HEALTH HOME

Health Action Plan
Instructions

The Health Action Plan (HAP) is completed for each client upon assignment to a Care Coordination Organization (CCO) for the Health Home program. The HAP provides the documentation of the care plan developed by the Care Coordinator, the client, the parent, and/or their caregiver. The HAP is established for one assignment year with three columns representing a four month time period ranging from 120 to 123 days.

The Health Action Plan establishes:

a. Client identified goals (Long Term and Short Term);

b. Prioritized action steps for the client, their personal care worker or caregiver, collaterals, the Care Coordinator, and other health or social service care providers.

The Health Action Plan is updated and modified as needed by the Care Coordinator monthly with each contact, when necessary to support a care transition, and when a client opts-out of the Health Home program. The Health Action Plan is also updated and modified as needed according to:

a. A change in the client's condition;

b. New immediate goals to be addressed through the Health Home program; or

c. Resolution of goals or action steps.

Documentation of face-to-face client visits, collateral contacts, consultations, telephone calls, or provider visits are documented in the Care Coordination Organization's client file or medical record.

HAP FORM FIELDS FOR COMPLETION

Client's First Name: Enter the first name of the client.

Client's Last Name: Enter the last name of the client.

Gender: check the appropriate box. Check unknown until the gender of the client is known. Check other if the client does not identify as male or female, for example, identifies as transgender male to female or transgender female to male.

Date of Birth: Enter the client's date of birth.

ProviderOne Client ID: Enter the ProviderOne client identification number (9 digits followed by WA).

Health Home Lead Organization: Enter the name of the Lead Organization.

Health Home Lead Organization Telephone Number: Enter the number the client calls to talk with a Lead Organization client representative.

Care Coordination Organization: Enter the name of the Care Coordination Organization.

Care Coordinator's Name and Telephone Number: Enter the name of the Care Coordinator and their contact number.

Begin Date of HAP: Enter the date the Care Coordinator initiates the HAP. For the first year, the Initial HAP Begin Date and Opt-in Date are the same.

End Date of HAP: Enter the End Date when the Eight Month Update period ends. If the client leaves the program before the end of the 12 month cycle (i.e. dies or is no longer eligible) enter the date the client leaves the program. Do not enter an end date if the client remains enrolled and moves or changes their Lead Organization or CCO.

Date Opted In: Enter the date the client agrees to participate in the HAP, signs the consent form, and begins the development of the HAP with the Care Coordinator. This date becomes the client's anniversary date. It triggers the start of a new HAP for the next HAP reporting year.

Example Opt In date 2/1/2014

Reason for Closure of HAP: If applicable check the reason for closing the HAP (beneficiary opted out, moved to a county that does not have Health Home services, no longer eligible, or death). Enter an end date for the HAP.

Reason for Transfer of HAP: If applicable check the reason for transferring the HAP (client choice to change CCO or Lead Organization, or eligibility changed to or from fee-for-service or managed care). Do not enter an end date as the HAP is still in effect during the transfer.

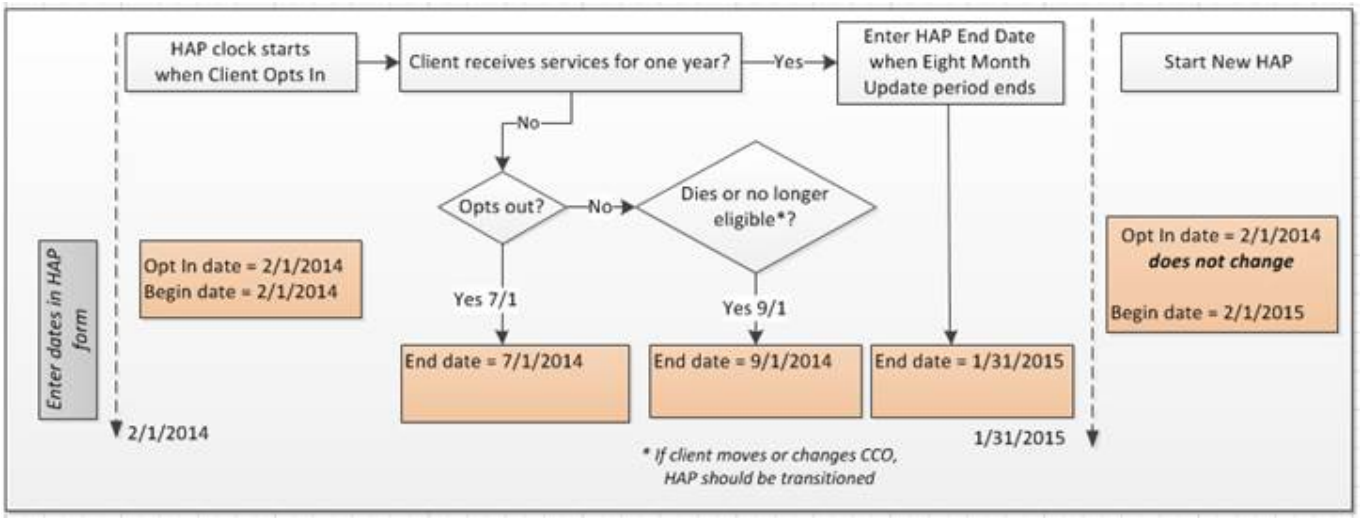
Client Introduction: Enter a brief introductory statement about the client. The introductory statement may include client preferences and demographics (e.g. call in the afternoon, monolingual Spanish, call caregiver, gender, ethnicity, and/or background) or any other significant information (e.g. the client lives alone, lives with daughter and grandchildren, or resides in a senior housing complex, etc.).

Client's Long Term Goal: Enter the client's long term goal for self. What would they like to happen as a result of their care? What would they like be able to do that they can't currently do? What is the most important thing they want to achieve related to their chronic disease? For example, client states, "I want to feel better", "I want to be able to travel to Florida for a family reunion next year", or "I want to see my grandchildren grow up." Connect the Long Term Goal with the Short Term Goal(s).

Diagnosis (Pertinent to the HAP): Enter the diagnosis(es) being addressed by the client and Care Coordinator. This list should only include the diagnoses being addressed by the HAP and may not reflect all of the client's diagnoses and health care needs. The list of diagnoses may need to be prioritized by the Care Coordinator and client for planned interventions. ICD-9 codes for the diagnoses are optional.

The HAP must be updated a minimum of once every four months. The form provides three columns for entry of the initial or annual HAP, the four month update, and the eight month update. At the completion of a year a new HAP is started on the anniversary date. Long term goals, short term goals, and action steps may be revised, deleted, or carried over to the next HAP period.

HAP Dates Flowchart



HAP Required Screenings: Mandatory screenings are determined by the client's age and may include the PAM, CAM, or PPAM, BMI, Katz ADL, and PHQ-9 or PSC-17. If the client, their caregiver, or parent is unable or declines to complete a required screening provide an explanation in the "if not complete / explain field." Do not enter zero for the score. If a screening was completed enter the date, the score, and activation level if indicated. Administer and report these mandatory screenings within each of the three HAP periods (Initial/Annual, Four Month Update, and Eight Month Update). For example: if the begin date is February 1st, administer the screenings in the Initial/Annual period between February 1st and May 31st, then again in the Four Month Update period between June 1st and September 30th, etc.

Patient Activation Measure Survey: A PAM, CAM, or PPAM must be entered for the client. The client's age determines if a PAM, CAM, or PPAM must be administered.

a. The PAM is required if the client is 18 year of age and over and a CAM has not been submitted. The PAM is not used for clients under 18 years of age.

b. The CAM is required if a PAM has not been submitted. It is optional if a PAM has been submitted. The CAM is not used if the client is less than 18 years of age.

c. The PPAM is required if the client is less than 18 years of age.

Score: Enter the activation score. The value range is 0.0 to 100.0.

Level: Enter the PAM, CAM, or PPAM activation level. The value range is Level 1 to Level 4.

Body Mass Index (BMI): Enter the client's actual BMI, the following links provide a BMI calculator. The value range is 0.0 to 125.9.

a. Adults (20 years and older): http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

b. Children and Teens (2-19 years): http://apps.nccd.cdc.gov/dnpabmi/

c. The BMI is neither used nor required for children less than two years of age and no value is accepted.

Katz Index of Independence in Activities of Daily Living: Enter the total number of points. The value range is 0 to 6. The Katz ADL screening is not administered to clients under the age of 18 years and no value is accepted.

PHQ-9 (Patient Health Questionnaire - Depression Screening): Enter the client's PHQ-9 score. This is required for clients 18 years of age and older. The value range is 0 to 27. Values for clients under age 18 will not be accepted.

PSC-17 (Pediatric Symptoms Checklist – 17): Enter the client's PSC-17 score. This is required for clients ages 4 through 17 years of age. The value range is 0 to 34.

Optional Screenings: Enter the date the screening was completed and the score. Optional screenings may include but are not limited to:

- DAST = Drug Abuse Screening: Enter the score. The accepted value range is 0 to 10.
- GAD-7 = Generalized Anxiety Disorder 7 item scale: Enter the score. The value range is 0 to 21.
- AUDIT = Alcohol Use Disorders Identification (age 14 and older): Enter the score. The value range is 0 to 40.
- Falls Risk: Enter the falls risk score. The value range is 0 to 11.
- Pain Scales: Enter the score and check the type of scale used (FLACC, Faces, or Numeric). The value range is 0 to 10.

Comments: For the paper form only, enter any comments or notes that relate to any of the fields above. For example, information shared by a caregiver or parent.

Short Term Goal: Enter the client identified goal(s). Goals should be specific, measurable, attainable, relevant, and time-based and must be mutually agreed upon. For example: "client wants to cut back on smoking over the next three months or by the end of the year"; "client wants to understand how to use her blood pressure medication by the end of January"; "client wants to be able to communicate with PCP and address questions and concerns at next medical appointment."

Goal Start Date: Enter the date the client chooses to begin working toward the stated short term goal.

Goal End Date: Enter the date of the resolution of a goal, if a client chooses to end a goal, or there is no further need for a specific goal.

Outcome: Check the applicable reason (completed, revised, no longer pertinent-life or health change, or client request to discontinue). Goals that will continue from one trimester to another should be copied and continued with modifications as needed for specific actions steps.

Action Steps: Enter the Care Coordinator and client identified action steps the client, the parent, the Care Coordinator, their personal care worker or other caregivers, or health care providers plan to take to achieve the client's Short Term Goal(s). The Care Coordinator will document planned client, coordinator, and other caregiver / provider steps on the HAP. These action steps should be established mutually with the client recognizing the client's abilities and readiness for change and teaching. (Refer to the PAM coaching guide for appropriate level of action steps for client to consider.)

For example the action step(s) for the above Goal(s) are:

a. Care Coordinator to attend PCP appointment with client to review treatment options for COPD.

b. Client and Care Coordinator will prepare list of questions to bring to the PCP appointment.

c. Review with client the "Your Guide to Lowering Blood Pressure" brochure to help client understand her medications.

d. The personal care worker will walk with the client in the hallway three times each week for ten minutes.

Start Date and Completion Date: Enter the date(s) for each Action Step.

Actual Care Coordinator interventions, telephone contacts, home visits, and the status of the client's progress towards achieving goals and action steps are documented in the client chart or medical record.