

Health Home Provider Standards

Under South Dakota's approach to Health Home implementation, a Health Home designated provider is the central point for directing patient centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up and improving patient outcomes by addressing primary medical, specialist, long term care, home health and behavioral health care needs through direct provision, or through arrangements with appropriate service providers of comprehensive integrated services. General qualifications are as follows:

- Health Home providers must be enrolled (or be eligible for enrollment) in the SD Medicaid program and agree to comply with all Medicaid program requirements, including those outlined in this HH Provider Standards document and the Health Home Core Services document.
- Health Home providers can either directly provide, or arrange for the provision of, Health Home services. The Health Home designated provider remains responsible for all program requirements.
- Health Home providers must have completed Electronic Health Record (EHR) implementation and use the EHR as its primary medical record solution, prior to becoming a Health Home provider.
- Health Home providers must electronically report to the State (in a manner defined by the Department of Social Services) information about how the Core Services are being met and the outcome measures.
- Health Home providers must work in concert with the South Dakota Department of Social Services, on an as needed basis, to evaluate and continually improve the South Dakota Health Home model as a means to achieve accessible, high quality care, and demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model.
- Health Home providers must comply with 42 CFR as it pertains to sharing data for patients with substance abuse disorders.
- Health Home providers must attend all required Health Home trainings.
- Health Home providers must provide the services as outlined in the Medicaid Directors letter SMDL 10-24 including
 - Provide quality driven, cost effective, culturally appropriate and person-and family center health home services;
 - Coordinate and provide access to high quality health care services informed by evidence based clinical practice guidelines;
 - Coordinate and provide access to preventive and health promotion services including prevention of mental illness and substance use disorders;
 - Coordinate and provide access to mental health and substance abuse services
 - Coordinate and provide access to comprehensive care management, care coordination and transitional care across settings. Transitional care includes appropriate follow-up from transfer from a pediatric to an adult system of health care
 - Coordinate and provide access to chronic disease management including self-management support to individuals and their families.

- Coordinate and provide access to individual and family supports including referral to community, social support and recovery services.
- Coordinate and provide access to long-term care supports and services
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices as feasible and appropriate

Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes and quality of care outcomes.