan; and
b. individual care coordination and monitoring of services.

(FP) ICHH 4.02

The care planning team includes at a minimum:

a. a designated care coordinator;

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

b. a primary care professional such as a physician's assistant or nurse practitioner with access to a physician for needed consultation;
c. a behavioral health professional such as a social worker, psychologist, or other licensed clinician with access to a psychiatrist for needed consultation; and
d. other providers and supports based on the individual needs of the person.

Interpretation: *The qualifications of the designated care coordinator will vary given the needs of the identified service population. For adults with serious and persistent mental health conditions, for example, a medical professional such as a nurse practitioner may be preferred given the high prevalence of comorbid, chronic, physical health conditions present in this population. For children, however, where chronic medical conditions are far less common, the coordination of behavioral health care and linkages to community and social support services might best be carried out by a behavioral health practitioner with experience working with children and families.*

Interpretation: *Organizations should leverage alternative service delivery methods such as telehealth and telemental health when regional shortages of certain professional groups, such as psychiatrists, make in-person consultation impractical.*

Interpretation: *Supports that might also be included on the care planning team can include, but are not limited to, peer mentors and natural supports as appropriate to the needs of the individual.*

ICHH 4.03

The roles and responsibilities of each team member are clearly defined.

ICHH 4.04

The organization has established communication procedures for collaboration:

a. across disciplines, both internal and external; and
b. with the person and his or her family.

Research Note: *In a 2009 survey of families whose children have mental health needs, parents identified open communication with their child's providers as the greatest contributor to increased quality of care.*

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

ICHH 4.05

The organization facilitates access to the full array of community and social support, behavioral health care, and physical health care services by:

a. establishing partnerships and coordination procedures with direct service providers in the community;
b. maintaining a comprehensive, up-to-date referral list;
c. removing barriers to the initiation of needed services including procedures for providing a warm hand off when needed services are provided directly by the program or on-site through a partnering provider; and
d. assisting the person with system navigation.

Interpretation: *Examples of community and social support services and behavioral and physical health care services that should be made available to persons served include:*

a. *preventative and health promotion services;*
b. *mental health and substance use services;*
c. *comprehensive care management, care coordination, and transitional care;*
d. *chronic disease management, including self-management;*
e. *community, social support, and recovery services; and*
f. *long-term care supports and services.*

ICHH 4.06

Persons served are assisted in making appointments for needed or requested services, and the care coordinator follows up to:

a. ensure the service was received;
b. identify any needed follow-up; and
c. make needed changes to the care plan in partnership with the person and his or her family.

ICHH 4.07

The care coordinator supports smooth transitions between care settings by:

a. coordinating information sharing and service provision with providers and the person;

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

b. developing, or supporting the development of, a comprehensive discharge or transition plan with steps for follow-up; and
c. facilitating face-to-face interactions between providers, whenever possible.

Interpretation: *Supported transitions can include, but are not limited to, transitioning from inpatient hospitalization, residential treatment, therapeutic group care, the juvenile justice system, foster care, and from pediatric to adult settings.*

(FP) ICHH 4.08

The organization has mechanisms in place to track medication reconciliation and adherence.

Related: RPM 3.03

Note: *While it may not be the organization's responsibility to conduct medication reconciliation, they should have processes in place to ensure it is being done as part of their care coordination activities.*

ICHH 4.09

Care coordination activities are documented in the case record, including:

a. linkages to community providers as well as completed follow-up;
b. communication with partnering providers both internally and externally; and
c. communication with the person.

Interpretation: *Care coordination activities that are documented in the case record could also include sharing the results of screenings and diagnostic and laboratory testing.*

ICHH 4.10

Persons served and their families are connected with peer support services appropriate to their request or need for service.

Research Note: *Peer support services connect individuals and families with peers who have similar lived experiences. Research has suggested that peer models increase social contacts, improve daily functioning, and increase the individual's sense of empowerment and hopefulness. In a 2009*

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

survey of parents with children who have mental health needs, the majority of surveyed parents reported that they gained needed information from other parents. One to one support, support groups, and family advocacy organizations were all identified by respondents as valuable resources.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

ICHH 5: Health Promotion

The organization ensures that persons served and their families have access to health information and resources that enable them to manage their chronic conditions and improve their overall health.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

Rating Indicators

1) All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted, however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations (HR 6.02) and training (TS 2.03); or
- Active client participation occurs to a considerable extent.

3) Practice requires significant improvement, as noted in the ratings for the Practice standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- A number of client records are missing important information Â or
- Client participation is inconsistent; or
- One of the Fundamental Practice Standards received a rating of 3 or 4.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing; or Â
- Two or more Fundamental Practice Standards received a rating of 3 or

4.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

Table of Evidence

Self-Study Evidence

- A description of health promotion activities
- A description of how individual characteristics and abilities, health data, and evidence-based practices inform health promotion activities

On-Site Evidence

- Health promotion educational materials, training curricula, and other information made available to clients
- Aggregate reports and analysis from health data tracking
- Evidence of improvements made to health promotion activities based on data collection activities

On-Site Activities

- Interview:
  a. Program director
  b. Relevant personnel
  c. Persons served
- Review case records
- Observe system for tracking health data

ICHH 5.01

When choosing or designing health promotion activities, the organization considers:

a. individual characteristics and abilities;
b. health data for persons served; and
c. evidence-based practices and concepts.

Interpretation: *Characteristics and abilities to be considered can include age, developmental level, race, gender identity, sexual orientation, culture, ethnicity, language, literacy level, and any additional characteristics that will ensure the information is accessible to persons served. Additionally, the organization should consider evidence-based practices and concepts that have proven effective when working with individuals to change health behaviors including motivational interviewing and the stages of change.*

Note: *See ICHH 5.04 for more information on collecting and using health data for persons served.*

ICHH 5.02

The organization offers persons served and their families health education on topics relevant to their needs that will empower them to manage their chronic conditions and promote wellness.

Interpretation: *Examples of health education topics include, but are not limited to, smoking cessation, nutrition, physical fitness, obesity education, the connection between mental and physical health, chronic disease management, medication use, and resilience and recovery.*

ICHH 5.03

Services promote self-advocacy and independence by:

a. connecting individuals and families to informal support systems in their community; and
b. educating individuals and families on where to access needed services.

ICHH 5.04

Health data for persons served is collected, aggregated, and analyzed to inform individual and organization-wide health promotion activities.

Interpretation: *Patient registries are one effective method for collecting, organizing, and analyzing health data.*

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

ICHH 6: Personnel

Personnel qualifications and workloads allow staff to effectively perform their job responsibilities.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

Rating Indicators

1) All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice standards; e.g.,Â

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, including: education, experience, training, skills, temperament, etc., but the integrity of the service is not compromised.
  - Supervisors provide additional support and oversight, as needed, to staff without the listed qualifications.
  - Most staff who do not meet educational requirements are seeking to obtain them.
- With some exceptions staff have received required training, including applicable specialized training.
  - Training curricula are not fully developed or lack depth.
  - A few personnel have not yet received required training.
  - Training documentation is consistently maintained and kept up-to-date with some exceptions.
- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies.
  - Supervisors provide structure and support in relation to service outcomes, organizational culture and staff retention.
- With a few exceptions caseload sizes are consistently maintained as required by the standards.
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services, and are adjusted as necessary in accord with established workload procedures.
  - Procedures need strengthening.
  - With few exceptions procedures are understood by staff and are being used.
- With a few exceptions specialized staff are retained as required and possess the required qualifications.
- Specialized services are obtained as required by the standards.

3) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice standards; e.g.,

?For example:

- Two or more Fundamental Practice Standards received a rating of 3 or 4.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing; or Â
- Two or more Fundamental Practice Standards received a rating of 3 or 4.

Table of Evidence

Self-Study Evidence

- Program staffing chart that includes lines of supervision
- List of program personnel that includes:
  a. Name
  b. Title
  c. Degree held and/or other credentials
  d. Paid staff or volunteer
  e. Length of service at the organization
  f. Time in current position
- Table of contents of training curricula
- Procedures and criteria used for assigning and evaluating workload

On-Site Evidence

- Training curricula
- Documentation of training

On-Site Activities

- Interview:
  a. Supervisors
  b. Relevant personnel
- Review personnel files

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

ICHH 6.01

Staff demonstrate competency in:

a. coordinating and providing access to needed services;
b. facilitating transition planning and coordination;
c. applicable evidence-based interventions;
d. physical health issues commonly associated with mental health or substance use conditions;
e. chronic disease management, including promoting self-management;
f. connecting individuals with needed formal and informal supports in the community;
g. building relationships with persons served, community providers, and family members to promote engagement and achievement of service goals;
h. developing a person- or family-centered care plan;
i. understanding the roles played by different child-serving systems, as applicable; and
j. using health information technology to link services and facilitate collaboration among providers, the person, and his or her family.

Interpretation: *Competency in these areas may be demonstrated through education, training, experience, and performance reviews. Needed skills may vary by job category.*

ICHH 6.02

Employee workloads support the achievement of client outcomes, are regularly reviewed, and are based on an assessment of the following:

a. the qualifications, competencies, and experience of the worker including the level of supervision needed;
b. services provided by other professionals or team members;
c. the work and time required to accomplish assigned tasks and job responsibilities; and
d. service volume, accounting for assessed level of needs of new and current clients and referrals.

Research Note: *Studies have shown that care coordination programs serving children with serious behavioral health conditions have improved outcomes when caseloads remain small. This is due to the fact that this population requires more intensive, face-to-face contact. Additionally, these cases are further complicated by multi-system involvement and the need for a broader array of support services such as intensive in-home services and*

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.

respite care.

ICHH 6.03

Staff is trained on the health conditions and treatment responses particular to the service population including relevant, evidence-based care guidelines.

Purpose

Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes.