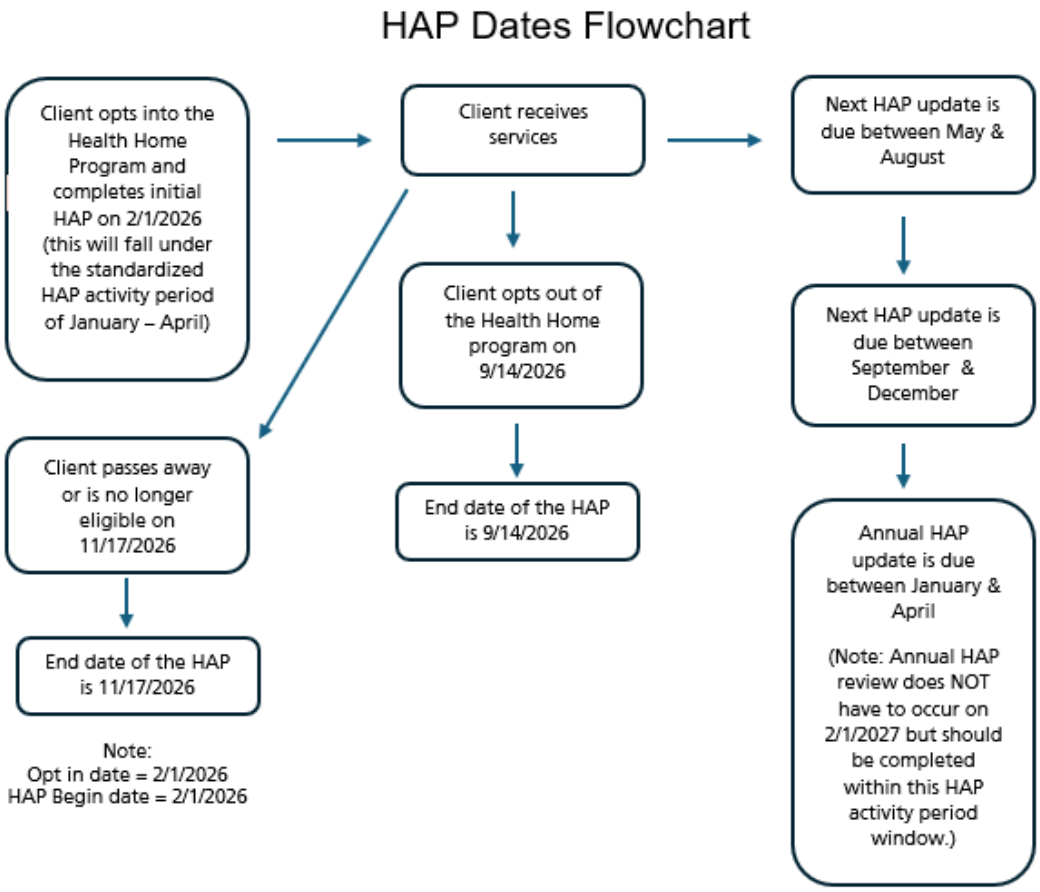
Health Home
Health Action Plan (HAP)
Instructions

Complete the Health Action Plan (HAP) for each client upon assignment to the Health Home program. The HAP provides documentation of the health plan developed by the Care Coordinator, the client, the family, the parent and/or their caregiver. The HAP is established for one assignment year with three columns representing a standardized HAP activity time period.

The HAP must be updated a minimum of once during each standardized activity period. The form provides three columns for entry of the first or annual HAP, the second HAP required screenings, and the third HAP required screenings. At the completion of the year a new HAP is started within the 1st activity period that the HAP was established. Long term / short term goal(s) and action steps may be revised, deleted or carried over to the next HAP activity period.



The HAP is updated by the Care Coordinator to address:

a. Outcomes of monthly contacts;
b. Changes in the client's condition;
c. Care transitions between settings;
d. Updated goals;
e. Resolution of goals or action steps; or
f. When a client opts out, dies or is no longer eligible for the program.

HAP Form Fields for Completion

The following are documented in the client's file or medical record: the client narrative, telephone calls, face-to-face visits, collateral contacts, consultations, referrals, interventions, visits to providers, etc.

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" only if the gender of the client is unknown. Check other if the client does not identify as either male or female, otherwise use male or female according to the client's self-identification

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.

HH 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 (CCO).

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

Date Opted In: Enter the date the client agrees to participate in the program.

Begin Date of HAP: Enter the date the Care Coordinator initiates the HAP.

End Date of HAP: Enter the End Date if the client leaves the program (e.g., is no longer eligible). Do not enter an end date if the client remains enrolled and moves or changes their Lead Organization or CCO.

Reason for Closure of the HAP: If applicable check the reason for closing the HAP (client opted out, no longer eligible, or death). Enter an end date for the HAP.

Reason for Transfer of the HAP: If applicable check the reason for transferring the HAP (client choice to change CCO or Lead Organization, or eligibility changed). 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) or any other significant information (e.g. the client's living arrangement).

Client's Long-Term Goal: Enter the client's person-centered long-term goal. What would they like to happen as a result of their care? What would they like to 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 diagnoses being addressed. 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.

HAP Required Screenings: Administer and report these mandatory screenings within each of the three HAP activity periods (January – April, May – August, and September - December). For example: if the begin date is February 1st, administer the screenings in the 1st activity period of January – April, then again in the 2nd activity period May – August and the 3rd activity period of September – December. If a screening was completed enter the date, the score and activation level if indicated. If the client, their caregiver, or parent is unable or declines to complete a required screening enter the date the assessment was offered and provide an explanation in the "if not complete / explain" field.

Do not enter a score of zero when no assessment was completed.

Patient Activation Measure: A Patient Activation Measure® (PAM), Caregiver Activation Measure® (CAM), or Parent Patient Activation Measure® (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 years 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.

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 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 the age of 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.

Body Mass Index (BMI): Enter the client's actual BMI. The value range is 0.0 to 125.9.

a. Use the Adult BMI chart for clients 20 years of age and older.
b. Use the Children and Teens BMI chart for children 2-19 years of age.
c. The BMI is neither used nor required for children less than two years of age (no value is accepted).

Additional Screenings: Additional screenings should be administered when applicable to identify possible issues, gaps in care or when they relate to a client's condition/s or goals. Enter the date the screening was completed and the score. Additional screenings may include:

a. DAST = Drug Abuse Screening Test (age 16 and older): Enter the score. The value range is 0 to 10.
b. GAD-7 = Generalized Anxiety Disorder 7 item scale (age 12 and older): Enter the score. The value range is 0 to 21.
c. AUDIT = Alcohol Use Disorders Identification Test (age 14 and older): Enter the score. The value range is 0 to 40.
d. Falls Risk = My Falls-Free Plan (age 18 and older): Each "yes" response is equal to one point. Enter the score. The value range is 0 to 11.
e. Pain Scales: Enter the score and check the type of scale used (FLACC, Faces, or Numeric). The value range is 0 to 10.

Comments: 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 (SMART) specific, measurable, attainable, relevant, and time-based and must be mutually agreed upon. For example: "client wants to cut back on smoking to half a pack per day 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" or "client wants to be able to communicate with their physician and address questions and concerns at the 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 a goal is achieved, if a client chooses to end a goal, or there is no further need for the 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 activity period to another should be copied and continued with modifications as needed for specific action steps.

Action Steps: Enter the Care Coordinator and client identified action steps the client, the parent, the family, 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). These action steps should be established mutually with the client recognizing the client's abilities and readiness for change and coaching. For example, "the Care Coordinator will review the 'Your Guide to Lowering Blood Pressure' brochure with the client to help her understand her medications," "the personal care worker will remind the client to track her blood pressure daily."

Start Date and Completion Date: Enter the start and completion dates for the action steps