

Health Home 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. 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 to determine the level of participation in care management services;
- b. Designated provider assesses preliminary service needs; develops a treatment plan, which will include recipient's goals, preferences and optimal clinical outcomes;
- c. Health Home Care Manager monitors individual and population health status and service use to determine adherence to or variance from treatment plan;
- d. Health Home Health Coach develops and disseminates reports that indicate progress toward meeting outcomes for recipient satisfaction, health status, service delivery and costs; and
- e. Health Home Health Coach provides education to recipients on how to access care during office hours, appropriate utilization of both 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 manager or care management team is responsible for the management of the recipient's overall care plan. The Health Home should share key clinic information (problem list, medication list, allergies, diagnostic test results) with other providers involved in the care of recipients. Specific activities may include, but are not limited to the following:

- a. Health Home Health Coach monitors and evaluates the recipient's continuing needs, including health maintenance, prevention and wellness, long term care services and supports;
- b. Health Home Health Coach coordinates and/or arranges services for the recipient;
- c. Health Home Health Coach conducts referrals and follow-up monitoring;
- d. Health Home Health Coach supports the recipient's compliance with treatment recommendations;
- e. Health Home Care Manager participates in hospital discharges; and
- f. Designated provider and Health Home Care Manager 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. Health Home Health Coach provides health education to recipients and their family members specific to the recipient's chronic conditions;
- b. Health Home Health Coach develops disease specific self-management plans;
- c. Health Home Health Coach provides education regarding the importance of immunizations and screenings, child physical and emotional development; and
- d. Health Home Health Coach 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 within 72 hours from outpatient/inpatient to other settings including home)

Comprehensive transitional care services are the process to connect the designated provider team and the recipient to needed services available in the community and ensure that the recipient and family is able to successfully follow discharge instructions including securing needed medications and attending scheduled follow-up appointments. A defined member of the designated provider care team has overall responsibility and accountability for coordinating all aspects of transitional care. Specific activities may include, but are not limited to the following:

- a. Member of the team contacts the recipient within 72 hours after the discharge.
- b. Health Home Care Manager facilitates interdisciplinary collaboration among providers during transitions;
- c. 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;
- d. Health Home Care Manager provides comprehensive transitional care activities, including, whenever possible, participating in discharge planning;
- e. Health Home Care Manager collaborates with physicians, nurses, 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
- f. Health Home Health Coach 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. Health Home Health Coach advocates for recipients and families;
- b. Health Home Health Coach identifies resources for recipients to support them in attaining their highest level of health and functionality in their families and in the community;
- c. Health Home Health Coach coordinates transportation to medically necessary services; and
- d. Designated provider or Health Home Care Manager provide information on advance directives in order to allow recipients/families to make informed decisions.

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 manage appropriate referrals. Specific activities may include, but are not limited to the following:

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