Integrated Health Home

Integrated Health Home (IHH) is built upon the evidence-based practices of the patient-centered medical home model. IHH builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including Addiction care) in keeping with the needs of persons with multiple chronic illnesses. IHH is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. IHH teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. IHH uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support.

IHH activities are focused in four areas:

1. **Care coordination and health promotion**

   Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised and updated as clients' needs change and advocate for client rights and preferences. In addition, collaborate with primary and specialty care providers as required and provide education about medical medications (e.g. educating through written materials, etc.). The Health Home team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with care plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include but are not limited to: smoking cessation; nutrition; increasing activity levels; relaxation strategies; and stress management.

2. **Chronic condition management and population management**

   The IHH team supports its consumers as they participate in managing the care they receive. Interventions provided under IHH may include, but are not limited to:

   - Assisting in the development of symptom self-management, communication skills and appropriate social networks to assist clients in gaining effective control over their psychiatric symptoms and their life situations, including minimizing social isolation and withdrawal brought on by mental illness, to increase client opportunities for leading a normal, socially integrated life;

- Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of chronic medical illness as advised by the client's primary/specialty medical team.

- Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of required services;

- Assisting the client in locating and effectively utilizing all necessary community services in the medical, social and psychiatric areas and ensuring that services provided in the mental health area are coordinated with those provided through physical health care professionals;

- Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage the symptoms of their psychiatric and medical issues to live in the community. This includes:

    - Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance; Social Services; Transportation and Legal advocacy).

    - Find housing which is safe, of good quality and an affordable place to live-apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating and procuring necessities (i.e. telephone, etc.).

    - Provide ongoing assessment, problem solving, side-by-side services, skill training, supervision (e.g. prompts, assignments, monitoring, and encouragement) and environmental adaption to assist support client to maintain housing).

    - Teach money-management skills (e.g. budgeting and bill paying) and assist client assessing financial services.

    - Develop skills related to reliable transportation (help obtain driver's license, use of mass transit, arrange for cabs.

    - Provide individual supportive therapy (e.g. problem solving, role playing, modeling and support), social skill development, and assertive training to increase client 's social and interpersonal activities in community settings) e.g. Plan, structure, and prompt social and leisure activities on evenings, weekends, and holidays, including side-by-side support and coaching.

- Assistance with other activities necessary to maintain personal and medical stability in a community setting and to assist the client to gain mastery over their psychiatric symptoms or medical conditions and disabilities in the context of daily living. For example:

- Support the client to consistently adhere to their medication regimens (e.g. daily scheduling, delivering and supervision of medication regime, telephone prompting, Motivational interviewing, etc.), especially for clients who are unable to engage due to symptom impairment issues.
- Accompanying clients to and assisting them at pharmacies to obtain medications.
- Accompany consumers to medical appointments, facilitating medical follow up.
- Provide side-by-side support and coaching to help clients socialize (e.g. going with a client to a baseball game, etc.) - structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support.

The IHH team will conduct the necessary analysis related to how well they are managing entire populations, based on measurable health outcomes and utilization. This information helps IHHs improve their care delivery system, to the benefit of each IHH clients receiving care.

3. Comprehensive transitional care

The IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The IHH team will communicate and ensure collaboration between consumers, professionals across sites of care and the Contractor's care management and utilization review staff potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

a. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.

b. Upon hospital discharge (phone calls or home visit):
   i. Ensure that reconciliation of pre-and post-hospitalization medication lists is completed.
   ii. Assist consumer to identify key questions or concerns.
   iii. Ensure Consumer understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent health problem becoming worse; has scheduled all follow- up appointments.
   iv. Prepare consumer for what to expect if another next level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).

v. The Contractor's care management and utilization review staff will work with the IHH team to review transition care goals, relevant transfer information (i.e. all scheduled follow-up appointments; any barriers preventing making appointments), function as resource to IHH consumers – to clarify all outstanding questions.

c. Identify and facilitate linkages between long-term care and home and community-based services.

4. Individual and Family support services

IHH team will provide practical help and support, advocacy, coordination, side-by-side individualized support with problem solving, direct assistance, helping clients to obtain medical and dental health care. Services include individualized psycho-education about the client's illness and the role of the family and their significant people in the therapeutic process. Also, to assist clients with children regarding service coordination (e.g. services to help client fulfill parenting responsibilities; services to help client restore relationship with children, etc.).

IHH peer support specialists will help IHH consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Peer support serves to validate clients' experiences, guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, offer peer support services to:

a. Help clients establish a link to primary health care and health promotion activities.

b. Assist clients in reducing high- risk behaviors and health risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise.

c. Assist clients in making behavioral changes leading to positive lifestyle improvement.

d. Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

Assessment
The CMHOs are expected to use a single, standardized assessment tool approved by the State. Assessments based on other tools will not be accepted.

<u>Assessment Frequency</u>

- An assessment will be administered at the time of initial engagement and every 6 months or more frequently when a significant change is identified.

- A reassessment with the standardized tool will be conducted within 48 hours of a discharge from a hospital or nursing home.

Plan of Care
A comprehensive Plan of Care must address behavioral health needs, medical and social needs with measurable, realistic and time sensitive goals. The following are required:

- Plan of care developed within thirty (30) days of completion of the assessment.
- Plan of care developed with and agreed to by the member or caregiver, or those chosen by the member to participate in the care plan. (verbal or written acceptance)
- Reviewed at least every 6 months and when a significant change is identified

Reporting
A complete listing of quality and monitoring measures is listed below. The State reserves the right to make modifications to required data elements and aggregate reports.

5. Assertive Community Treatment (ACT) and IHH Requirements

The requirements of ACT and IHH have several shared requirements but differ in the characteristics of the participants and the level of service intensity, as determined by the functional level score. ACT and IHH participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.

Service Requirements
Participants are outreached by members of the ACT Team continually to engage in care to the maximum extent necessary to achieve individual goals. If a member refuses care or declines participation for ninety (90) days, the CMHO must notify the Contractor to review the Care Plan.

Participants are outreached and engaged by members of the IHH Team over the course of each month. The IHH Team members must be flexible and available to meet more frequently when needed. The IHH Team Leader is available 24 hours/day 7 days a week if needed.

The ACT and IHH Teams provides or coordinates the following services:

• Crisis Stabilization Services 24/7
• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports
• Medication Management Medication administration, monitoring and reconciliation
• Individual, Group and Family Therapy
• Medical and Substance Use Treatment Coordination Activities
• Recovery and Rehabilitation Skills
• Substance Use Treatment (for ACT participants only)
• Supported Employment/Schooling Assessment and Assistance
• Care Transition – hospital, incarceration or nursing home to home
• Outreach and engagement
• Identification and engagement of natural supports and Social relationships
• Peer Support and IADL Support Services
• Education, Support, and Consultation to Clients' Families and Other Major Supports

A. Service Coordination/Care Management

Each client will be assigned a service coordinator (care manager) who coordinates and monitors the activities of the client's individual treatment team and the greater ACT/IHH team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client's needs change, and advocate for the client's wishes, rights, and preferences. The service coordinator is the first staff person called upon when the client is in crisis and is the primary support person and educator to the individual client's family. Members of the client's individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is unavailable. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

B. Crisis Stabilization

Crisis stabilization will be available and provided 24 hours per day, seven days per week. Crisis intervention response must be provided in a timely manner.

These services will include telephone and face-to-face contact. The Contractor will make available a current listing of all subcontractors engaged for this service.

A. Therapy

This will include but is not limited to the following:

1. Ongoing comprehensive assessment of the client's mental illness symptoms, accurate diagnosis, and response to treatment.
2. Individual and family Psychoeducation regarding mental illness and the effects and side effects of prescribed medications
3. Symptom-management efforts directed to help client identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
4. Individual, group and family supportive therapy
5. Psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to facilitate recovery.

B. Medication Prescription, Administration, Monitoring and Documentation

The ACT/IHH team psychiatrist or registered nurse will provide education about medication, benefits and risks, obtain informed consent and assess and document the

client's mental illness symptoms and behavior in response to medication. Team members will monitor and document medication side effects and provide supportive services. This clinical team will also assist the client with medication adherence strategies for all psychiatric and medical prescriptions.

C. Dual Diagnosis Substance Use Disorder Services

Provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance use, and has client-determined goals. This will be provided by an addiction specialist and include but is not be limited to individual and group interventions in:

1. Engagement (e.g., empathy, reflective listening, avoiding argumentation)

2. Assessment (e.g., stage of readiness to change, client-determined problem identification)

3. Motivational enhancement (e.g., developing discrepancies, psych education)

4. Active treatment (e.g., cognitive skills training, community reinforcement)

5. Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

D. Supportive Employment-Related Services

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with community-based employers. The principles of the evidence-based practice Individual Placement and Support (IPS) will be used to find employment. Services Include but are not limited to:

a. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.

b. Assessment of the effect of the client's mental illness on employment with identification of specific behaviors that interfere with the client's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.

c. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job.

d. Individual supportive counseling to assist clients to identify and cope with mental illness symptoms that may interfere with their work performance.

e. On-the-job or work-related crisis intervention.

f. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.

g. Job Development

h. On-site supports as needed

i. Coordination of supports through in collaboration with the Office of Rehabilitation Services (ORS)

j. Job coaching

E. Activities of Daily Living/ADL's

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist clients to gain or use the skills required to:

a. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, decorating; and procuring necessities such as telephones, furnishings, linens)

b. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry

c. Carry out personal hygiene and grooming tasks, as needed

d. Develop or improve money-management skills

e. Use available transportation

f. Have and effectively use a personal physician and dentist

F. Natural Supports and Social/Interpersonal Relationship Identification

Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support required to:

a. Improve communication skills, develop assertiveness, and increase self-esteem

b. Develop social skills, increase social experiences, and develop meaningful personal relationships

c. Plan appropriate and productive use of leisure time

d. Relate to landlords, neighbors, and others effectively

e. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

G. Peer Support Services

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, services to help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce clients' self- imposed stigma. Services include:

1. Peer counseling and support

2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery

H. Instrumental Activities of Daily Living Support Services (IADL)

Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not limited to:

1. Medical and Dental services

2. Safe, clean, affordable housing

3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance)

4. Social services

5. Transportation

6. Legal advocacy and representation

I. Education, Support, and Consultation to Clients' Families and Other Major Supports

Services provided regularly under this category to clients' families and other major supports with client agreement or consent, include:

1) Individualized psycho education about the client's illness and the role of the family and other significant people in the therapeutic process

2) Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people

3) Ongoing communication and collaboration, face-to-face and by telephone, between the ACT/IHH team and the family

4) Introduction and referral to family self-help programs and advocacy organizations that promote recovery

5) Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:

   a) Services to help clients throughout pregnancy and the birth of a child

   b) Services to help clients fulfill parenting responsibilities and coordinate services for the child/children

   c) Services to help clients restore relationships with children who are not in the client's care and custody

J. Care Transitions

The ACT/IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

1. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.

2. Upon hospital discharge (phone calls or home visit):

   - Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.

   - Assist consumer to identify key questions or concerns.

   - Ensure the client understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent worsening of health conditions and facilitate the scheduling of all follow-up appointments.

   - Review transition care goals with the team, provide relevant follow up and transfer information, function as resource to the client on all matters related to transition.

3. Identify and educate on linkages between primary and specialty medical care, behavioral healthcare, long-term care and home and community-based services.