

## **Primary Care Provider Core Services**

CMS requires that all Health Homes provide the following Core Services. States have the ability to define what each of the Core Services is and who will perform the role within the Health Home. The South Dakota Health Homes Core Services are defined as follows:

### **1. Comprehensive Care Management**

Comprehensive Care Management is the **development** of an individualized care plan developed by the designated provider with active participation from the recipient and all health care team members. As part of developing each recipient's individual care plan, the health home will use a standardized tool to conduct an assessment. Each recipient will be screened for both mental health and substance abuse issues. Issues identified during the assessment will be incorporated into the care plan which is documented in the EHR. The designated provider is responsible for providing for all of the recipient's health care needs or taking responsibility for appropriately arranging care (monitoring, arranging, and evaluating appropriate evidence based and/or evidence informed preventive services) with other qualified professionals. The designated provider should provide same day appointments, timely clinical advice by telephone during office hours, and document clinical advice in the medical record. Comprehensive care management services may include but are not limited to the following:

- a. Designated provider uses clinical information and claims history to assess potential level of participation in care management services;
- b. Designated provider assesses preliminary service needs including behavioral health; develops a treatment plan, which will include recipient's goals, preferences and optimal clinical outcomes;
- c. Care Coordinator monitors individual and population health status and service use to determine adherence to or variance from treatment plan;
- d. Care Coordinator develops and disseminates reports that indicate progress toward meeting outcomes for recipient satisfaction, health status, service delivery and costs; and
- e. Care Coordinator provides education to recipients on how to access care during office hours, appropriate utilization of urgent care and emergency room visits, specialty services and support services.

### **2. Care Coordination**

Care coordination is the **implementation** of an individualized care plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports. The Health Home Care Coordinator in collaboration with the designated provider and the other applicable members of the health team is responsible for the management of the recipient's overall care plan. The Health Home should share key clinical information (problem list, medication list, allergies, and diagnostic test results) with other providers involved in the care of recipients. If a recipient is being served in the primary care setting and has behavioral health needs, the care management team will ensure that a behavioral health provider is part of the team. Vice versa if a recipient with a severe mental illness has co morbid physical conditions the care management team will ensure that a primary care provider is part of the team. DSS will use its staff nurses to conduct a random sample of case reviews to monitor that care coordination is being provided. Specific activities may include, but are not limited to the following:

- a. Care Coordinator monitors and evaluates the recipient's continuing needs, including health maintenance, prevention and wellness, long term care services and supports;
- b. Care Coordinator coordinates and/or arranges services for the recipient;
- c. Care Coordinator conducts referrals and follow-up monitoring;
- d. Care Coordinator supports the recipient's compliance with treatment recommendations;
- e. Care Coordinator participates in hospital discharges and home visits; and
- f. Designated provider and Care Coordinator communicate with other providers and recipient/family members.

### 3. Health Promotion

Health promotion services **encourage and support** healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self-manage their health. The Health Home care manager or health coach will provide health promotion activities. Specific activities may include, but are not limited to the following:

- a. Care Coordinator provides health education to recipients and their family members specific to the recipient's chronic and/or behavioral health conditions;
- b. Care Coordinator develops disease specific self-management plans;
- c. Care Coordinator provides education regarding the importance of immunizations and screenings, child physical and emotional development; and
- d. Care Coordinator promotes healthy lifestyle interventions for substance use and prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity

### 4. Comprehensive Transitional Care (including appropriate follow up from inpatient to other settings)

Comprehensive transitional care services are a **process** to connect the designated provider team and the recipient to needed services available in the community. A defined member of the designated provider care team has overall responsibility and accountability for coordinating all aspects of transitional care including transitions to home, long term care, rehab and other settings. The Health Home will be responsible for working with settings to ensure this information is being provided to the Health Home. At the time that HIE becomes operational, HIE will be used to make this notification. A follow-up contact will be required within **72** hours. Specific activities may include, but are not limited to the following:

- a. Care Coordinator facilitates interdisciplinary collaboration among providers during transitions;
- b. Designated provider encourages the PCP's, recipients and family/caregivers to play a central and active role in the formation and execution of the care plan;
- c. Care Coordinator provides comprehensive transitional care activities, including, whenever possible, participating in discharge planning;
- d. Care Coordinator collaborates with physicians, nurses, mental health professional, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing the recipient's and family members' ability to manage care and live safely in the community; and

e. Care Coordinator shifts the use of reactive care and treatment to proactive health promotion and self-management.

**5. Individual and Family Support**

Recipient and family **support services** reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes. A defined member of the designated provider care team is responsible for engaging and educating the recipient/family about implementing the care plan using methods that are educationally and culturally appropriate. This includes assessing the barriers to care and working with the recipient/family to overcome barriers such as medication adherence, transportation and keeping appointments. Specific activities may include, but are not limited to the following:

- a. Care Coordinator advocates for recipients and families;
- b. Care Coordinator identifies resources for recipients to support them in attaining their highest level of health and functionality in their families and in the community;
- c. Care Coordinator coordinates transportation to medically necessary services; and
- d. Designated provider or Care Coordinator provides information on advance directives in order to allow recipients/families to make informed decisions.
- f. Health Homes will provide information in a variety of ways including electronic, telephonic, in person, or group settings.

**6. Referrals to Community and Social Support Services**

Referrals to community and social support services **provide** recipients with referrals to a wide array of support services that help recipients overcome access or service barriers, increase self-management skills and improve overall health. The Health Home designated provider has responsibility for identifying available community-based resources and manages appropriate referrals. Specific activities may include, but are not limited to the following:

- a. Care Coordinator coordinates or provides access to recovery services and social health services available in the community (may include support groups, housing, personal need and legal services);
- b. Care Coordinator provides assistance to obtain and maintain eligibility for health care, disability benefits, etc;
- c. Care Coordinator supports effective collaboration with community based resources; and
- d. Care Coordinator and/or assess long-term care and other support services.