

BENEFITS OF A HEALTH HOME

The South Dakota State Employee Health Plan (SDSEHP) is rolling out a Health Home Pilot Program in Brookings, Pierre and Rapid City. Here is summary of the features and benefits of the Health Home which we ask you to review as you consider participating in the Pilot.

If you participate in the Health Home Pilot Program, you will receive an approach to health care that focuses on you and your needs. This personalized approach is designed to support you in achieving your healthcare goals, lessen the burdens of dealing with chronic health conditions and improve your overall well-being.

The providers who participate in this unique model of healthcare deliver the following “Core Services” to support you and your care team. Your care team is not only the medical professionals who work with you but those people in your life you designate as your “home team”. This is your team that you rely on for personal support and may be made up of family and/or friends. You can designate some of these people to receive information from the Health Home coordinators. You may experience any one or several of the following Core Services while you participate in this program. Following is a narrative summary of how these services function on your behalf.

1. Comprehensive Care Management:

This is an individualized care plan developed by your designated provider with active participation from you and all health care team members. As part of developing each individual care plan, the health home will use a standardized tool to conduct an assessment.

Your provider will assess your healthcare needs and goals. A treatment plan will be developed and discussed with you, your preferences, and optimal clinical goals will be reviewed. The provider will arrange any care that is necessary.

A Care Coordinator will monitor your health progress, provide education how to access care during office hours as well as appropriate utilization of after-hours care, and gauge your satisfaction with the program along the way.

2. Care Coordination

Care coordination is the **implementation** of your 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 your overall care plan.

This team will communicate about your progress and, if you have any acute events, all involved health team members will be notified to ensure your treatment is coordinated effectively. Follow-ups will occur to ensure compliance with treatment recommendations, hospital discharge instructions are understood and followed, any scheduled home visits are completed, and your “home team” support system of family and friends is included, as you permit.

3. Health Promotion

Health promotion activities **encourage and support** healthy ideas and concepts to motivate the adoption of healthy behaviors, enabling you to self-manage your 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 education specific to your needs
- b. Self-management plans
- c. Education on preventive services, physical and emotional development
- d. Healthy lifestyle interventions

All these promotional activities can be shared with those you have designated as part of your “home team” support system of family and friends.

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

This is a process to connect you and your designated provider team 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. This is much like having a healthcare concierge for complex, long-term care planning. The Care Coordinator will facilitate interdisciplinary collaboration among your providers during care transitions and include your “home team” support in forming and executing the care plan. These teams will participate whenever possible in discharge planning for successful transition from inpatient care to successful transition back to community living and, ultimately, back to the routine goals of health care and health promotion activities and goals.

5. Individual and Family Support

Sometimes having the right team to back you up is critical. This is where the interaction of your “home team” support system is vital. This important support network can reduce any barriers to care coordination when you are not at your best.

The health home will define a member of your provider care team to be responsible for engaging and educating your designated family and/or friend(s) on implementing your care plan. This coordination ensures you are taken care of in areas such as:

- Medication adherence
- Transportation for keeping your needed follow-up appointments
- Assisting in informed decision-making, such as long-term care or advanced directives, when warranted

These conversations take place in the most effective way for your team, whether that is one on one, a group, secure electronic communication, or by phone dictated by schedules and distance. These vital services are here to support you and your “home team”.

6. Referrals to Community and Social Support Services

When you or your “home team” need additional help, the Health Home will work to find supportive resources for you. Referrals to a wide array of community and social support services for assistance in increasing self-management skills or overcoming service barriers can be just the help that is needed. These services have a variety of purposes and levels including but not limited to: support groups, social health services, housing, personal need or legal services, disability benefits, or other community based resources to assist with your specific needs.