Appendix B-1
Example Health System Characteristics

This document is meant to provide potential applicant Integrated Health Partnerships (IHPs) with an example of what health system characteristics Department of Human Services (DHS) expects to be present in a health system that is meeting, or intends to meet, the requirement of providing or coordinating for the full scope of primary care services for its attributed IHP population.

This should be used by applicant IHPs in the following ways:

- To understand the expected characteristics of its participating clinics/providers that are not certified or recognized under the models listed in Section 6.1 System Requirements in the IHP RFP.
- To self-assess their ability to provide the scope of services as an IHP, to evaluate areas of potential growth and focus as an IHP.
- As a reference when answering the questions in the RFP Application (Appendix A of the IHP RFP), Section 5, Clinical Care Model, and Section 6, Quality Measurement.

1. **Primary Care Services:** All entities should be able to offer or have a partner entity offer a full array of primary care services, including:
    - Age and situationally appropriate medical screening (e.g. Child and Teen check-up)
    - Prevention services (e.g. programs to address pre-diabetes, vaccinations for age, preventative medical examinations)
    - Primary Care visits for acute condition (e.g. sick visits)
    - Primary Care visits for management of chronic conditions
    - Coordination of primary and specialty care

2. **Access to Care**
    - 24/7 access to a provider or medical triage staff that have access to medical triage information
    - Appropriate levels of same day and next day primary care availability
    - Culturally and linguistically appropriate service availability
    - Appropriate screening of recipients for health, behavioral health, and chemical dependency

3. **Registry**
    - Registry that includes at a minimum demographic, screening, diagnostic, procedural, pharmacy data that can be shared across IHP participating entities
    - The entity can document that the registry is used for coordination of care for recipients

4. **Care Planning/Care Coordination**
    - Dedicated care coordination for clinical and social service aspects of care
        - Care coordinator(s) must have dedicated time and appropriate caseloads to provide support and integrated care planning
    - Integration of medical/behavioral-substance use disorder (SUD)/social service community care coordination and planning via an established and ongoing process that assures case reviews at intervals determined by recipient need

- Transition Care Planning – Care plans address transitions of care where the primary coordination responsibility will be changed between relevant providers
    - Pediatric and adult providers
    - Inpatient and outpatient settings
- Development of care plans for patients meeting pre-specified criteria for this level of interventions
    - Care plans are developed with and shared with recipients and families where appropriate. Shared decision making is a document component of the care plans
- Child and Teen Checkups (C&TC) outreach- Informing eligible members/patients about the C&TC benefits they are eligible to receive, encouraging and assisting with accessing complete well-child visits in accordance with the C&TC periodicity schedule.