The Health Action Plan (HAP) establishes:

- Client and Care Coordinator prioritized action items
- Client identified goals (Long Term and Short Term)
- Goal Outcome status
- Action Steps
Each client is in charge of their
- Own health;
- Action plans; and
- Whether or not they make lifestyle changes.

Most people desire better health and quality of life

Coaching and the HAP

- Use your coaching and Motivational Interviewing Training and professional skills to guide the individual to:
  - Appropriate choices
  - Attainable goals
  - Action steps
  - Improved health
Key Skills for health action planning include:

• Active and reflective listening

• Guiding; not directing

• Gain understanding of individual’s values and priorities

• Helping each individual identify strengths, abilities and successes

• Collaborate to improve self-efficacy and capacity

Key Skills for health action planning include:

• Helping the individual start to engage in their health and healthcare by taking an active role in the process

• Demonstrate positive belief in the individual’s ability to accomplish the Patient Activation Measure Level-appropriate goals and action steps

• Emphasize stress management and coping skills
Emphasize Problem Solving

Care Coordination requires solving problems!

Adults learn best by “doing” rather than through reading materials or hearing information.

Working through a problem with a coach increases and enhances retention.

Help the client identify long term and short term goals

Tell me about your health concerns?

Which concerns are having the biggest impact on your life?

Which concerns do you feel you are managing well?

What would you like to do to improve your health?
Explore possible solutions

*Ask* the client to review possible solutions, but not make a decision just yet …

*Ask* the client to identify possible solutions; “do you have any ideas on how you could solve this problem?”

*Ask* the client if they would like you to share your thoughts and/or provide ideas using Health Home resources.

*Ask* the client if they would like you to provide additional health education information; if so, review and discuss the information with them at the next visit.

*Ask* the client how their caregivers and/or family can support them in their plan.

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Explore Barriers

- Ambivalence?
- Understanding?
- Support system?
- Energy levels?
- Depression?
- Health literacy?
- Financial?
- Confidence?
- Social Isolation?
Active and Reflective Listening

- Use active & reflective listening skills
  - What are the client’s values?
  - Acknowledge successes and what is right with the client.
  - Encourage client to identify "what are the barriers to change?"

Long Term Goal

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."
  - "I want to see my grandchildren grow up."

- Connect the Long Term goal with the Short Term Goal(s).
Short Term Goal

The client identified goal(s) 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.
- Client wants to understand how to use her blood pressure medication by the end of March.
- Client wants to be able to communicate with PCP and address questions and concerns at next medical appointment.

The Health Action Plan

- The HAP is a dynamic tool
  - A road map for the client, their care providers and the care coordinator
  - A record of required and optional screenings.
  - Needs to be updated when there is improvement, decline or a change in the client’s care needs/condition.
Developing an Action Plan

1. Coach the client to select the Action Steps with the least number of barriers and prioritize them.

2. Save the list of Action Steps so alternatives can be tried if the first ones are not successful; reassure client that many problems are not easily solved and may take time and multiple approaches.

3. Use the Goal Setting and Action Planning Worksheet.

Action Steps

The action steps the client and/or the Care Coordinator plan to take to achieve the client's Short Term Goal.

- The Care Coordinator (CC) will document planned client, CC, personal care worker and health care provider action steps on the HAP.
- These interventions should be established mutually with the client recognizing the client's abilities and readiness for change and teaching. (Refer to PAM coaching guide for appropriate level of action steps for client to consider).
- The CC will enter the Start Date and Completion Date for each Action Step.
Action Steps Examples

• Care Coordinator to attend PCP appointment with client to review treatment options for COPD.
• Client and Care Coordinator will prepare list of questions to bring to the PCP appointment.
• Review with client and their caregiver the “Three Questions” brochure to help client prioritize needs with MD.
• The AskMe3 Website is located at: http://www.npsf.org/?page=askme3

The Three Questions

• What is my main problem?
• What do I need to do?
• Why is this important for me to do this?
Goal Setting and Action Planning Worksheet

- Use this tool to support the client in establishing an action plan.
  - What can you do now to improve your health?
  - What, where, frequency, duration
  - Possible barriers and plans
  - Conviction and confidence
  - Plan for follow up
**HAP Example: page 1**

![Image of page 1](image1.png)

**HAP Example: page 2**

![Image of page 2](image2.png)
**HAP Example: page 3**

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**Action Steps**

1. Bobby will contact the client to tell them that Bobby will be taking the waiting room over the next few weeks. Due to a high no show rate and the current limited availability of the Past Support Specialist, the waiting room will be used for an increasingly longer amount of time. The waiting room will now be utilized.
2. Bobby will take up to two weeks to get to the client, with the Past Support Specialist.
3. Bobby will go to the client and has attempted to contact the Past Support Specialist.
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**Client Notes**

- No longer patient - Life of health change
- Client request to discontinue
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**HAP Example: page 4**

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HAP Example: page 1

HAP Example: page 2
### Contact Information

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Certificate of Completion

Goal Setting and Action Planning

presented by Candace Goehring, RN, MN
Office Chief
Office of Service Integration - DSHS

Webinar aired on: February 12, 2015 in Lacey, Washington
for Health Home Care Coordinators

Please sign and date this slide to attest that you attended this training Webinar

______________________________  ________________________
Your Signature                Date Reviewed

______________________________  ________________________
Supervisor’s Signature        Date