Pediatric Integrated Health Home Program

- The Pediatric Integrated Health Home (P-IHH) Program provides care coordination and family support services to children and youth with mental health challenges and their families.
- This program serves children and youth who are Medicaid members *and* have a Severe Emotional Disorder (SED) that impacts their lives in school, in the community, or at home.
- The P-IHH is not a building or place of residence. It's an approach to care that provides families with a team of professionals that work together to meet the needs of children and youth.

Vision

The vision of the P-IHH Program is that all children in Iowa have access to an integrated system of coordinated services and supports, in their communities that they need to successfully reach their optimal potential.

This program is based on System of Care (SOC) principles, assuring that all services and supports are:

- Child-centered, family focused, and family-driven
- Community-based
- Culturally competent and responsive

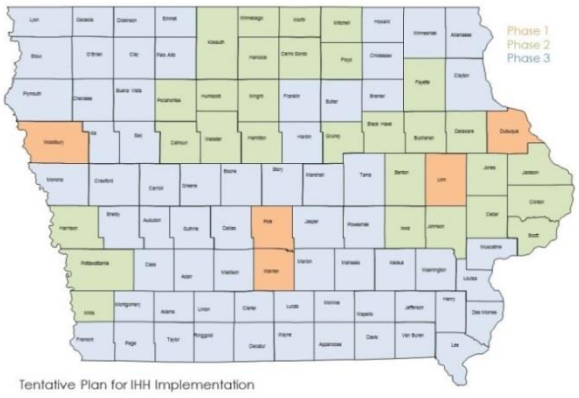
The P-IHH program activities are strengths-based and individualized, building on each family's informal and natural supports while connecting them to available community resources.

"This program is doing wonders for one of the families I've been working with. If it wasn't for you, I don't think they would have come this far or been able to get their kids back" – DHS Worker

Statewide Implementation

This program will be implemented throughout Iowa in three different phases (see map below). Phase 1 began on July 1, 2013; Phase 2 is scheduled to begin April 1, 2014; and Phase 3 is scheduled to begin July 1, 2014. Pediatric Integrated Health Homes were created as part of the Affordable Care Act. In Iowa, this means that 10 times more children will be eligible for reimbursable care coordination services.

"Thank you, I just hope my son and I can finally get the help from someone that gets it."
- P-IHH Parent



Tentative Plan for IHH Implementation

Technical Assistance

The University of Iowa Center for Child Health Improvement and Innovation (CCHII) is providing Technical Assistance (TA) training and Quality Improvement Coaching to P-IHH provider agencies throughout Iowa. TA activities include conducting practice readiness assessments and providing training for new and existing staff on topics such as family driven care, SOC values and principles, quality improvement, integrated health, wraparound planning and care coordination processes.

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Getting Better All the Time

THE UNIVERSITY OF IOWA
Center for Child Health Improvement & Innovation

9/2013

Staff of the Integrated Health Home program work in teams. Members of the **Community Child Health Team** include a Registered Nurse, a Family Peer Support Specialist and a Care Coordinator who help children and families develop strategies and find local resources that will help them reach their optimal potential. See what people are saying about the program below:

Family Peer Support Specialists	•One of our peer support staff attended a court hearing with a mom during which tensions were so high that the mom was in jeopardy of being arrested. The Family Peer Support Specialist was able to take the mom aside and help her understand that her behavior was inappropriate and could result in further complications for her family. Mom was able to return to the courtroom calm and actively participated in the proceeding.
Care Coordinators	•Our team was able to help a single mother and her four sons transition to a new home after being homeless for almost eight months. They had no furniture or beds, only blankets and pillows to sleep on the floor. We were able to provide them with resources to start living comfortably again. Now that their basic needs are being met, we can help this family access therapy and other services to address the boys' mental health needs.
Registered Nurses	•We have been working with the family of a 10 year-old girl diagnosed with ADHD , ODD and asthma. Our staff have arranged for outpatient and BHIS services and provided peer support for mom. The nurse helped mom and daughter develop an asthma action plan as she was having frequent asthma attacks. A home visit was made to help identify asthma triggers which has led to better medication adherance and control of the asthma. The family has avoided emergency room visits.
Family Peer Support Specialists	•We have encountered families with no diapers for their baby, others with no food, and one family who could not afford clothes for their children. Our staff were able to connect these families to community-based services and supports to fill some of their basic needs. We have helped one family avoid having their utilities shut off.
Care Coordinators	•We connected with a mom who was too nervous to make appointments for her child because she felt the health care providers would "shame" her. We have been working with this family for six weeks, initially attending appointments with her until she felt comfortable going on her own.
Registered Nurses	•A ten year old boy diagnosed with Autism, ADHD, Degenerative Hearing Loss, Cerebral Palsy and PICA was not getting the proper supports at school. We convened a meeting at school, and described the difference between IEP and 504 plans. Mom felt strongly that an IEP was the most appropriate for her child given her child's health concerns. Due to her advocacy for her son, the school district is in the process of conducting a formal evaluation for an IEP.