Health Home Core Services

All Health Homes are required provide the following Core Services. The term "Care Coordinator" is used throughout. This term refers to the position that manages the Health Home Program in your clinic. The South Dakota Health Homes Core Services are defined as follows:

1. **Comprehensive Care Management**
   Comprehensive Care Management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral, specialty health care, and community support services. Comprehensive care management requires developing a comprehensive person-centered care plan which addresses all clinical and non-clinical needs. Examples:
   a. Conducting outreach activities to gather information from the recipient, the recipient's caregiver, and other primary and specialty care providers;
   b. Completing a comprehensive needs assessment which includes, behavioral health screenings such as depression and substance use, social determinants of health screening, and other screenings as determined necessary by the team.
   c. Developing a comprehensive person-centered care plan including individualized goals and action steps to achieve the goals.

2. **Care Coordination**
   Care coordination is the implementation of the person-centered care plan. The plan must be implemented through appropriate linkages, referrals, coordination, and follow-up to needed services and supports. Examples:
   a. Monitoring progress towards goals in the person-centered care plan;
   b. Coordinating with other healthcare providers;
   c. Assisting and supporting the recipient with scheduling health appointments with other healthcare providers;
   d. Supporting the recipient's compliance with treatment recommendations; and
   e. Communicating and consulting with other providers and recipient/caregiver as appropriate.

3. **Health Promotion**
   Health promotion services encourage and support healthy ideas and concepts. The intent of the service is to motivate recipients to adopt healthy behaviors and enable recipients to self-manage their health. The Care Coordinator will provide health promotion activities. Examples:
   a. Providing health education to recipients and their caregivers specific to the recipient's chronic conditions;
   b. Conducting medication reviews and regimen compliance;
   c. Teaching self-management skills; and
   d. Promoting 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**
   Comprehensive transitional care services are for individuals transitioning between levels of care and ensures the recipient/caregiver is supported during those transitions. This includes post-discharge education, follow-up appointments, and access to community resources. Examples:
   a. Contacting the recipient/caregiver within five business days after admission or discharge from the hospital or emergency department;
   b. Providing post-discharge contact with recipient/caregiver to ensure discharge orders are understood and action taken;
   c. Coordinating with the recipient/caregivers and providers to ensure smooth transitions to new settings; and
   b. Ensuring a follow-up visit with the primary care provider.

5. **Individual and Family Support**
   Recipient/caregiver or family support services reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes using methods that are educationally and culturally appropriate. This includes assessing the barriers to care and working with the recipient/caregiver/family to overcome barriers such as medication adherence, transportation, and keeping appointments. Examples:
   a. Providing education and guidance in support of self-advocacy;
   b. Identifying resources for recipient/caregiver/family to support the recipient in attaining their highest level of health and functionality in their families and in the community;
   c. Coordinating transportation for the recipient/caregiver/family to medically necessary services; and
   d. Helping recipient/caregiver to access long-term care and other support services.

6. **Referrals to Community and Social Support Services**
   Referral to community/social supports is providing information and assistance to refer the recipient/caregiver to community-based resources that support the needs identified on the recipient's person-centered care plan. Examples:
   a. Providing referral and information assistance to obtain community-based supports or social service supports (may include housing, personal need, and legal services);
   b. Providing assistance to recipient/caregiver to obtain and maintain eligibility for health care, disability benefits, etc.;
   c. Supporting effective collaboration with community-based resources; and
   d. Identifying resources to reduce barriers to help recipient in achieving their highest level of function and independence.