**Integrated Care (IC)**

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

# Definition

Integrated care is the systematic coordination of behavioral health, physical health, and social care in order 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 that is located on-site, or establishing written agreements with a primary care provider that is located in the community.

Two common models for providing integrated care include 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 and the Certified Community Behavioral Health Clinic (CCBHC), which was established by the Protecting Access to Medicare Act (PAMA) to provide comprehensive and coordinated care for mental health and substance use 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 making linkages 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.

The CCBHC provides low barrier, comprehensive, person- or family-centered mental health and substance use services to people of all ages. Through the coordination of behavioral health, physical health, and social care, CCBHCs promote whole-person wellness and recovery. CCBHCs serve anyone who requests care and include the following services:

1. crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention, and crisis stabilization;
2. [screening, assessment, and diagnosis including risk assessment](https://www.samhsa.gov/certified-community-behavioral-health-clinics" \t "_blank);
3. [patient-centered treatment planning or similar processes, including risk assessment and crisis planning](https://www.samhsa.gov/certified-community-behavioral-health-clinics" \t "_blank);
4. [outpatient mental health and substance use services](https://www.samhsa.gov/certified-community-behavioral-health-clinics" \t "_blank);
5. [outpatient clinic primary care screening and monitoring of key health indicators and health risk](https://www.samhsa.gov/certified-community-behavioral-health-clinics" \t "_blank);
6. [targeted case management](https://www.samhsa.gov/certified-community-behavioral-health-clinics" \t "_blank);
7. [psychiatric rehabilitation services](https://www.samhsa.gov/certified-community-behavioral-health-clinics" \t "_blank);
8. [peer support, counselor services, and family support services](https://www.samhsa.gov/certified-community-behavioral-health-clinics" \t "_blank); and
9. [intensive community-based mental health care for members of the armed forces and veterans](https://www.samhsa.gov/certified-community-behavioral-health-clinics" \t "_blank).

**Note:** Certified Community Behavioral Health Clinics (CCBHCs) will complete all applicable standards in IC 3 and IC 6. CCBHCs will also be assigned Mental Health and Substance Use Services (MHSU). Additional Service Standards may be assigned based on which of the nine CCBHC core services the organization is providing directly.

**Note:** *Throughout the IC standards, family involvement has been emphasized due to the significant impact family engagement can have 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 as well as the needs of the child.*

**Note:** *Please see [IC Reference List](https://socialcurrent.my.salesforce.com/sfc/p/" \l "300000000aAU/a/500000000Goj/TQMIoA8fvtbH3MhGRtOmf1i8qchAeYtMq6r2r7RMMXs" \t "_blank) 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*](https://socialcurrent.my.salesforce.com/sfc/p/#300000000aAU/a/1T000000gAQo/4McEh9wCB2Hfae69g6xaGGNMyvsYipLaO9kLrtPdaY0)*.*

# IC 1: Person-Centered Logic Model

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*](https://socialcurrent.my.salesforce.com/sfc/p/#300000000aAU/a/1T000000p05H/XvrhmC.bjHkrW7CtebqzH4NAYG5lQJsWNP.f90tIpYE) *Template for additional guidance on this standard.*

**NA** The organization’s only Integrated Care (IC) program is a Certified Community Behavioral Health Clinic (CCBHC), which is also assigned Mental Health and/or Substance Use Services (MHSU).

| Self-Study Evidence | On-Site Evidence | On-Site Activities |
| --- | --- | --- |
| * See program description completed during intake * Program logic model that includes a list of outcomes being measured | *No On-Site Evidence* | * Interviews may include:   1. Program director   2. Relevant personnel |

## IC 1.01

A program logic model, or equivalent framework, identifies:

1. needs the program will address;
2. available human, financial, organizational, and community resources (i.e. inputs);
3. program activities intended to bring about desired results;
4. program outputs (i.e. the size and scope of services delivered);
5. desired outcomes (i.e. the changes you expect to see in individuals and families); and
6. 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 Tool Kit](https://socialcurrent.my.salesforce.com/sfc/p/300000000aAU/a/Hs000001YYFm/vR2IBCXq.3fM5.t1dPugKLoIeeYxxmLHp8xwYtWessk) 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.*

## IC 1.02

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

1. change in clinical status;
2. change in functional status;
3. health, welfare, and safety;
4. permanency of life situation;
5. quality of life;
6. achievement of individual service goals;
7. access to needed health and social care services;
8. treatment adherence and self-management of chronic conditions; and
9. 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).*

# IC 2: Personnel

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.*

**NA** The organization’s only Integrated Care (IC) program is a Certified Community Behavioral Health Clinic (CCBHC), which is also assigned Mental Health and/or Substance Use Services (MHSU).

| Self-Study Evidence | On-Site Evidence | On-Site Activities |
| --- | --- | --- |
| * 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 * Table of contents of training curricula * Procedures or other documentation relevant to continuity of care and case assignment | * 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 | * Interviews may include:   1. Program director   2. Relevant personnel * Review personnel files |

## IC 2.01

Personnel are trained on, or demonstrate competency in:

1. effectively communicating and coordinating care across disciplines, systems, and services;
2. applicable evidence-based or culturally-relevant, evidence-supported practices;
3. physical health issues and social factors commonly associated with mental health or substance use conditions;
4. health conditions and treatment responses particular to the service population;
5. chronic disease management, including promoting self-management;
6. developing person- or family-centered, recovery-oriented care plans; and
7. using health information technology to link services and facilitate collaboration among providers, the person, and their family.

## IC 2.02

The organization promotes stability and service continuity by:

1. assigning the care planning team at intake or early in the contact; and
2. minimizing the number of workers assigned to the individual or family over the course of their contact with the organization.

## IC 2.03

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 assessed level of needs of individuals and families.*

# IC 3: Administrative Practices

The organization's administrative practices support effective care integration.

| Self-Study Evidence | On-Site Evidence | On-Site Activities |
| --- | --- | --- |
| * Procedures that outline appropriate terminology and concepts to use for documentation | * Copies of informational materials provided to individuals and families and other stakeholders | * Interviews may include:   1. Program director   2. Relevant personnel   3. Individuals and families * Review case records * Observe health information technologies |

## IC 3.01

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

## FP[[1]](#footnote-2) IC 3.02

The organization clearly defines for its stakeholders:

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

**CCBHC Interpretation:** CCBHCs should consider any designated collaborating organizations (DCOs) providing CCBHC core services on their behalf when responding to this standard.

## IC 3.03

The organization uses health information technologies to:

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

# IC 4: Intake and Assessment

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

**NA** The organization’s only Integrated Care (IC) program is a Certified Community Behavioral Health Clinic (CCBHC), which is also assigned Mental Health and/or Substance Use Services (MHSU).

| Self-Study Evidence | On-Site Evidence | On-Site Activities |
| --- | --- | --- |
| * Screening and intake procedures * Assessment procedures * Copy of assessment tool(s) * Procedures for referring individuals to specialized screenings, assessments, or tests when needed | * Community resource and referral list | * Interviews may include:   1. Program director   2. Relevant personnel   3. Individuals and families * Review case records |

## IC 4.01

Individuals and families served are screened and informed about:

1. how well their request matches the organization’s services; and
2. what services will be available and when.

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

## FP IC 4.02

Prompt, responsive intake practices:

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

## IC 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*](https://socialcurrent.my.salesforce.com/sfc/p/300000000aAU/a/Hs000001M7SW/5dwGmVulIkgXQ3wrzy1mV.XWElVfkW2TqZJ0H5GyDUc) *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.*

## IC 4.04

Assessments are conducted using a standardized assessment tool to identify:

1. 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;
2. the person's behavioral health, physical health, and social care needs and goals;
3. history of trauma;
4. risk of suicide, self-injury, withdrawal or overdose, neglect, exploitation, and violence towards others;
5. individual and family values, preferences, strengths, risks, and protective factors; and
6. 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.*

## IC 4.05

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

1. medical and/or clinical case records;
2. the results of screening tools; and

relevant content from assessments. **Examples:** *Organizations can review information from partnering or referring providers to identify, for example:*

1. *gaps in information;*
2. *out-of-date information; and*
3. *information that can be used to minimize duplication of effort and reduce the number of times individuals and families need to repeat their history.*

## IC 4.06

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

# IC 5: Care Planning and Monitoring

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.

**NA** The organization’s only Integrated Care (IC) program is a Certified Community Behavioral Health Clinic (CCBHC), which is also assigned Mental Health and/or Substance Use Services (MHSU).

| Elf-Study Evidence | On-Site Evidence | On-Site Activities |
| --- | --- | --- |
| * Service planning and monitoring procedures | *No On-Site Evidence* | * Interviews may include:   1. Program director   2. Relevant personnel   3. Individuals and families * Review case records |

## IC 5.01

An assessment-based care plan is developed in a timely manner with the full participation of individuals and families and includes:

1. the person's behavioral health, physical health, and social care needs and goals, including those related to social factors impacting their overall health and wellbeing;
2. steps for working toward achievement of desired goals including timeframes where appropriate;
3. services and supports to be provided, and by whom;
4. agreed upon timelines for conducting regular case reviews; and
5. 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 make their own decisions regarding what services and supports will be provided and by whom.*

## FP IC 5.02

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

1. is individualized and centered around strengths;
2. identifies individualized warning signs of a crisis;
3. identifies coping strategies and sources of support that can be implemented during a suicidal crisis, as appropriate;
4. specifies interventions that may or may not be implemented to help the individual or family de-escalate and promote stabilization; and
5. 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 feelings in order 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 in accordance with 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.*

## IC 5.03

The care planning team partners with the individual or family to actively review their case and:

1. determine continued accuracy of the assessment;
2. assess care plan implementation;
3. evaluate the person’s continued engagement in their treatment;
4. review progress toward achieving goals and desired outcomes; and
5. determine the continuing appropriateness of agreed upon service goals.

## IC 5.04

Case reviews follow established timeframes that:

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

# **Interpretation:** 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. IC 6: Care Coordination

The care planning team collaborates with individuals and families to coordinate and monitor needed behavioral health, physical health, and social care 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.*

| Self-Study Evidence | On-Site Evidence | On-Site Activities |
| --- | --- | --- |
| * Care coordination procedures * Care transition procedures * Procedures for conducting or tracking medication reconciliation and adherence | * 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 | * Interviews may include:   1. Program director   2. Relevant personnel   3. Individuals and families * Review case records |

## FP IC 6.01

The care planning team includes at a minimum:

1. a designated care coordinator with qualifications appropriate to the needs of the identified service population;
2. a primary care professional such as a physician’s assistant or nurse practitioner with access to a physician for needed consultation;
3. a behavioral health professional such as a social worker, psychologist, or other licensed clinician with access to a psychiatrist for needed consultation;
4. the individual or family, and
5. other providers and supports based on the needs and preferences of the individual.

**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.*

***NA*** *The organization’s only Integrated Care (IC) program is a Certified Community Behavioral Health Clinic (CCBHC).*

**Interpretation:** *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:** *Supports that may 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 and preferences of the individual.*

## IC 6.02

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

**NA** The organization’s only Integrated Care (IC) program is a Certified Community Behavioral Health Clinic (CCBHC).

## IC 6.03

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

1. establishing partnerships and coordination procedures with direct service providers in the community;
2. establishing communication procedures with individuals and families and across disciplines, both internally and externally;
3. maintaining a comprehensive, up-to-date referral list;
4. removing barriers to the initiation of needed services including taking advantage of telehealth services to increase access to needed specialists and establishing procedures for providing a warm hand off whenever possible when linking the individual to needed services; and
5. 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 social care services;*
7. *peer support services; and*
8. *long-term care supports and services.*

**CCBHC Interpretation:** Additionally, CCBHCs are required to have formal partnerships and care coordination procedures with the following direct service providers in the community:

1. primary care providers that are not affiliated with the CCBHC, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and other primary care providers;
2. acute care hospitals and their affiliated facilities or departments, including emergency departments;
3. psychiatric facilities, including state psychiatric hospitals, private psychiatric hospitals, and psychiatric units within general hospitals;
4. residential substance use treatment facilities, including withdrawal management and detoxification services;
5. residential mental health treatment facilities, including crisis stabilization units, psychiatric residential treatment facilities, and other residential treatment facilities;
6. school-based mental health and substance use services, including school counselors, psychologists, social workers, and nurses;
7. social service providers, including child welfare agencies, juvenile justice programs, housing and homeless services, employment services, and peer support and recovery services;
8. Veterans Affairs medical centers and other veterans’ health care providers;
9. specialty mental health and substance use providers, including providers of medication-assisted treatment, assertive community treatment, mobile crisis teams, and peer specialists;
10. providers of services for individuals with intellectual and developmental disabilities, including developmental disability agencies, intermediate care facilities, and supported living programs;
11. providers of services for older adults, including Area Agencies on Aging, senior centers, and home health agencies;
12. providers of services for individuals who are deaf or hard of hearing, including sign language interpreters, captioning services, and assistive technology;
13. providers of services for individuals who are blind or have low vision, including orientation and mobility specialists, vision rehabilitation therapists, and assistive technology;
14. providers of services for individuals with physical disabilities, including physical therapists, occupational therapists, and speech-language pathologists;
15. providers of services for individuals with co-occurring chronic physical health conditions, including diabetes educators, nutritionists, and pain management specialists;
16. providers of services for individuals with co-occurring infectious diseases, including HIV/AIDS, hepatitis C, and tuberculosis;
17. providers of services for individuals with co-occurring oral health conditions, including dentists, dental hygienists, and oral surgeons; and
18. providers of services for individuals with co-occurring traumatic brain injuries, including neurologists, neuropsychologists, and rehabilitation specialists.

## IC 6.04

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

1. ensure the service was received;
2. identify any needed follow-up; and
3. make needed changes to the care plan in partnership with the individual or family.

## IC 6.05

The care coordinator supports smooth transitions between care settings by:

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

**CCBHC Interpretation:** In regard to element a, CCBHC’s must have systems in place for tracking when people served by the CCBHC are admitted to or discharged from partnering facilities and document reasonable attempts to contact anyone who is discharged from inpatient acute-care hospital services/facilities (e.g. emergency departments, residential crisis settings, urgent care clinics) within 24 hours of discharge.

**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.*

## FP IC 6.06

The organization:

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

# IC 7: Health Promotion

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.

**NA** The organization’s only Integrated Care (IC) program is a Certified Community Behavioral Health Clinic (CCBHC).

| Self-Study Evidence | On-Site Evidence | On-Site Activities |
| --- | --- | --- |
| *No Self-Study Evidence* | * 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 | * Interviews may include:   1. Program director   2. Relevant personnel   3. Individuals and families * Observe system for tracking health data * Review case records |

## IC 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.*

## IC 7.02

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

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

## IC 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.*

## IC 7.04

Services promote self-advocacy and independence by:

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

1. Standards with an FP designation are fundamental practice standards.  These standards prioritize client rights, health and safety, or organizational effectiveness and must be implemented in order to achieve accreditation.   [↑](#footnote-ref-2)