Service Standards

Integrated Care; Health Homes

Purpose

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

Definition

Integrated care is the systematic coordination of behavioral and physical health care to promote whole-person wellness. Integrated care is focused on the delivery of high-quality, coordinated care that considers the person's preferences, values, and goals.

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

One common 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 a person's behavioral, medical, and oral health care while linking them to needed community and social support services. Health homes are only available to individuals who meet specific eligibility criteria and include the following services:

1. comprehensive care management;
2. care coordination and health promotion;
3. comprehensive transitional care, including appropriate follow-up from inpatient to other settings;
4. individual and family support;
5. referral to community and social support services, as applicable; and
6. the use of health information technology (HIT) to link services.

Note: *Throughout the ICHH standards, family involvement has been emphasized due to the impact family engagement has on resilience and recovery. However, family should be defined by the person and their involvement will vary given the age and preferences of the person and as permitted by law.*

For example, 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 and the needs of the child.

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

Note: *For information about changes made in the 2020 Edition, please see the ICHH Crosswalk.*

Table of Evidence

Self Study Evidence

No Self Study Evidence

Integrated Care; Health Homes

ICHH 1: Person-Centered Logic Model

Purpose

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

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes.
Note: *Please see the Logic Model Template for additional guidance on this standard.?*

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.

Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Logic models need improvement or clarification; or
- Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
- At least one outcome has been identified for all of its programs.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Logic models need significant improvement; or
- Logic models are still under development for a majority of programs; or
- A logic model has not been developed for one or more high-risk programs; or
- Outcomes have not been identified for one or more programs.

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.,
- Logic models have not been developed or implemented; or
- Outcomes have not been identified for any programs.

Table of Evidence

Self Study Evidence

*

• Program logic model that includes a list of outcomes being measured	
• See program description completed during intake	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
  1. Program director
  2. Relevant personnel

ICHH 1.01

A program logic model, or equivalent framework, identifies:

a. needs the program will address;
b. available human, financial, organizational, and community resources (i.e. inputs);
c. program activities intended to bring about desired results;
d. program outputs (i.e. the size and scope of services delivered);
e. desired outcomes (i.e. the changes you expect to see in individuals and families); and
f. expected long-term impact on the organization, community, and/or system.

Examples: *Please see the W.K. Kellogg Foundation Logic Model Development Guide and COA Accreditation's PQI Guide for more information on developing and using program logic models.*

Examples: *Information that may be used to inform the development of the program logic model includes, but is not limited to:*

1. *characteristics of the service population;*
2. *needs assessments and periodic reassessments; and*
3. *the best available evidence of service effectiveness.*

ICHH 1.02

The logic model identifies desired outcomes in at least two of the following areas:

a. change in clinical status;
b. change in functional status;
c. health, welfare, and safety;
d. permanency of life situation;
e. quality of life;
f. achievement of individual service goals;
g. access to needed health care and social services;
h. treatment adherence and self-management of chronic conditions; and
i. other outcomes as appropriate to the program or service population.

Interpretation: *Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.*

Examples: *Quality measures for integrated programs serving adults can include, but are not limited to:*

1. *body mass index;*
2. *screening for clinical depression;*
3. *hospital admissions and readmissions;*
4. *emergency room visits;*
5. *skilled nursing facility admissions;*
6. *initiation and engagement of alcohol and other drug use treatment;*
7. *tobacco use;*
8. *appointment attendance; and*
9. *measures related to chronic medical conditions (e.g., hypertension, diabetes, and asthma) including symptom control.*

Quality measures for integrated programs serving children can include, but are not limited to:

1. *body mass index;*
2. *immunization status;*
3. *well-child visits;*
4. *school attendance;*
5. *placement disruptions in child welfare;*
6. *juvenile justice recidivism;*
7. *residential placements;*
8. *hospital admissions and readmissions;*
9. *measures related to chronic conditions such as asthma, diabetes, and ADHD; and*

10. *other clinical and functional outcomes found on standardized, child-oriented tools such as the Child and Adolescent Needs and Strengths (CANS).*

Integrated Care; Health Homes

ICHH 2: Personnel

Purpose

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

Personnel have the competency and support needed to provide services and meet the needs of individuals and families.
Interpretation: *Competency can be demonstrated through education, training, experience, or licensure. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.*

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.,

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, but the integrity of the service is not compromised; or
- Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
- Most staff who do not meet educational requirements are seeking to obtain them; or
- With few exceptions, staff have received required training, including applicable specialized training; or
- Training curricula are not fully developed or lack depth; or
- Training documentation is consistently maintained and kept up-to-date with some exceptions; or
- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
- With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
- Specialized services are obtained as required by the standards.

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

- A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications and, as a result, the integrity of the service may be compromised; or
- Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
- Supervisors do not typically provide additional support and oversight to staff without the listed qualifications; or
- A significant number of staff have not received required training, including applicable specialized training; or
- Training documentation is poorly maintained; or
- A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
- There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
- Workloads are excessive, and the integrity of the service may be compromised; or
- Specialized staff are typically not retained as required and/or many do not possess the required qualifications; or
- Specialized services are infrequently obtained as required by the standards.

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.

Table of Evidence

Self Study Evidence

*	• Table of contents of training curricula	
*		

• Procedures or other documentation relevant to continuity of care and case assignment	

* • List of program personnel that includes:
  • Title
  • Name
  • Employee, volunteer, or independent contractor
  • Degree or other qualifications
  • Time in current position
• See organizational chart submitted during application	

Site Visit Evidence

* • Training curricula • Documentation tracking staff completion of required trainings and/or competencies • Caseload size requirements set by policy, regulation, or contract, when applicable • Documentation of current caseload size per worker

On-Site Activities

* • Interviews may include: 1. Program director 2. Relevant personnel • Review personnel files

ICHH 2.01

Personnel are trained on, or demonstrate competency in:

a. effectively communicating and coordinating care across disciplines, systems, and services;
b. applicable evidence-based or culturally-relevant, evidence-supported practices;
c. physical health issues and social factors commonly associated with mental health or substance use conditions;
d. health conditions and treatment responses particular to the service population;
e. chronic disease management, including promoting self-management;
f. developing person- or family-centered care plans; and
g. using health information technology to link services and facilitate collaboration among providers, the person, and their family.

ICHH 2.02

When staff with lived experience provide peer support to individuals and families, the organization:

a. clearly defines their roles and responsibilities;
b. includes peer support staff as equal partners on the care planning team;
c. helps other program personnel understand the position and its purpose at the program;
d. establishes guidelines for recruitment and selection;
e. ensures peer support staff are trained to perform their roles and responsibilities;
f. provides ongoing support and supervision to address any issues that occur, including helping peer support staff manage personal triggers that may arise on the job; and
g. facilitates opportunities for peer support staff to connect and consult with others performing similar roles.

NA: The program does not utilize peer support staff.

Examples: *Peer support staff can play an important role in welcoming, engaging, empowering, supporting, and advocating for individuals and families. When viewed and included as full partners who have input into program decisions, peer support staff can help organizations ensure their culture and practices prioritize the experience and involvement of individuals and families.*

Organizations may also use other terms to refer to peer support staff such as peer support specialists, recovery coaches, peer navigators, peer/family partners, parent peer specialists, youth advocates, family advocates, family mentors, and/or family liaisons.

ICHH 2.03

The organization promotes stability and service continuity by:

a. assigning the care planning team at intake or early in the contact; and
b. minimizing the number of workers assigned to the individual or family during their contact with the organization.

ICHH 2.04

Employee workloads support the achievement of positive outcomes and are regularly reviewed.
Examples: *Factors that may be considered when determining employee workloads include, but are not limited to:*

1. *the qualifications, competencies, and experience of the worker including the level of supervision needed;*
2. *services provided by other professionals or team members;*
3. *the work and time required to accomplish assigned tasks and job responsibilities; and*
4. *service volume, accounting for the assessed level of needs of individuals and families.*

Integrated Care; Health Homes

ICHH 3: Administrative Practices

Purpose

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

The organization's administrative practices support effective health care integration.

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 and training; or
- Active participation of persons served 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
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

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.

Table of Evidence

Self Study Evidence

*

• Procedures that outline appropriate terminology and concepts to use for documentation	

Site Visit Evidence

*

- Copies of informational materials provided to individuals and families and other stakeholders

On-Site Activities

*

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Individuals and families
- Review case records
- Observe health information technologies

ICHH 3.01

Documentation techniques utilize common terms and concepts to facilitate clear and effective communication across disciplines, systems, and services.

ICHH 3.02 (FP)

The organization clearly defines for its stakeholders:

a. the scope of services offered directly by the organization;
b. how information will be shared both internally and externally among collaborating providers; and
c. the nature of the relationship that exists between providers when direct services are provided through contract or other agreement between separate legal entities.

ICHH 3.03

The organization uses health information technologies to:

a. capture physical health, behavioral health, and community and social support information;
b. link services including shared access to the person's health information and effective communication across disciplines, systems, and services;
c. organize, track, and analyze critical program information or data including referrals and needed follow-up, engagement or participation in services, and progress in treatment;
d. satisfy applicable reporting requirements; and
e. support billing and other administrative functions.

Integrated Care; Health Homes

ICHH 4: Intake and Assessment

Purpose

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

The organization ensures that individuals and families receive prompt and responsive access to appropriate services and supports.

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
- In a few rare instances, urgent needs were not prioritized; 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 and training; or
- Active participation of persons served 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
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; 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
- Several case records are missing important information; or
- Participation of persons served is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

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.

Table of Evidence

Self Study Evidence

*	• Screening and intake procedures	
*	• Assessment procedures	
*	• Copy of assessment tool(s)	
*		

- Procedures for referring individuals to specialized screenings, assessments, or tests when needed

Site Visit Evidence

*

- Community resource and referral list

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Individuals and families
- Review case records

ICHH 4.01

Individuals and families served are screened and informed about:

a. how well their request matches the organization's services; and
b. what services will be available and when.

NA: Another organization is responsible for screening, as defined in a contract.

ICHH 4.02 (FP)

Prompt, responsive intake practices:

a. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
b. identify emergency situations and facilitate immediate access to stabilization and harm reduction activities;
c. give priority to urgent needs including access to expedited assessment and care planning;
d. support timely initiation of services for routine needs; and
e. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly.

ICHH 4.03

Individuals and families participate in an individualized, trauma-informed, culturally and linguistically responsive assessment that is completed within established timeframes and appropriately tailored to meet the age and developmental level of persons served.

Interpretation: *The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA Accreditation's Service Sections. The assessment elements of the Matrix can be tailored according to the needs and preferences of specific individuals and service design.*

ICHH 4.04

Assessments are conducted using a standardized assessment tool to identify:

a. social factors that may influence overall health including housing instability, food insecurity, unemployment, financial insecurity, social supports, systems involvement, and any other factors known to be impacting individuals and families;
b. the person's behavioral health, physical health, and community and social support service needs and goals;
c. history of trauma;
d. risk of suicide, self-injury, withdrawal or overdose, neglect, exploitation, and violence towards others;
e. individual and family values, preferences, strengths, risks, and protective factors; and
f. the impact of the individual's health care needs on the family unit.

Examples: *For organizations serving children, systems involvement can include education, child welfare, and juvenile justice.*

ICHH 4.05

The assessment incorporates applicable information from partnering or referring providers, which includes, but is not limited to:

a. medical and/or clinical case records;
b. the results of screening tools; and
c. relevant content from assessments.

Examples: *Organizations can review information from partnering or referring providers to identify:*

1. *gaps in information;*
2. *out-of-date information; and*
3. *information that can be used to minimize duplication of effort.*

ICHH 4.06

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

Integrated Care; Health Homes

ICHH 5: Care Planning and Monitoring

Purpose

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

Individuals and families participate in the development and ongoing review of a care plan that is the basis for delivery of appropriate services and support.

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 and training; or
- With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or
- Active participation of persons served 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
- Case reviews are not being done consistently; or
- Level of care for some people is clearly inappropriate; or
- Service planning is often done without full participation of persons served; or
- Appropriate family involvement is not documented; or
- Documentation is routinely incomplete and/or missing; or
- Individual staff members work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc., but this is the exception.

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.

Table of Evidence

Self Study Evidence

*

• Service planning and monitoring procedures	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:

1. Program director
2. Relevant personnel
3. Individuals and families

- Review case records

ICHH 5.01

An assessment-based care plan is developed promptly with the full participation of individuals and families and includes:

a. the person's behavioral health, physical health, and community and social support service needs and goals, including those related to social factors impacting their overall health and wellbeing;
b. steps for working toward the achievement of desired goals including timeframes where appropriate;
c. services and supports to be provided, and by whom;
d. agreed-upon timelines for conducting regular case reviews; and
e. documentation of the individual's or family's participation in care planning.

Interpretation: *Although personnel should help identify available services and their potential risks and benefits and participate in evaluating options, individuals and families should be the primary planners of their goals and objectives and have the right to decide what services and supports will be provided and by whom.*

ICHH 5.02 (FP)

The organization determines whether a crisis plan is necessary and, when indicated, engages individuals and families in crisis and/or safety planning that:

a. is individualized and centered around strengths;
b. identifies individualized warning signs of a crisis;
c. identifies coping strategies and sources of support that can be implemented during a suicidal crisis, as appropriate;
d. specifies interventions that may or may not be implemented to help the individual or family de-escalate and promote stabilization; and
e. does not include "no-suicide" or "no-harm" contracts.

Interpretation: *For people who have been deemed to be at high risk of suicide, a safety plan includes a prioritized written list of coping strategies and sources of support that people can use before or during a suicidal crisis. A personalized safety plan and appropriate follow-up can help suicidal people cope with suicidal thoughts to prevent a suicide attempt or possibly death. The safety plan should be developed once it has been determined that no immediate emergency intervention is required.*

Interpretation: *For organizations serving children and youth, when safety issues are identified, the organization:*

1. involves supervisory personnel in reviewing safety concerns and plans; and
2. *reports safety concerns following mandated reporting requirements.*

Examples: *Depending on the needs and preferences of the person, crisis plans may reference advanced mental health directives, also known as psychiatric advanced directives.*

Examples: *Components of a safety plan can also include: internal coping strategies, socialization strategies for distraction and support, family and social contacts for assistance, professional and agency contacts, and lethal means restriction.*

Examples: *Warning signs for people assessed as being at high risk for suicide can include a missed appointment or significant change in status, and personnel may conduct active outreach and service engagement strategies such as phone calls, text messages, or home visits until contact is made.*

Examples: *Safety plans may look different depending on the specific needs of the individual or family. For example, safety plans for survivors of domestic violence may focus on helping people prepare for immediate escape, while safety plans for people at risk for suicide may address coping strategies and sources of support, such as socialization strategies for distraction and support, family and social contacts for assistance, professional and agency contacts, and lethal means restriction. Organizations may also provide family members with information on crisis prevention. For example, Mental Health First Aid is a one-day training that can prepare someone to recognize, understand, and respond to a person's mental health crisis.*

ICHH 5.03

The organization partners with the individual or family to actively review their case and:

a. determine the continued accuracy of the assessment;
b. assess care plan implementation;

c. evaluate the person's continued engagement in their treatment;
d. review progress toward achieving goals and desired outcomes; and
e. determine the continuing appropriateness of agreed-upon service goals.

ICHH 5.04

Case reviews follow established timeframes that:

a. are determined collaboratively by the individual or family and the care coordinator;
b. consider the issues, preferences, and needs of the person; and
c. align with the frequency and intensity of services provided.

Interpretation: *Traumatic events or other significant life changes such as loss of housing, disclosure of abuse, hospitalization, or contact with the criminal justice system should trigger an immediate review of the case.*

Integrated Care; Health Homes

ICHH 6: Care Coordination

Purpose

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

The care planning team collaborates with individuals and families to coordinate and monitor needed behavioral health, physical health, and community and social support services in accordance with the individual's care plan.
Note: *Care coordination in this context includes coordination of any services provided directly by the organization as well as those provided through linkages to or partnerships with community providers.*

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 and training; or
- Active participation of persons served 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
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

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.

Table of Evidence

Self Study Evidence

*	• Care coordination procedures	
*	• Care transition procedures	
*	• Procedures for conducting or tracking medication reconciliation and adherence	

Site Visit 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
- Community resource and referral list

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Individuals and families
- Review case records

ICHH 6.01 (FP)

The care planning team includes at a minimum:

a. a designated care coordinator with qualifications appropriate to the needs of the identified service population;
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;
d. the individual or family; and
e. other providers and supports based on the needs and preferences of the individual.

Interpretations: *Organizations can 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.*

Examples: *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.*

ICHH 6.02

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

ICHH 6.03

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. establishing communication procedures with individuals and families and across disciplines, both internally and externally;
c. maintaining a comprehensive, up-to-date referral list;
d. removing barriers to the initiation of needed services including taking advantage of telehealth services to increase access to needed specialists;
e. providing a warm handoff whenever possible when linking the individual to needed services; and
f. assisting the person with system navigation.

Interpretation: *The array of community and social support services and behavioral and physical health care services that should be made available to individuals and families include:*

1. *preventative and health promotion services;*
2. *mental health and substance use services;*
3. *comprehensive care management, care coordination, and transitional care;*
4. *chronic disease management, including self-management;*
5. *recovery services;*
6. *housing, entitlement, vocational, and other community and social support services;*

7. *peer support services; and*
8. *long-term care supports and services.*

ICHH 6.04

Individuals and families 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 individual or family.

ICHH 6.05

The care coordinator supports smooth transitions between care settings by:

a. coordinating information sharing and service provision with providers and the person;
b. developing, or supporting the development of, a comprehensive discharge or transition plan with steps for follow-up;
c. providing expedited discharge planning and follow-up when suicide or overdose risks are present; and
d. facilitating face-to-face interactions between providers, whenever possible.

Examples: *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.*

Examples: *Admission-Discharge Transfer (ADT) systems embedded in electronic health records are an effective way to manage movement between healthcare facilities and ensure continuity of care and the efficient transfer of relevant health information between care providers.*

ICHH 6.06 (FP)

The organization:

a. conducts medication reconciliation and adherence; or
b. tracks that it is being done by another provider as part of their care coordination activities.

ICHH 6.07

Care coordination activities include

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

Examples: *Care coordination activities can also include sharing the results of screenings and diagnostic and laboratory testing.*

Integrated Care; Health Homes

ICHH 7: Health Promotion

Purpose

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

The organization ensures that individuals and their families have access to health information and resources that enable them to manage their chronic conditions, participate in shared decision-making regarding their care, and improve their overall health.

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 and training; or
- Active participation of persons served 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
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

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.

Table of Evidence

Self Study Evidence

No Self Study Evidence

Site Visit Evidence

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

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Individuals and families

- Observe system for tracking health data
- Review case records

ICHH 7.01

Health data for persons served is collected, aggregated, and analyzed to inform individual and organization-wide health promotion activities.
Examples: *Patient registries can be one effective method for collecting, organizing, and analyzing health data.*

ICHH 7.02

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

a. individual characteristics, abilities, and preferences; and
b. evidence-based or culturally-relevant, evidence-supported practices and concepts.

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ICHH 7.03

The organization offers individuals and families health education on topics relevant to their preferences and needs that will empower them to manage their chronic conditions, make informed decisions regarding their health, and promote wellness.
Examples: *Education topics can 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 7.04

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.