LEVEL OF CARE GUIDELINES: INTEGRATED HEALTH HOME – UNITED HEALTHCARE PLAN OF THE RIVER VALLEY, INC.

Guideline Number: BH803IAIHH_032017 **Effective Date**: March, 2017

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Related Behavioral Clinical Policies & Guidelines:

- Optum Level of Care Guidelines

INTRODUCTION

The *Level of Care Guidelines* is a set of objective and evidence-based behavioral health criteria used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing[1] for behavioral health benefit plans that are managed by UnitedHealthcare Plan of the River Valley.

The *Level of Care Guidelines* is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The *Level of Care Guidelines* is also derived from input provided by clinical personnel, providers, profesisonal specialty societies, consumers, and regulators.

For more information on guiding principles for the *Level of Care Guidelines* and their development, approval, dissemination, and use, please see the *Introduction to the Level of Care Guidelines*, available at: www.providerexpress.com > Clinical Resources > Level of Care Guidelines.

Before using this guideline, please check the member's specific benefit plan requirements and any federal or state mandates, if applicable.

INTEGRATED HEALTH HOME

INTEGRATED HEALTH HOME IHH is an integrated and comprehensive form of healthcare delivery and coordination for adult members diagnosed with a Serious Mental Illness (SMI)[i] or for child/adolescent members diagnosed with a Serious Emotional Disturbance (SED)[ii] who may or may not be diagnosed with additional chronic conditions.

An Integrated Health Home (IHH) is comprised of a team of professionals including family and peers support working together to provide whole-person, patient-centered, coordinated care serving individuals .across all aspects of an

[1] The terms "recovery" and resiliency" are used throughout the Psychological and Neuropsychological Testing Guidelines. SAMHSA defines "recovery" as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA defines "resilience" as the ability to adapt well over time to life-changing situations and stressful conditions. The American Society of Addiction Medicine defines "recovery" as a process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety, and also refers to the overall goal of helping a patient to achieve overall health and well-being.

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individual's life, including coordination of physical health and success transitions from inpatient and other residential settings.

IHHs provide:
- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Support Services.

1. Admission Criteria
    - see "*Common Criteria and Best Practices for All Levels of Care*": **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**
      AND
    - The member is Medicaid eligible.
      AND
    - Adult members are diagnosed with a Serious Mental Illness (SMI)
        - SMI includes a diagnosis of psychotic disorders, Schizophrenia, Schizoaffective disorder, Bipolar disorder, Major Depression, delusional disorder, obsessive-compulsive disorder, or other serious mental health conditions that cause significant impairment in daily functioning; or
    - Children or youth members are diagnosed with a Serious Emotional Disturbance (SED)
        - SED includes a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of mental disorders (DSM) that results in a functional impairment. SED may co-occur with substance use disorders, learning disorder, or intellectual disorders that may be a focus of clinical attention.

      AND
    - IHH Providers are Iowa accredited community mental health centers, federally qualified health centers and child health specialty clinics staffed with physicians, nurse care coordinators, social workers, behavioral health professionals and peer/family peer support specialists.
      AND
    - The service team oversees the total care of the member from the point of access providing health prevention, health promotions, care coordination among providers, and referrals to needed community resources so that members and families do not have to navigate services on their own.
      AND
    - Integrated Health Homes are responsible for providing the following:
        - **Comprehensive Care Management**:

          This service is provided by IHH Nurse Case Managers.
            - Outreach activities to engage members.
            - Comprehensive whole person screening conducted for all members using medical and behavioral claims data, medical provider records and patient reporting within 90 days of reporting.
            - Assessment-driven whole person member profile development provided to inform local IHH provider.
            - At least monthly reporting of member gaps in case and predicted risks based on medical and behavioral claims data matched to Standard of Care Guidelines.
            - Predictive modeling reports generated through Medicaid data mining, identifying whole person risk information to be shared with IHH providers.
            - Regular report distribution to the local IHH provider teams using secure provider portal.
            - Oversight of care management plans that address the needs of the whole person. Care management plan based on information pulled from multiple sources.
            - Organize, authorize and administer joint treatment planning with local providers, members, families and other social supports to address total health needs of members.
            - Administration of online provider tools, including Health and Wellness Questionnaire to assess initial risk level, and Care Coordination Plan.
            - Information technology functionality developed to allow online receipt of standardized Continuity of Care document (CCD) for SPMI population.

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- Continuous claims-based monitoring of care to ensure evidence-based guidelines are being addressed with members and families.
- Serve as a communication hub facilitating the timely sharing of information across providers 24 hours a day, 7 days a week.
- Serve as an active team membership, monitoring and intervening on progress of treatment goals using holistic clinical expertise.

o **Coordination**:

This service is provided by IHH Nurse Care Coordinators and Social Worker Care Coordinators. Peer Support and Family Support Specialists may also assist with the following care coordination services: Follow-up monitoring, scheduling appointments, attending joint staffing treatment meetings, support coordination of care with providers and specialists.

MD/DO and Psychiatrists may also support Care Coordination activities by attending joint treatment meetings and consultation as needed.

- Outreach activities to members to engage in care coordination.
- Conduct individualized, comprehensive, whole person-centered assessments.
- Scheduling appointments.
- Making referrals.
- Tracking referrals and appointments.
- Follow-up monitoring.
- Communicating with providers on interventions/goals
- Conducting joint treatment staffings – meeting with multidisciplinary treatment team and member/parent/guardian to plan for treatment and coordination.
- Support coordination of care with primary care providers and specialists.

o **Health Promotion**:

These services are provided by IHH Nurse Case Managers or Social Work Care Coordinators.

- Promoting members' health and ensuring that all personal health goals are included in person-centered care management plans.
- Promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and increased physical activity.
- Providing health education to members and family members about preventing and managing conditions using evidence-based sources.
- Providing self-management support and development of self-management plans and/or relapse prevention plans so that members can attain personal health goals.
- Promote self-direction and skill development in the area of independent administering of medication and mediation adherence.
- Coordination of multiple systems for children with SED as a part of a child and family driven team process.
- Providing prevention educations to members and family members about health screening, childhood developmental assessments and immunizations standards.
- Wraparound planning process: identification, development and implementation of strengths-based individualized care plans addressing the needs of the whole child and family.

o **Comprehensive Transitional Care:**

IHH Nurse Care Coordinators or Social Work Care Coordinators will provide these services. MD/DO or Psychiatrists may also support transitional activities through consultation as needed and participating in the development of crisis plans. Peer and Family Support Specialists may assist with the following transitional services: Engage member and/or caretaker as an alternative to emergency care, participate in development of crisis plans, monitor for potential crisis escalation/need for intervention, follow-up phone calls and face to face visits with members/families after discharge from emergency room or hospital.

- Engage member and/or caretaker as an alternative to emergency room or hospital care.
- Participate in hospital discharge process.
- Perform medication reconciliation.
- Facilitate development of crisis plans.
- Monitor for potential crisis escalation/need for intervention.
- Follow up phone calls and face to face visits with members/families after discharge from the emergency room or hospital.
- Identification of linkage to long-term care and home and community-based services.

o **Individual and Family Support Services**:

- IHH Nurse Care Coordinators or Social Work Care Coordinators will provide these services. Peer and Family Support Specialists may assist with all of the below.

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- Providing assistance to members in accessing needed self-help and peer/family support services.
    - Advocacy for members and families.
      Family support services for members and their families.
    - Assisting members to identify and develop social support networks.
    - Support Medicaid adherence efforts.
    - Identifying community resources that will help members and their families reduce barriers to their highest level of health and success.
    - Linkage and support for community resources, insurance assistance, waiver services.
    - Connection to peer advocacy groups, family support networks, wellness centers, NAMI and family psychoeducational programs.
  - **Referral to Community and Social Support Services:**
    - IHH Nurse Care Coordinators, Social Work Care Coordinators, or Peer support or Family Support Specialist may provide these services.
    - Provide resource referrals or coordinate to the following as needed:
    - Primary care providers and specialists
    - Wellness programs, including tobacco cessation, fitness, nutrition or weight management programs, and exercise facilities or classes.
    - Specialized support groups.
    - School supports.
    - Substance treatment links in addition to treatment supporting recovery with links to support groups, recovery coaches, and 12-step programs.
    - Housing services
    - Transportation services
    - Programs that assist members in their social integration and social skill building.
    - Faith-based organizations.
    - Employment and educational programs or training.
    - Volunteer opportunities.

2. Continued Service Criteria
   - see "*Common Criteria and Best Practices for All Levels of Care*": **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**
     AND
   - The member continues to be eligible and is participating in IHH services outlined in the person-centered service plan.

3. Discharge Criteria
   - see "*Common Criteria and Best Practices for All Levels of Care*": **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**
     AND
   - The member moves outside the geographic area of the IHH's responsibility.

4. Clinical Best Practices
   - see "*Common Criteria and Best Practices for All Levels of Care*": **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**

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2. Commission on Accreditation of Rehabilitation Facilities. (2015). Behavioral health standards manual. Tucson, AZ: CARF International.
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*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines and in the related Behavioral Clinical Policy

HISTORY/REVISION INFORMATION

Date	Action/Description
March, 2016	• Version 1
March, 2017	• Version 2

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[i] An adult with a Serious Mental Illness (SMI) – SMI includes a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, major depression or other serious mental health conditions that cause significant impairment in daily functioning or

[ii] A child or youth with a Serious Emotional Disturbance (SED) – SED includes a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of mental disorders (DSM) that results in a functional impairment.

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