HEALTH HOMES
CLASSROOM MANUAL
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Health Home Services

1. Comprehensive Care Management

Health Home Care Coordinators deliver comprehensive care management, primarily in person with periodic follow-up. Care management services include state approved screens and development of a person-centered Health Action Plan (HAP). Care Coordinators provide continuity and coordination of care through face-to-face visits and telephonic support. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers. By working with beneficiaries, Care Coordinators support the achievement of self-directed, person-centered health goals designed to attain recovery, improve functional or health status, or prevent or slow declines in functioning.

The initial HAP is developed in collaboration with the client and may include parents, family members, caregivers, legal representatives, and other collaterals. The HAP establishes a long-term goal, a short-term goal or goals, and action steps to achieve these goals.

Screens include clinical and functional screens, including depression, alcohol or substance use disorder, functional impairment, falls risk, and pain, appropriate to the age and risk profile of the beneficiary. Screens support referrals to services when needed such as specialty care and and/or long-term services and supports. The beneficiary's activation level is reassessed at least once during each four-month activity period while receiving health home services.

Other screens and assessments that may supplement comprehensive care management are Medicaid managed care organizations' contractually required health risk assessments for beneficiaries with special health care needs, mental health treatment plans, substance use disorder treatment plans, and/or other pre-existing care plans.

Care Coordinators offer beneficiaries the opportunity to consider and discuss advance care planning. The Care Coordinator may assist the beneficiary to access legal assistance to develop advance directives.

Health Home services do not duplicate other services, such as case management. Care Coordinators bridge the beneficiary's services across multiple settings to ensure access and coordination of needed medical, behavioral, and social support services.

2. Care Coordination

The Care Coordinator plays a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. Care

Coordinators have the ability to accompany beneficiaries to health care appointments as needed. The Care Coordinator fosters communication between care providers including primary care providers, medical specialists, and entities authorizing behavioral health and Long Term Services and Supports (LTSS). Care coordination bridges all of the beneficiary's systems of care, including non-clinical support such as food, housing, legal services, and transportation.

When providing intensive care coordination to the beneficiary, the Care Coordinator caseload is maintained at a level that ensures fidelity in providing required health home services. Community Health Workers, peer counselors, wellness or health coaches, and other non-clinical staff are used to provide outreach, engagement, and support under the direction and supervision of the Care Coordinator.

Care coordination shall provide informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors that impact a beneficiary's health and health care choices. Joint office visits by the beneficiary and the Care Coordinator with health care providers offer opportunities for mentoring and modeling communication with providers. Care Coordinators may establish multidisciplinary care teams or participate on an existing team. Their participation aids to better coordinate services, identify and address gaps in care, and ensure cross-systems coordination to ensure continuity of care.

Care Coordinators will promote:

1) optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the HAP;
2) outreach and engagement activities that support the beneficiary's participation in their care and promote continuity of care; and
3) use of peer supports, support groups, and self-care and self-management programs to increase the beneficiary's knowledge about their health conditions and improve adherence to prescribed treatments and medications.

The HAP is reviewed and revised during each four-month activity period or as needed to address the achievement of goals and action steps and changes in the client's self-management of their chronic conditions. Screening assessments are offered and administered during each activity period.

3. Health Promotion

Health promotion begins for health home beneficiaries with the commencement of the HAP. Health education and coaching is designed to assist beneficiaries to increase self-management skills and improve health outcomes. Each Washington health home must demonstrate use of self-management, recovery, and resiliency principles using person-centered supports including family members and paid and unpaid caregivers. The Care Coordinator uses the beneficiary's activation score and level to determine the coaching methodology for each beneficiary to

develop a teaching and support plan. Educational materials are customized and introduced according to the beneficiary's readiness for change and progress with a beneficiary's level of confidence and self-management abilities. The health home will provide wellness and prevention education specific to the beneficiary's chronic conditions and HAP. Health promotion and education includes assessment of need, facilitation of routine and preventive care, support for improving social connections to community networks, and linking beneficiaries with resources that support a health promoting lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder prevention, nutritional counseling, obesity prevention and reduction, physical activity, disease specific or chronic care management, self-help resources, and other services. Health promotion and education may also occur with parents, family members, caregivers, legal representatives, and other collaterals to support the beneficiary in achieving improved health outcomes.

4. Comprehensive Transitional Care

Comprehensive transitional care is provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment, or residential habilitation setting) and to ensure proper and timely follow-up care.

The beneficiary's HAP includes transitional care planning. Transitional care planning includes:

1) A notification system with managed care plans, hospitals, nursing facilities, and residential/rehabilitation facilities to provide the health home prompt communication of a beneficiary's admission and/or discharge from an emergency department, inpatient facility, skilled nursing or residential/rehabilitation facility, and with proper, permissions, a substance use disorder treatment setting. Progress notes or a case file will document the notification. The HAP is updated as a part of transition planning.

2) Active participation of the Care Coordinator in all phases of care transition including: discharge planning visits during hospitalizations or nursing facility stays, post discharge face-to-face visits, and telephone calls.

3) Beneficiary education to support discharge care needs including: medication management, follow-up care, and self-management of chronic or acute conditions. Information on when to seek medical care and emergency care is also provided. Involvement of formal or informal caregivers is facilitated when requested by the beneficiary.

4) A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care.

5) Medication reconciliation prior to or soon following discharge to the community or other setting.

5. Individual and Family Support

The Care Coordinator recognizes the unique role the beneficiary may give family members, identified decision makers, and caregivers in assisting the beneficiary to access and navigate the health care and social service delivery system as well as support health action planning.

Peer supports, support groups, and self-management programs are used by the Care Coordinator to increase beneficiary and caregiver knowledge of the beneficiary's chronic conditions, promote the beneficiary's engagement and self-management capabilities, and help the beneficiary improve adherence to their prescribed treatment.

The Care Coordinator will:

1) identify the role that parents, family members, informal supports, and paid caregivers provide to the beneficiary to achieve self-management and optimal levels of physical and cognitive function;
2) educate and support self-management, self-help, and recovery by accessing other resources necessary for the beneficiary, their family, and their caregivers;
3) discuss advance care planning with beneficiaries and their families;
4) communicate and share information with beneficiaries, their families, and their caregivers with appropriate consideration of language, activation level, literacy, and cultural preferences.

6. Referral to community and social support services

The Care Coordinator identifies available community based resources and actively manages referrals. They assist the beneficiary in advocating for access to care and promote engagement with community and social supports related to goal achievement documented in the HAP. When needed and not provided through other case management systems, the Care Coordinator provides assistance to obtain and maintain eligibility for health care services, Medicaid, disability benefits, housing, personal needs, and legal services. These services are coordinated with appropriate departments of local, state, and federal governments, and community based organizations. Referral to community and social support services includes LTSS, mental health, substance use disorder, and other community and social service support providers needed to support the beneficiary in achieving health action goals.

The Care Coordinator documents referrals to and access by the beneficiary of community and other social support services.

HEALTH HOME CARE COORDINATOR'S CHECKLIST

Health Home Care Coordinator's Checklist	
☐	Receive assigned client from the Lead Organization
☐	Review assigned client in PRISM and other records and databases
☐	Contact client to engage in Health Home Services and arrange first face-to-face visit • Fill out referral for Non-Emergency Medical Transportation and submit to local Medicaid broker if client needs transportation to meet outside of residence to participate in the program
☐	Provide Tier 1 services with a face-to-face visit to develop the initial Health Action Plan (HAP) • Administer required screening • Administer optional screenings as indicated • Obtain signature on the Participation Authorization and Information Sharing Consent form and other specialized releases as needed • Discuss advance care planning with client and/or family (must be completed within first year of engagement) • Establish long term goal and short term goal(s) with associated action steps
☐	Establish follow up plan with the client, family, caregiver, and other health and social service providers as indicated on the HAP. Complete face-to-face, telephonic, or other contacts as needed.
☐	Provide ongoing Tier Two or Tier Three Health Home Services according to the HAP each month as appropriate and document contact(s) and service(s) provided: • Comprehensive Care Management • Care Coordination • Transitional Care Services with each in patient admission or emergency department visit • Individual and Family Support • Referral to Community and Social Support Services • Health Promotion
☐	Update HAP at least every trimester (four-month activity period) and more frequently as needed and administer required and optional screenings
☐	Review documentation by allied staff (e.g. Peer Support Specialists, Wellness Coaches, Community Connectors, Community Health Workers, etc.) to determine if revisions are needed to the HAP. Consult with client as needed to review and revise the HAP.
☐	Educate client, family, and other collaterals about eligibility for the Advanced Home Care Aide Specialist Pilot or the Community Integration in Adult Family Home Program and assist with accessing these special benefits. Document collaboration with appropriate case managers.
☐	Participate on or organize a multidisciplinary care team and coordinate meetings as needed
☐	Complete comprehensive transitional care activities following in-patient admission or emergency department care

Health Home Tiers for Billing

Washington State Health Homes have designated three tiers that define the level of care coordination services provided:

1. Initial engagement and health action plan. (HAP) completion = Tier One
2. Intensive level of care coordination = Tier Two
3. Low level of care coordination = Tier Three

The Tier Level of the client is intended to reflect the overall level of:

1. Engagement and activation level of the client and/or their caregivers
2. Activity in the Health Action Plan
3. Provision of at least one of the qualified Health Home services
4. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).

Selecting the appropriate Tier should most closely reflect the above activities. Typically the Tier will not change from month to month, between Tier Two and Tier Three, but does change when the client and/or their caregivers consistently demonstrate an *intensive* or *low* level Health Home need. At least one of the six qualifying Health Home services must be provided within each Tier Level in order to bill and receive payment for the service.

Qualifying Health Home services include;

- **Comprehensive Care Management:** The initial and ongoing assessment and care management services aimed at the integration of physical, behavioral health, long-term services and supports, and community services, using a detailed person-centered HAP which addresses all clinical and non-clinical needs.
  Examples:
  - Conduct outreach and engagement activities
  - Develop the HAP setting client centered goals and action steps to achieve the goals
  - Complete comprehensive needs assessment such as the Patient Activation Measure (PAM) and other required assessments for the HAP
  - Prepare crisis intervention and resiliency plans
  - Support the client to live in the setting of their choice
  - Identify possible gaps in services and secure needed supports
- **Care Coordination and Health Promotion:** Facilitating access to, and monitoring of progress toward goals identified in the HAP to manage chronic conditions for optimal health and to promote wellness. Accomplished through face-to-face and collateral contacts with the client, family, caregivers, physical care, and other providers.
  Examples:
  - Support to implement the HAP
  - Encourage and monitor progress towards individualized short and long term goals
  - Coordinate with service providers, case managers, and health plans
  - Conduct or participate in interdisciplinary teams
  - Assist and support the client with scheduling health appointments and accompany if needed
  - Communicate and consult with all providers and the client
  - Provide individualized educational materials according to the needs and goals of the client

    - Promote participation in community educational and support groups
- **Comprehensive Transitional Care:** The facilitation of services for the client, family, and caregivers when the client is transitioning between levels of care.
  Examples:
    - Follow-up with hospitals/ED upon notification of admission or discharge
    - Provide post-discharge contact with client, family, and caregivers to ensure discharge orders are understood and acted upon
    - Assist with access to needed services or equipment and ensure it is received
    - Provide education to the client and providers that are located at the setting from which the person is transitioning
    - Communicate and coordinate with the client, family, caregivers, and providers to ensure smooth transitions to new settings
    - Ensure follow-up with Primary Care Provider (PCP)
    - Review and verify medication reconciliation post discharge is completed
- **Individual and Family Supports:** Coordination of information and services to support the client and their family or caregivers to maintain and promote quality of life, with particular focus on community living options.
  Examples:
    - Provide education and support of self-advocacy including referral to Peer Support specialists
    - Identify and access resources to assist client and family supports in finding, retaining and improving self-management, socialization, and adaptive skills
    - Educate client, family or caregivers of advance directives, client rights, and health care issues
    - Communicate and share information with the client, family, and caregivers with appropriate consideration of language, activation level, literacy and cultural preferences
- **Referral to Community and Social Supports:** The provision of information and assistance for the purpose of referring the client and their family or caregivers to community based resources as needed.
  Examples:
    - Identify, refer and facilitate access to relevant community and social services that support the client's HAP
    - Assist the client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided though other case management systems
    - Monitor and follow-up with referral resources to ensure appointments and other activities were established and the client engaged in the services
- **Use of Health Information Technology to link services:** Determine level of service provided and update client health records and HAP according to the Health Home Qualified Lead required information systems.

The descriptions below of each Tier Level are to be used as a guide when selecting the Health Home Tier.

Tier One – **<u>Outreach, Engagement and Health Action Plan (HAP) Development</u>**

- Lead Entity assigns an eligible client to a Care Coordination Organizations (CCO) using PRISM information or other data systems to match the client to the CCO which will provide the Health Homes services and outreach begins.

a. The CCO assigns the client to a Care Coordinator who completes a preliminary assessment of the client's Health Home needs, based upon known health and other risk factors.
b. Contact is made with the client to arrange a face-to-face meeting to confirm the client's desire to participate in the Health Home Program.
c. Together, the Care Coordinator and the client identify the client's health goals (long term and short term) and develop the HAP.
d. The client 's Health Action Plan shall provide evidence of:
    1. Chronic conditions, severity factors and gaps in care, the client 's activation level, and opportunities for potentially avoidable emergency department visits, inpatient hospitalizations and institutional placement;
    2. Client self-identified goals, needed interventions or action steps, transitional care planning, supports and interventions; and
    3. Use of self-management, recovery and resiliency principles using person-identified supports, including family members, and paid and non-paid caregivers.

- Once the client agrees to participate in the Health Home program and the HAP is developed, a Tier One claim using procedure code G9148 may be submitted for payment. The Tier One payment will only be paid once in a client's lifetime to a lead entity for each enrolled and engaged client.

Tier Two - <u>Intensive Health Home Care Coordination</u>

- Intensive Health Home care coordination is the highest level of care coordination. This level of care coordination includes evidence that the Care Coordinator, the client and the client 's caregivers are actively engaged in the HAP, participating in activities that are in support of improved health and well-being, have value for the client and caregivers, and support an active level of care coordination through delivery of the Health Home services. Typically intensive Health Home care coordination includes one face-to-face visit with the beneficiary every month in which a qualified Health Home service is provided
    - ***Exceptions*** can be approved to the monthly care coordinator's face-to-face visit by the Health Home Lead entity. A face-to-face visit with other service providers or allied staff directly related to the client's HAP goals and included in the action steps may be considered as an exception.
    - ***Exceptions*** can be approved to monthly care coordinator's face-to-face visit by the Health Home Lead entity as long as there is evidence of other types of qualifying health home activities being provided.
- Document health home services provided in the client's health record. Examples of services may include:
    a. Administration and follow up on clinical, functional, and resource use screenings, including screens for depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual.
    b. Continuity and coordination of care services through in-person visits, telephone calls and team meetings, and the ability to accompany beneficiaries to health care provider appointments, as needed.
    c. Client assessments to determine readiness for self-management and promotion of self-management skills so the client is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning.

d. Fostering communication between the client and providers of care including the treating primary care provider and medical specialists and entities authorizing behavioral health, chemical dependency, developmental disability and long-term services and supports.
e. Promoting optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the HAP.
f. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes.
g. Referrals and assessment of the use of peer supports, support groups and self-care/self-management programs to increase the client's knowledge about their health care conditions and improve adherence to prescribed treatment.

- At least one of the six qualifying Health Home services must be provided during the month prior to submitting a Tier Two claim using procedure code G9149 for payment.

Tier Three – **<u>Low Level Health Home Care Coordination</u>**

- Tier Three is selected when one of the situations described below matches the care coordination needs of the client. Typically after the Tier One activity of establishing the HAP is completed a client will move to the Tier Two level. In some cases, based on the preference of the client, and their individual needs, they may move directly from Tier One to Tier Three. For example, a client with an Activation Level of Four who is actively self-directing their care and needs infrequent coaching to maintain their health.
- The Health Home Tier system was not designed to have beneficiaries changing Tiers month to month based solely on the number or types of contacts. The movement to a Tier or between Tiers is based on:
    a. Engagement of the client and/or their caregivers;
    b. Activity within the HAP;
    c. Provision of at least one of the six qualifying Health Home services; and
    d. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).
- The following situations describe when Tier Three (Low Level Care Coordination) would apply for a client.
    a. Low Level Health Home care coordination supports maintenance of the client's self-management skills with periodic home visits and/or telephone calls to reassess health care needs.
    b. The client expresses their preference to have fewer contacts or a lower level of engagement with the care coordinator.
    c. The client and the Care Coordinator identify that the client has achieved a sustainable level of self-management for their primary chronic conditions.
    d. Activity level supports a high level of activation and client demonstrates optimal self-management and health promotion skills.
- At Tier Three the review of the HAP must occur at least every four months reviewing progress towards goals, level of activation, and new or unidentified care opportunities.

- At least one of the six qualifying Health Home service must be provided prior to submitting a Tier Three claim with procedure code G9150 for payment.

Client Movement Between Tiers

- Based on the needs and preferences of the client they may move between Tiers Two and Three; higher intensity to lower or lower intensity to higher**.**
- Examples of moving a client from **Tier Two to Tier Three** include:
    a. The client's Patient Activation Measure (PAM) score has stabilized over the past four month period with optimal level of activation and HAP goals have been achieved.
    b. The client's PRISM risk score is under 1.0 for eight months and the client's PAM Level is at least a three.
    c. A client has met their goals and is actively sustaining self-management activities.
    d. The client has no new HAP goals to set or current issues to achieve requiring a higher level of coordination, and has achieved and demonstrated self-management skills. Goals may be modified or new goals added in collaboration by the client with the care coordinator.
    e. The client requests a lower level of care coordination.
    f. The client was not available during the month and the care coordinator provided follow-up care coordination with service providers or community resources.
- Examples of moving a client from **Tier Three to Tier Two** include:
    a. An adverse health condition or new diagnosis resulting in increased emergency department use, hospital admissions, readmissions, escalation or exacerbation of a behavioral health or social concern.
    b. The client expresses a desire to set a new HAP goal.
    c. Environmental or psychosocial changes trigger a need for more intensive Health Home services.
    d. Life events trigger a need for higher Health Homes Services.

Unsuccessful Initial Outreach and Engagement:

- Some beneficiaries may not be successfully reached or engaged in Health Home services despite multiple attempts to contact them in person, by phone, by mail, or through collateral contacts. In these situations a Tier One claim for the engagement attempts cannot be submitted. The Care Coordinator must consult with their organization for direction regarding policy and procedure for engagement attempts and documentation of failed attempts to reach a client.
- When a client is not actively participating in the Health Home Program a claim cannot be submitted to reflect the outreach attempts only.

REMEMBER: A qualifying Health Home service must be provided each month in order to submit a claim for Tier Two or Tier Three payment.

Tier Level	Minimum Contact	Activity Examples
Tier One	Contact is made with the client to arrange a face to face meeting to confirm the client's desire to participate in the Health Home Program. Care Coordinator visits the client to complete required assessments and develop the Health Action Plan (HAP) with client centered goals and action steps to achieve those goals.	Review PRISM and other available client records Administer required screenings. Administer optional screenings as needed. Together, the Care Coordinator and the client identify the client's health goals (long term and short term) and develop a Health Action Plan (HAP). Establish a follow up plan with the client. Submit Tier One Claim for payment with date of service when the HAP has been completed.
Tier Two **Intensive Health Home care coordination**	Typically intensive Health Home care coordination includes one face-to-face visit with the beneficiary every month in which a qualified Health Home service is provided. ***Exceptions*** can be approved to the monthly care coordinator's face-to-face visit by the Health Home Lead entity. A face-to-face visit with other service providers or allied staff directly related to the client's HAP goals and included in the action steps may be considered as an exception. ***Exceptions*** can be approved to	Administration and follow up on clinical, functional, and resource use screenings Continuity and coordination of care services through in-person visits, telephone calls, and team meetings, and the ability to accompany beneficiaries to health care provider appointments, as needed. Beneficiary assessments to determine readiness for self-management and promotion of self-management skills so the beneficiary is better able to engage with health and service providers.

Tier Level	Minimum Contact	Activity Examples
	monthly care coordinator's face-to-face visit by the Health Home Lead entity as long as there is documented evidence of other types of qualifying health home activities being provided. At least one qualifying Health Home service must be provided prior to submitting a Tier Two claim for payment.	Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes. Referrals and assessment of the use of peer supports, support groups and self-care/self-management programs. Medication reconciliation as part of care transitioning. Education and coaching of caregivers, family members, and other supports.
Tier Three **Low level Health Home care coordination**	Low Level Health Home care coordination supports maintenance of the client's self-management skills with periodic home visits and/or telephone calls to reassess health care needs. The client expresses their preference to have fewer contacts or a lower level of engagement with the care coordinator. Contact may not occur every month depending on the HAP and the needs of the client. At least one qualifying Health Home Service must be provided prior to submitting a Tier Three claim for payment.	Monthly calls to the client to discuss success with maintaining health and/or behavioral changes. Monthly call to check in on HAP progress and to identify new or changing goals. At Tier Three the review of the HAP must occur at least every four months for progress towards goals, level of activation, and new or unidentified care opportunities.

Health Home Care Coordination Documentation Guide

Health Home Activities	Activities	Documentation
General guidelines	• Documents all activities related to the provision of Health Home services • Use of interpreters for client contact and translation of documents that are culturally and linguistically appropriate for the client	• Document in the client's record: ○ Date of contact ○ The type of contact: telephone call, secure email message, written correspondence, face-to-face visits, telehealth, multidisciplinary care team meetings, and attendance at appointments or other meetings ○ Attempted or completed contacts ○ Name(s) and relationships of those contacted if not the client ○ Highlights from the conversation ○ Objective observations ○ Outcome of the contact ○ Other important information and relevant comments ○ Location of the visit and name(s) and relationship of collateral(s) (e.g. family members, guardians, agency staff, caregivers, or others) present ○ Name(s) of staff person completing the activity (include the writer's title for the first entry) ○ Core Health Home service provided ○ Health Home Tier provided ○ Discussion with client of movement to another Tier when applicable ○ Discussion with client of reasons for Tier 2 exception when applicable
Outreach	• Completes required activities for due diligence: ○ Telephone contacts	• Document in the client's record: ○ Date and type of contact (letter or telephone call) ○ Alternate addresses used for clients that are homeless

This document serves as a guide for documentation of Health Home activities by Care Coordinators and allied staff. Allied staff means Community Health Workers, peer counselors, wellness or health coaches or other non-clinical personnel who provide supportive services, outreach, and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Please contact your Lead Organization for additional documentation requirements. Consult your supervisor for documentation requirements established within your agency.

Health Home Activities	Activities	Documentation
	○ Letters	○ Date letter mailed to the client if a new address is known or to a collateral(s) who may be able to deliver the letter to the client ○ Date telephone contact initiated and outcome of the call ○ Date telephone contact attempted and outcome (e.g., phone disconnected, wrong number, etc.) ○ Note if contact was made with someone other than the client and the outcome of the call (e.g. left message for the client) ○ Date face-to-face visit scheduled, location, and time. Include collateral(s) who will be present and their relationship to the client ○ Outreach by mail; phone; or other methods. When these attempts do not result in contact with the client, document and date contact with the Lead to discuss how to proceed with the case • For this and any other activities, document other forms of communication used to contact the client or collateral(s) such as secure email and include the date • Due diligence: All contacts and attempted contacts must be documented in the client's record
Initial contact: client opts in the program	• Complete the Health Home Participation Authorization and Information Sharing Consent Form	• Document in the client's record the date of contact and their agreement to participate in the program • Document if the client has agreed to sharing information with providers

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Health Home Activities	Activities	Documentation
		• Document reasons (if known) if client chooses not to share information with providers at this time
Initial contact: client opts out of the program	• Complete the Opt-out form • Send the Opt-out Form to the client	• Document in the client's record the type of contact (e.g. telephone call), the date services were offered, and if known, the reason client opted out of the program • Complete the Opt-out form on behalf of the client • Document the date the completed form was submitted to the Lead • Document the date the Opt-out Form (HCA 22-853) was mailed to the client • If the form was completed in person, and the client signed the form, document that a copy of the form was provided to the client
Loss of Contact	• Attempts to contact the client by mail, secure email, and telephone • Accesses available databases to locate updated contact information for client • Contacts collateral(s) and other providers to identify client's current location and contact information	• Document in the client's record: ○ Dates and types of contact attempted with client ○ Dates and types of contact attempted with collateral(s), their relationship to the client, and the outcome of the contact ○ Letters mailed to the client including the dates ○ Contact with the Lead and decision on how to proceed with the case (return case to the Lead or retain and attempt to contact in the future)
The Six Core Services: Comprehensive Care Management	• Check ProviderOne to ensure client eligibility • Review PRISM data prior to initial client contact or face-to-face visit	• Document in the client's record: ○ Outreach attempts to locate and contact the client ○ Date outreach was completed, who completed the outreach, and name(s) of collateral(s) if client was not contacted

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Health Home Activities	Activities	Documentation

	• Initiate contact with client and/or collateral(s)
	• Complete initial and follow up visits with the client and/or collateral(s)
	• Complete telephone contacts and follow up
	• Complete the required and optional screenings
	• Assesses the client's self-management skills and readiness
	• Completes the initial Health Action Plan (HAP) OR
	• Complete a review and update the HAP (e.g. ReHAP)
	• Provides monthly contacts to:
	  ○ Ensure continuity of care between providers
	  ○ Support the client to achieve their self-directed health goal(s)
	  ○ Assist as needed to improve functional or health status or prevent slow declines in functioning
	• Provides cross-system care coordination to identify gaps in
		○ Verbal approval by the client or client's representative to contact collateral(s) and/or share client information
		○ Date and time of the initial and other face-to-face visits
		○ Other persons present during visits
		○ Summary of the purpose of the contact and highlights from the discussion
		○ Notable comments and exchanges
		○ Objective observations
		○ Scores, levels, and dates of required and optional screenings. Include the name(s) and relationship of the person if another completes the screening.
		  ▪ Follow-up (including referrals) to screenings when there is an elevated score or a jump in score from the previous HAP
		  ▪ Relevant discussions with the client or their providers/supports
		  ▪ When the client or representative declines to complete a required screening note the date, reason if given, and the name(s) and relationship of the person who declined
		○ Discussion with the client about their activation and readiness to initiate behavioral changes should be noted
		○ A summary of conversations with the client and collateral(s) to establish or review the HAP and their reported progress on the goal(s) and action step(s)

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Health Home Activities	Activities	Documentation
	care and assist the client in navigating and accessing needed services • Reviews PRISM for updated claims and utilization activity • Reviews and revises the HAP if needed at every contact to: ○ Assess completion of action step(s) and progress toward meeting short- and long-term goal(s)	○ Provision of the HAP and the format (e.g. paper copy, a secure email message, etc.) ○ Activities completed or completed by others to support the client

The Six Core Services: Care Coordination	• Ensures communication between the providers
	• Coordinates and acts as a bridge between the client's system of care including non-clinical support for food, housing, legal services, transportation, and other supports
	• Facilitates the work of allied staff to assist in care coordination
	• Provides opportunities for mentoring and modeling communication with health providers such as:
	  ○ Demonstrating how to schedule an appointment
		• Document in the client's record:
		  ○ Reviews of the HAP and completion of the required screenings for each four-month activity period
		  ○ Completion of action step(s) and any revision to action step(s) and short-term and long-term goal(s) in the HAP
		  ▪ Enter end date and reason if applicable
		  ○ If client or collateral(s) declines to participate and note any subsequent attempts to complete screenings and/or update the HAP
		  ○ Closure or transfer of the HAP including an end date and reason
		  ○ Name(s) of organizations used to provide social supports clearly noting who will make the contact with the provider
		  ○ When contact is made describe the interactions, conversations, and the plan of action

This document serves as a guide for documentation of Health Home activities by Care Coordinators and allied staff. Allied staff means Community Health Workers, peer counselors, wellness or health coaches or other non-clinical personnel who provide supportive services, outreach, and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Please contact your Lead Organization for additional documentation requirements. Consult your supervisor for documentation requirements established within your agency.

Health Home Activities	Activities	Documentation
	or leave a message for a provider ○ Participating in joint medical or other appointments ○ Monitoring and offering support during telephone conversations with health care and other staff • Provides interventions and fosters cross-systems communication between providers of care that are tailored to the client's medical, social, economic, behavioral health, cultural, and environmental factors that impact the client's health and health care choices • Reviews progress on action step(s), short- and long-term goal(s), and updates or revises the HAP	○ Client's participation in social/support groups that have increased their knowledge about health care and their chronic conditions ○ Interactions with the client, their representatives, allied staff, and other providers ○ Gaps in care or needed services for the client and how these were addressed and the outcome ○ Activities completed by the Care Coordinator or allied staff such as accompanying the client to an appointment ○ Activities that facilitated communication and coordination between the client, their providers, and other support systems to address barriers to achieve goal(s)
The Six Core Services: Health Promotion	• Develops a HAP that is person-centered and promotes recovery and resiliency • Using the client's activation level determines the coaching, teaching, and support plan for the client	• Document in the client's record: ○ The activation levels, how they may influence the client's ability to self-manage their chronic conditions, and the client's response to the PAM® and HAP ○ Discussions with caregivers and parents who complete the CAM® or PPAM®

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Health Home Activities	Activities	Documentation
	• Provides person-centered wellness and prevention education to include routine and preventative care • Links the client with resources to promote a healthier lifestyle such as disease-specific classes and support groups	○ Visual or audio educational materials given to client or others to promote improved clinical outcomes and increase self-management skills ○ Use of peer supports to increase the client's knowledge about health conditions and adherence to treatment ○ Activities completed by allied staff with the client, collateral(s), and providers, including the date and type of contact. Documentation may include next step(s) for the client, Care Coordinator, and allied staff
The Six Core Services: Comprehensive Transitional Care	• Coordinates with client and/or collateral(s) to prevent avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment, or residential habilitation setting) • Participation in appropriate phases of care transition including discharge planning, face-to-face meetings and follow-up telephone calls • Ensures that the client and/or collateral(s) received and understand the discharge plan and orders	• Document in the client's record: ○ Follow up calls and visits before and after discharge ○ Notification of client's admission and/or discharge from an emergency department or inpatient setting ○ Timely follow-up and discussions with inpatient facility staff, the client, parents, family members, paid and unpaid caregivers, providers, collateral(s), and others involved with the client's discharge ○ Participation on multidisciplinary care teams, outcomes, and plans developed to transition to the community or other setting ○ Review of the information sharing consent form noting added or deleted providers with the date ○ Review of the discharge plan ○ Who received the written discharge plans and if they are understood ○ Scheduled timely appointments with the PCP and/or other specialists

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Health Home Activities	Activities	Documentation
	• Ensures proper and timely follow-up care with a Primary Care Physician (PCP) and specialists • When necessary, coordinates transportation and escort to medical and other appointments • Completes or ensures that medications have been reconciled • Ensures that red flags have been identified to the client and/or collateral(s) that require contacting their medical and behavioral health providers • Follows up with LTSS case manager when there has been a significant change with the client's functional ability to perform activities of daily living • Follows up to ensure that prescribed treatments and therapies, medications, supplies, and durable medical equipment have been ordered and received	○ Arrangements for transportation and escort to medical and other medical or behavioral health appointments ○ Name(s) of person who reconciled medications including the date and relationship to client ○ Contact with LTSS case manager ○ Additional support planned for management of high-risk clients
The Six Core Services: Individual and Family Support	• Identifies the role of family members, informal supports, and paid and unpaid caregivers	• Document in the client's record: ○ Name(s) of family members, caregivers, legal representatives and other providers and contact information. The Participation Authorization and

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Health Home Activities	Activities	Documentation

	• Provides education and support to family, informal supports, and caregivers to:
	  ○ Increase their knowledge of chronic conditions
	  ○ Promote the client's engagement and self-management
	  ○ Help the client adhere to their prescribed medications
	• Includes family members, caregivers, informal supports, and other collateral(s) in the development and implementation of the HAP
	• Works with peer supports, support groups, and self-management programs to support the client to achieve self-management of chronic condition(s)
	• Provides information about advance care planning to clients and their families within the first year of engagement
	• Facilitates communication and information sharing with the client, their families, and other caregivers
		Information Sharing Consent form, if signed, should include each of these individuals
		○ Client and family's engagement with peers and other formal and informal supports
		○ Client's participation in peer group or support group sessions
		○ Efforts to facilitate conversations with caregivers about chronic conditions and their participation in the HAP
		○ Discussion about advance care planning and any efforts to help the client or family members access legal assistance if an advance directive is requested
		○ Use of interpreters for client contact and translation of documents that are culturally and linguistically appropriate for the client

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Health Home Activities	Activities	Documentation
	• Provides support that considers language, activation level, health literacy, and cultural preferences of the client and family	
The Six Core Services: Referral to Community and Social Support Services	• Identifies community-based resources • Completes referrals to community and social support services • Actively manages referrals • Advocates on behalf of the client to access medical and behavioral health care and community and social supports • Helps acquire and maintain eligibility for services such as Medicaid and housing	• Document in the client's record: ○ Referrals to other agencies and providers and actions taken to actively manage these referrals ○ Support provided to client and collateral(s) in completing and submitting applications ○ Support or completion of eligibility reviews for Medicaid, housing, and other services ○ Resource and referral information including name(s) of resource, contact name(s) and phone number, and type of services/supports requested and provided ○ Contacts with other service providers
Health Action Plan (HAP)	• Works with the client, family members, parents, guardians, caregivers, and other collateral(s) to establish a person-centered long-term goal(s), short term goal(s), and action step(s) • Offers and completes required and optional screenings and Body Mass Index (BMI)	• Document in the client's record: ○ The client's person-centered long-term goal(s) ○ The client's short-term goal(s) or goal(s) ○ Actions step(s) specifying who will complete the action step(s) including a due date or general timeframe as appropriate ○ Results of required screenings including the PAM®, CAM®. PPAM®, PHQ-9, PSC-17, Katz ADL, and BMI. ▪ If declined note the person who declined, reason (if known), and date

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Health Home Activities	Activities	Documentation
	• In collaboration with the client and collateral(s) complete required fields for the HAP • Enters the HAP into the Lead's data platform	▪ Note subsequent offers to complete the screenings and the outcome ▪ Note that the caregiver completed the CAM® when applicable ○ When optional screenings (My Falls-Free Plan, Pain Scales [FLACC, Wong-Baker Faces, or Numeric scales], GAD-7, AUDIT, or DAST) were offered and completed during each four-month activity period or as clinically indicated ○ Initiation and completion of the first HAP and updates completed during each four-month activity period including: ▪ Completion or revision of the long-term goal(s), short-term goal(s), and action step(s) ▪ Obstacles to completing long-term goal(s), short- term goal(s), and/or action step(s) ○ Face-to-face visits for initial and subsequent HAPs and telephonic support of the client and collateral(s) in meeting goal(s) and action step(s) ○ That the HAP was offered and provided to the client or if the client declines the HAP
Transition Planning when client is opting out or no longer eligible for the HH program	• Facilitates discussion with the client and/or parents, caregivers, guardians, or representatives when client: ○ opts out of the program ○ is no longer eligible	• Document in the client's record: ○ Discussion of the HAP goal(s) and successes ○ Efforts to encourage client to continue to work with allied staff or other collateral(s) when Health Home services are terminated

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Health Home Activities	Activities	Documentation
	• Acknowledges and celebrates the client's successes and provides coaching to continue efforts to improve health • Develops a plan to ensure continuity of care after Health Home services end • Educates the client and collateral(s) about the process of health action planning if the client wishes to pursue future goal(s) • Identifies community resources and completes referrals • Provides contact information to client or collateral(s) for follow-up for referrals • Closes the HAP	○ Document the client's decision to continue or discontinue their pursuit of goal(s) ○ Contact with collateral(s) ○ Referrals to other providers ○ Client or collateral(s)'s acceptance of an offered service, such as a referral to a provider. Note if client or collateral(s) decline to accept assistance ○ Discussion about the transfer process with the client and collateral(s) and date of discussion ○ Closure of the HAP including the date and reason ○ Actions taken to transfer the case back to the Lead
Multidisciplinary Care Teams	• Organizes a team or participates on an existing team	• Document in the client's record: ○ Attempts to develop and execute a cross-system team ○ Members of the team and their role including contact information ○ Team meetings including the location and date, discussion highlights, decisions, and assignments to team members
Special Programs: Advanced Home Care Aide Specialist (AHCAS) Pilot	• Educates client and Individual Provider (IP) about the AHCAS Pilot	• Document in the client's record: ○ Discussions with the client and collateral(s) about the pilot and client's interest in participating

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Health Home Activities	Activities	Documentation
	• May collaborate with client and IP to develop a role for the IP to support the HAP	○ Discussion with the IP about the completion of required training and interest in participating with the client ○ Contact with the Area Agency on Aging, DSHS Home and Community Services case manager, or DSHS Developmental Disabilities Administration case manager ○ Revision of the HAP, with the client's agreement, to include a role and possible action step(s) for the IP to support the client and their goal(s)
Special Programs: Community Integration (CI) in Adult Family Homes (AFH)	• Educates the client, collateral(s), and AFH about the program • Identifies resources and opportunities for the client to better integrate into their community • When appropriate, incorporates CI activities into the HAP as goal(s) and action step(s)	• Document in the client's record: ○ Efforts to collaborate with the client, collateral(s), and AFH provider to assist the client in determining the type of community support they would like to pursue ○ Changes to the HAP to incorporate these CI activities as goal(s) and action step(s) ○ Contacts with the Developmental Disability Administration Case Resource Manager or DSHS Home and Community Services case manager or Nurse

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Health Home Program
Washington

Guidelines for
HH Staff Roles and Responsibilities

February 29, 2016

Health Home Care Coordinators have ultimate responsibility for ensuring the delivery of Health Home services. It is within the scope of their work to delegate some activities to Allied Staff* and non-clinical administrative support staff. The following graph provides a **guide** for potential delegation of Health Home services to Allied and Administrative staff.

CORE HEALTH HOME SERVICES	EXAMPLES OF CORE HEALTH HOME SERVICES, INTERVENTIONS and ACTIVITIES	CARE COORDINATOR functions	ALLIED STAFF potential roles under direction of the Care Coordinator	SUPPORT STAFF under the direction of the Care Coordinator
Outreach and Engagement	Contact the client to introduce Health Home benefits and schedule initial Care Coordinator face-to-face visit.	✓	✓	✓
Comprehensive Care Services	Conduct comprehensive health assessment/reassessment inclusive of medical/behavioral /rehabilitative and long term care and social service need.	✓		
	Complete or revise Health Action Plan (HAP), with a face to face visit with the client to identify client's goals and action steps. Development of the HAP may include family members, caregivers, and other social supports as appropriate.	✓		
	Consult with interdisciplinary care team on client's care plan/needs/goals.	✓		
	Consult with primary care physician and/or any specialists involved in the treatment plan.	✓		
	Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes.	✓	✓	
	Prepare client crisis intervention or resiliency plan.	✓		
Care Coordination	Coordinate with service providers and health plans as appropriate to secure necessary care and share crisis intervention (provider) and emergency information.	✓		
	Communicate with service providers and health plans as appropriate to secure necessary care and supports.	✓	✓	
	Link/refer client to needed services to support care plan/treatment goals, including medical/ behavioral health care; patient education, and self-help/recovery, medication adherence, health literacy, and self-management.	✓	✓	

Guidelines for
HH Staff Roles and Responsibilities

February 29, 2016

CORE HEALTH HOME SERVICES	EXAMPLES OF CORE HEALTH HOME SERVICES, INTERVENTIONS and ACTIVITIES	CARE COORDINATOR functions	ALLIED STAFF potential roles under direction of the Care Coordinator	SUPPORT STAFF under the direction of the Care Coordinator
	Conduct case reviews with interdisciplinary care team to monitor/evaluate client status and service needs.	✓		
	Advocate for services and assist with scheduling of needed services.	✓	✓	
	Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.	✓		
	Assist and support client with scheduling medical and applicable appointments.	✓	✓	
	Accompany the client to medical and other applicable appointments.	✓		
	Develop a crisis intervention or resiliency plan and revise care plan/goals as required.	✓		
Health Promotion	Provide customized educational materials according to the needs and goals of the client, caregiver, or other social supports as appropriate.	✓	✓	
	Promote participation in community educational and support groups.	✓	✓	
	Provide links to health care resources that support the client's goals.	✓	✓	
	Develop and execute cross-system care coordination activities to assist the client in accessing and navigating needed services.	✓		
	Support the execution of cross-system care coordination activities that assist clients in accessing and navigating needed services.	✓	✓	
	Distribute health education and other materials.	✓	✓	✓
	Assist with follow up calls and provide appointment reminders.	✓	✓	✓
Comprehensive Transitional Care	Follow up with hospitals/ER upon notification of a client's admission and/or discharge to/from an ER, hospital or rehabilitative setting.	✓		
	Facilitate discharge planning from an ER, hospital, or rehabilitative setting to	✓		

Guidelines for
HH Staff Roles and Responsibilities

February 29, 2016

CORE HEALTH HOME SERVICES	EXAMPLES OF CORE HEALTH HOME SERVICES, INTERVENTIONS and ACTIVITIES	CARE COORDINATOR functions	ALLIED STAFF potential roles under direction of the Care Coordinator	SUPPORT STAFF under the direction of the Care Coordinator
	ensure a safe transition/discharge that ensures care needs are in place.			
	Notify/consult with treating clinicians, schedule follow up appointments, and assist with medication reconciliation.	✓		
	Follow-up post discharge with client/family to ensure client understands discharge orders and medication reconciliation has been completed.	✓		
	Support client with connecting to community supports to ensure that needed services or equipment are received.	✓	✓	✓
Individual & Family Support	Develop, review, or revise the client's Health Action Plan with the client, family, or caregiver to ensure that the plan reflects client's preferences, goals, education, and health literacy to support health self-management.	✓		
	Educate client, family, or caregiver on advance directives, client rights, and health care issues, as needed.	✓	✓	
	Meet with client and family, inviting any other providers to facilitate needed interpretation services.	✓	✓	
	Refer client/family to peer supports, support groups, social services, entitlement programs as needed.	✓	✓	
Referral to Community & Social Support Services	Identify, refer and facilitate access to relevant community and social support services that support the client's health action goals.	✓	✓	
	Assist client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems.	✓	✓	
	Provide general information about upcoming community events.	✓	✓	✓

* Allied health care staff, as identified in the Washington State Plan Amendment, means community health workers, peer counselors or other non-clinical personnel who provide supportive services to the client under the direction and supervision of the Health Home Care Coordinator.

Health Home Program Washington

Health Home Participation Authorization and Information Sharing Consent Form Guidance

Health Home Consent	Guidance	How to complete the form
Purpose	• To create a streamlined process for completing the Health Home Participation Authorization and Information Sharing Consent Form.	• To be considered a valid consent the guidance provided in this document should be followed.
Page 1 – Health Home Participation Authorization		• Complete the Health Home Participation Authorization Information Sharing Consent form.
	• Print name of beneficiary	• Beneficiary name must be printed clearly.
	• Print name of Health Home Lead	• Health Home Lead name must be printed clearly.
	• Signature of beneficiary or beneficiary's legal representative	• There must be a signature on this line. Electronic signatures are acceptable per current guidance. Electronic signature guidance (18-0013).
	• Date	• The full date must be clearly written. Example: 12/1/2024 or December 1, 2024.
Providing verbal consent	• When it is not possible to get the beneficiary's signature prior to services or if the beneficiary is unable to sign due to a physical impairment, the Care Coordinator (CC) may explain or read the Health Home Participation Authorization form. The CC must clearly document the interaction.	• Document in the beneficiary's file if verbal consent was obtained. • Document name of person giving consent, the date consent was given and if there were any witnesses. Also document how the CC will follow up. For Example: ▪ Mailing a copy of the form with a return envelope for the beneficiary to sign, or ▪ Mailing a copy to the beneficiary. Note: Make sure to document on the form itself and in the file.
Adolescent Beneficiary	• If the beneficiary is between the ages of 13-17 you must fill out the	• Complete the Health Home Adolescent Information Sharing Consent form.

Health Home Program Washington

Health Home Participation Authorization and Information Sharing Consent Form Guidance

Health Home Consent	Guidance	How to complete the form
	Health Home Adolescent Information Sharing Consent form (this is in addition to the Health Home Participation form)	Note: The Health Home Adolescent Information Sharing Consent form may not be provided verbally.
Information Sharing Consent Portion of Document		
Optional disclosure for Behavioral health, HIV/AIDS and STD results, diagnosis, or treatment	• For the consent to be valid when the beneficiary health records include any behavioral health, HIV/AIDS or STD information, this section must also be complete.	• Initials must be next to the Behavioral health field and/or the HIV/AIDS and STD results, diagnosis, or treatment field if the beneficiary gives permission to disclose information. Note: A check mark or a line across the box is NOT considered a valid consent.
SUD – To give consent for the release of confidential alcohol or drug treatment	• Beneficiary must complete a separate Release of information (ROI) for substance use disorder (SUD) services form	• Complete the Release of information (ROI) for substance use disorder (SUD) services and attach in file. Note: The release of information for substance use disorder (SUD) form may not be provided verbally.
Validity of the consent form	• Beneficiary must initial option for consent to be valid	• Either initial “this consent is valid as long as the Health Home needs my records for the program” or initial “until” and print a clear date. Note: A check mark or line across the box is NOT considered a valid consent.
Print name of beneficiary	• Print the full name of the beneficiary	• Beneficiary name must be printed clearly.
Beneficiary’s date of birth	• Print the beneficiary’s full date of birth	• Print the beneficiary’s full date of birth. Example: 05/10/1982 or May 10, 1982.

Health Home Program Washington

Health Home Participation Authorization and Information Sharing Consent Form Guidance

Health Home Consent	Guidance	How to complete the form
Signature of beneficiary or beneficiary's legal representative	• Must be signed for the consent to be valid (See *Providing verbal consent*, below)	• Beneficiary or beneficiary's legal representative signs the Information Sharing Consent portion of the form. Electronic signatures are acceptable per current guidance. Electronic signature guidance (18-0013).
Providing verbal consent for beneficiary or beneficiary's legal representative	• When it is not possible to get the beneficiary's signature prior to services, the Care Coordinator (CC) may explain or read the Health Home Participation Authorization form. The CC must clearly document the interaction	• Document in the beneficiary's file if they provided verbal consent or not. • Document name of person giving consent and date/time if there were witnesses and how the CC will follow up. For Example: ▪ Mailing a copy of the form with a return envelope for the beneficiary to sign, or ▪ Mailing a copy to the beneficiary. Note: Make sure to document on the form itself and in the file.
Date	• Full date must be visible and clearly written	• Print the date the beneficiary signed the consent. Example: 12/1/2024 or December 1, 2024.
Print name of legal representative (if applicable)	• Print the full name of the legal representative if applicable	• Legal representative's name must be printed clearly.
Relationship of legal representative to beneficiary	• Print the relationship of legal representative to beneficiary	• Print the relationship of legal representative to beneficiary.
Page 2 – Release of information		
If there is a past CCO or Lead make sure to clearly write in their name	• Past lead or CCO will not be able to share information if this is section is not complete	• Print the name of the past CCO or Lead and have beneficiary date and initial**.** Note: If there is not a full date or initials of the beneficiary the release of information is NOT considered valid.

This document serves as a guide for documentation of Health Home Participation Authorization Information Sharing Consent. Please contact the Lead Organization for additional documentation requirements. Consult supervisor for documentation requirements established within the agency. January 2025.

Health Home Program Washington

Health Home Participation Authorization and Information Sharing Consent Form Guidance

Health Home Consent	Guidance	How to complete the form
List all providers/people/facilities in the following lines that the beneficiary would like to have the CC be able to share health information with	• Each entity, provider, or person listed must have their own line item to be considered as a valid recipient of disclosure privileges. • If the consent is prepopulated with provider types, example; Provider, PCP, Pharmacy – the CC should prompt the beneficiary to provide a specific provider and add their name on the form.	• Clearly print the name of the provider/facility/person. • Note: If there is not a full date or initials of the beneficiary, the release of information is NOT considered valid.
Annual Consent Review		
	Review date • (MM/DD/YYYY): Full date must be visible and clearly written	• Each year, the CC should be reviewing the consent document with beneficiary. • Print the date the care coordinator signed the consent. Example: 12/1/2025.
	• Care Coordinator Name	• Care Coordinator will print their name and sign each time they review document with beneficiary.
	• Care Coordinator Signature	• Care Coordinator will print their name and sign each time they review document with beneficiary. Electronic signatures are acceptable per current guidance. Electronic signature guidance (18-0013).
Providing a copy of the Health Home Participation Authorization and	• Provide a copy of the Health Home Participation Authorization and Information Sharing Consent Form upon request.	• Document in the case file if a copy was provided to the beneficiary.

Health Home Program
Washington

Health Home Participation Authorization and Information Sharing Consent Form Guidance

Health Home Consent	Guidance	How to complete the form
Information Sharing Consent Form		
Examples of a valid release of information		Name of provider/partner Date Beneficiary initials • Providence Health System 12/1/2024 AA • Jane Smith 12/1/2024 AA • Dr. Jimmy Waters 12/1/2024 AA
Examples of a non-valid release of information form	Do not write in generic provider categories such as "Dental Care Provider" or "Primary Care Doctor". A specific provider name and/or specific treating clinic should be identified by the beneficiary.	• "Any Provider" • "Any hospital" • No name at all • "Whoever needs information" • Acronyms for Health Care Providers such as "CHI" or "MHS"
When the beneficiary chooses to no longer participate in the Health Home program.	The beneficiary may opt-out from the Health Home program at any time. The Health Home Participation (Opt-Out/Decline Services must be completed and mailed to the beneficiary.	• The beneficiary will sign and date the form if they are available to do so. • If the beneficiary gives verbal consent to opt-out of the program, the care coordinator will complete section 4 of the opt-out form and mail a copy to the beneficiary. • Electronic signatures are acceptable per current guidance. Electronic signature guidance (18-0013).
Beneficiary adding or withdrawing consent for specific providers/partners	If the beneficiary chooses to add or withdraw consent for providers, they may do so by filling out the consent form. To add a provider/partner use the "beneficiary gives consent" section of the form. If the beneficiary would like to withdraw consent, they must fill out the "beneficiary	• The beneficiary must also initial and date the consent for the addition or withdrawal to be considered valid.

Health Home Consent	Guidance	How to complete the form
	withdraws consent" columns on the consent form	
Beneficiary information sharing consent process	• Explain to the beneficiary how their information and sharing process will be used.	• Provide information that providers/partners will use the beneficiary's health information to coordinate and help the beneficiary's health care. • Please see page 3 of the consent form for details regarding beneficiary information sharing consent process.

Notes		• A line down the page after first initial or first date is NOT considered valid.
		• A check mark instead of initials is NOT considered valid.
		• If there is not a full date the release is NOT considered valid.
		• Date must be filled out as follows:
		  ○ 12/1/2024
		  ○ December 1, 2024
		  ○ 12/01/2024
		• Beneficiary initials MUST be on each line that has an entity attached.
		• The Health Home Participation Authorization portion of the form (pg. 1) must be filled out by the beneficiary to begin Health Home services; however, the Information Sharing Consent portion of the form (pg. 2) is optional.
		• Both pages (1 & 2) of this document must be included in the beneficiary file even if the beneficiary chooses not to have any information shared.
		• Note: If the Information Sharing Consent portion of the form (pg. 2) is not filled out, the CC may NOT share any information with providers.

PRISM Eligibility Screen

Foster Care Placement

Recent Managed Care payments

MC program	MC provider	From	To
HH	OptumHealth-Health Homes	2013-12-01	2013-12-31
HH	OptumHealth-Health Homes	2014-01-01	2014-01-31

Monthly eligibility

Calendar year month	Living arrangement	Placement status	Dual	RAC	AU Medical coverage group	MC program	MC provider
201311	FOSTER CARE TITLE 4	DDD Client	Not Dual, Not a Medicare Beneficiary	Categorically Needy with SSI cash; Title IV-E Federal Foster Care	SSI Related FC/ASUR Medical		

Foster Care Placement – Tribal child

Recent Managed Care payments

MC program	MC provider	From	To
PCCM	SEATTLE INDIAN HEALTH BOARD	2014-01-01	2014-01-31

Monthly eligibility

Calendar year month	Living arrangement	Placement status	Dual	RAC	AU Medical coverage group	MC program	MC provider
201312	FOSTER CARE NON-TITLE 4	Foster Care Placement	Not Dual, Not a Medicare Beneficiary	Categorically Needy with SSI cash; Non IV-E State Foster Care	SSI Related FC/ASUR Medical	Native Health PCCM	

Relative Placement

Recent Managed Care payments

MC program	MC provider	From	To
HOBD	MHC Healthy Options Blind/Disabled	2014-01-01	2014-01-31
HO	MHC Healthy Options	2013-12-01	2013-12-31

Monthly eligibility

Calendar year month	Living arrangement	Placement status	Dual	RAC	AU Medical coverage group	MC program	MC provider
201311	FOSTER CARE NON-TITLE 4	Relative Placement	Not Dual, Not a Medicare Beneficiary	Categorically Needy Children's Medicaidage under 19 Mandatory	Categorically Needy Childrens	Healthy Options	

PRISM Health Report for JOHN DOE

Print Date: 2018-08-31

Date of Birth: 1989-12-09

Age: 28 years 8 months 22 days

Gender: Male

ProviderOne ID: 100000000WA

View or print as PDF

Last Well-Child exam/EPSDT

No record found.

Last dental appointment

No record found.

Health conditions

Recent diagnosis(ICD-9 Code)	Last Date	Provider	Provider Phone
FLAIL CHEST (8074)	2018-06-26		
TRACHEOSTOMY STATUS (V440)	2018-06-05		
PULMONARY COLLAPSE (5180)	2018-06-04		
PLEURAL EFFUSION NOS (5119)	2018-06-04		
MILD COGNITIVE IMPAIRMENT (33183)	2018-05-26		
ALCOHOL ABUSE-UNSPEC (30500)	2018-05-26		
MANDIBLE FX NOS-OPEN (80230)	2018-05-26		
HYPOPOTASSEMIA (2768)	2018-05-15		

Hospital stays

Admission Date	Service End Date	Primary Diagnosis(ICD-9 Code)	ER	Length of Stay	Provider	Provider Phone
2018-05-26	2018-06-01	REHABILITATION PROC NEC (V5789)	No	6 days	Hope Hospital	(xxx) xxx-xxxx
2018-06-26	2018-07-17	FLAIL CHEST (8074)	No	21 days	QUALITY HEALTH CARE SYSTEM	(xxx) xxx-xxxx

Emergency room visits

Visit Date	Primary Diagnosis (ICD-9 Code)	Alcohol	Drug	Injury	Psych	Other	Provider	Provider Phone
2018-02-26	OPEN WOUND OF FOREARM (88100)			yes			Healthy Options Blind/Disabled	(xxx) xxx-xxxx
2018-02-28	OPEN WOUND OF FOREARM (88100)			yes			Healthy Options Blind/Disabled	(xxx) xxx-xxxx
2018-06-04	PULMONARY COLLAPSE (5180)					yes	UNITED STATES HEALTH CONFERENCE	(xxx) xxx-xxxx

Professional Office and non-ER Hospital Outpatient Visits in last 180 days

May include ancillary professional claims associated with an outpatient ER visit

Visit Date	Primary Diagnosis (ICD-9 Code)	Procedure	Servicing Provider	Provider Phone
2018-03-25	OPEN WOUND OF FOREARM (88100)	Emergency dept. visit	Healthy Options Blind/Disabled	(xxx) xxx-xxxx
2018-03-19	OPEN WOUND OF FOREARM (88100)	Repair superficial wound(s)	Healthy Options Blind/Disabled	(xxx) xxx-xxxx
2018-03-19	OPEN WOUND OF FOREARM (88100)	Emergency dept. visit	BOWER, MARK	
2018-02-19	OPEN WOUND OF FOREARM (88100)	Emergency dept. visit	Healthy Options Blind/Disabled	(xxx) xxx-xxxx
2018-02-19	OPEN WOUND OF FOREARM (88100)	Repair superficial wound(s)	BOWER, MARK	

Prescriptions filled in last 90 days

No record found.

Prescriptions by drug classes in last two years

Fill Date	Generic Name	Drug Class	Prescriber	Pharmacy	Pharmacy Phone
2018-06-26	IBUPROFEN TAB 800 MG		JACOB BYRON MD	WAL-MART PHARMACY	(xxx) xxx-xxxx

2018-06-16	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	ANALGESICS,NARCOTICS	THOMAS JEFFERSON MD	WAL-MART PHARMACU	(xxx) xxx-xxxx
2018-06-01	SENNOSIDES SYRUP 8.8 MG/5ML	LAXATIVES AND CATHARTICS	Scott, Darrin	Hope Hospital	(xxx) xxx-xxxx
2018-06-01	RANITIDINE HCL TAB 150 MG	ANTI-ULCER PREPARATIONS	Scott, Darrin	Hope Hospital	(xxx) xxx-xxxx
2018-06-01	IPRATROPIUM-ALBUTEROL AEROSOL 18-103 MCG/ACT (20-120MCG/ACT)		Scott, Darrin	Hope Hospital	(xxx) xxx-xxxx
2018-06-01	AMOXICILLIN & K CLAVULANATE TAB 875-125 MG	PENICILLINS	Scott, Darrin	Hope Hospital	(xxx) xxx-xxxx

Disclaimer

The enclosed healthcare information is confidential and is to be used solely for meeting the medical needs of this patient. It may only be shared with the patient's healthcare provider(s). Redisclosure of this information can only be made with the patient's written consent or other appropriate legal authorization. This information is also protected under federal and state law. It is provided to you for the limited purposes of meeting the needs and ensuring the safety and well-being of patient placed in your care. You may discuss the information with the patient or the patient's healthcare providers.

Sacha

High-risk elder receiving in-home personal care

1. Demographics
    a. 69 year-old woman
2. Coverage status including plan enrollment
    a. Dually eligible for Medicaid and Medicare
3. Current living arrangements
    a. Living at home and authorized for about 4 hours per day of Community First Choice Program personal care
4. Major medical risk factors
    a. Chronic heart disease
    b. Chronic kidney disease
    c. Diabetes Type II, poorly controlled
    d. Rheumatoid arthritis
    e. Pulmonary collapse
    f. Chronic pain
5. Behavioral health risk factors
    a. Depression
6. IP use and primary diagnosis
    a. Hospitalized 4 times in past year
    b. Twice related to UTI
    c. Once for chest pain
    d. Most recently with diabetic coma
7. ED use and primary diagnoses
    a. 30 visits in past year
    b. Common primary diagnoses include
        i. Diabetes
        ii. UTI
        iii. Chest pain and other pain
        iv. Dizziness
        v. Headache
        vi. Injuries from falls
8. CARE assessment information
    a. Moderate ADL needs
    b. High depression score
    c. Mild-moderate cognitive impairment
    d. Current behaviors
        i. Easily irritated
        ii. Hallucinations

iii. Obsessed with her disease and limited abilities

e. Fall risk – recently fell in bathroom
f. Chronic pain limits activity
g. Multiple functional limitations

9. Primary care provider
    a. Frequently visits local community health clinic, with encounters with multiple servicing providers associated with evaluation and management procedure codes

Carmella

High-risk disabled adult with serious mental illness

1. Demographics
    a. 25 year old woman
2. Coverage status including plan enrollment
    a. SSI-related Medicaid, recently enrolled with a health plan but dropped back to Fee-For-Service
3. Current living arrangements
    a. Living at home
4. Major medical risk factors
    a. Diabetes
    b. Epilepsy
    c. Asthma
    d. Septicemia
    e. Hypertension
    f. Gastric acid disorder
5. Behavioral health risk factors
    a. Schizophrenia
    b. Bipolar
    c. PTSD
    d. Borderline personality
    e. Depression
    f. No co-occurring substance abuse identified
6. IP use and primary diagnoses
    a. Hospitalized 8 times in past 15 months
    b. Most recently for apparent suicide attempt led to medical hospitalization for analgesic overdose, followed by an E&T admission for mental health, followed by transfer to community psychiatric hospital
    c. Prior admissions for:
        i. Depression (psych E&T)
        ii. Gastritis
        iii. Septicemia
        iv. Epilepsy
        v. Muscle pain

7. ED use and primary diagnoses
    a. 49 visits in past 15 months
    b. Common primary diagnoses include
        i. Depression, anxiety, bipolar
        ii. Convulsions
        iii. Adult sexual abuse
        iv. Analgesic overdose
        v. Diabetes
        vi. Asthma
        vii. Contusions
        viii. Injuries
        ix. Pain
8. CARE assessment information
    a. N/A
9. BHO services
    a. Frequent therapy visits and crisis intervention services
10. Primary care provider
    a. Little evidence of primary medical provider relationship

Tom

High medical risk disabled with serious mental illness and co-occurring substance use disorder

1. Demographics
    a. 54 year old man
2. Coverage status including plan enrollment
    a. SSI-related Medicaid
3. Current living arrangements
    a. Currently homeless following release from jail 12 months ago.
4. Major medical risk factors
    a. Renal – cystostomy, catheter, frequent UTI
    b. Spinal cord injury, Hemiplegia/hemiparesis
    c. Arthritis
    d. Cardiovascular – complications/auto cardiac defibrillator
    e. Diabetes
    f. Cataracts
    g. Pneumonia
5. Behavioral health risk factors
    a. Schizophrenia
    b. Co-occurring alcohol abuse
6. IP use and primary diagnosis
    a. Hospitalized once in past 15 months for UTI
7. ED use and primary diagnosis
    a. 78 visits in past 15 months primarily to treat problems with urinary catheter and chronic UTI
8. CARE assessment information
    a. Applied for personal care but never received assistance
9. BHO services
    a. Currently receiving BHO-funded services, 2-3 OP visits per month
10. Primary care provider
    a. Does not appear to have established medical PCP

Luchita

High medical risk child with developmental delay and behavioral factors

1. Demographics
    a. 6 year old girl
2. Coverage status including plan enrollment
    a. SSI-related Medicaid
3. Current living arrangements
    a. Began living at home with her mother in the past three months, prior to that she was in foster care for over one year
4. Major medical risk factors
    a. Gastrostomy
    b. Immune system disorder
    c. Spontaneous ecchymosis (bruising)
    d. Heart disease
    e. Conduct disorder not otherwise specified
    f. Failure to thrive
5. Behavioral health risk factors
    a. Conduct disorder not otherwise specified
    b. Developmental delay
    c. PSC-17 score: 12 (scored 7 points on the attention scale)
6. IP use
    a. Hospitalized 3 times in past 15 months (general medical)
7. ED use and diagnosis
    a. One ED visit in past 15 months for vomiting
8. No CARE assessment information is available, no nursing facility admissions
9. Receives speech therapy on a weekly basis for hearing and language development
10. Primary care provider
    a. Appears to have an established relationship with a PCP and her cardiologist

Jacob

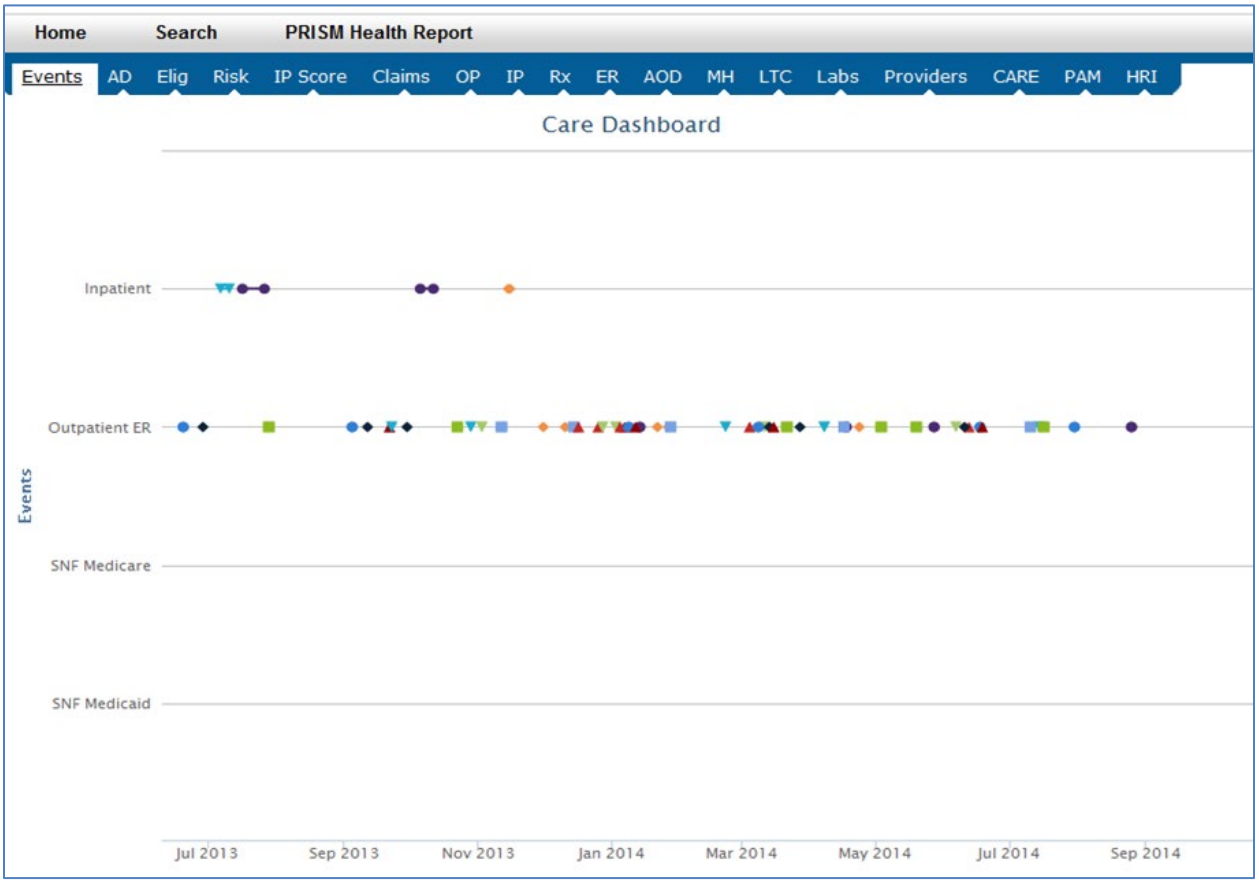
High-risk developmental delay

1. Demographics
    a. 21 year old man
2. Coverage status including plan enrollment
    a. SSI-related Medicaid
3. Current living arrangements
    a. Living at home with parents for past three months after being evicted from an adult family home
4. Major medical risk factors
    a. Splenomegaly
    b. Cardiac dysrhythmias
    c. Asthma
    d. Fractures
    e. Esophageal reflux
    f. Pain medication use
5. Behavioral health risk factors
    a. Mild intellectual disability
    b. Oppositional disorder
    c. Psychosis
    d. Prescribed antipsychotics, antidepressants, and narcotics
6. IP use
    a. Not hospitalized in past 15 months
7. ED use and primary diagnoses
    a. 54 visits in past 15 months
    b. Common primary diagnoses include
        i. Concussions, contusions, open wounds, and other injuries
8. CARE assessment information
    a. Moderate cognitive impairment
    b. Problem behaviors
        i. Paranoia
        ii. Mood swings
        iii. Verbally abusive
9. BHO services
    a. Ongoing (at least monthly) community mental health center visits
10. Primary care provider
    a. No indication of stable PCP relationship

PRISM SCREENS

The following images display the types of information available in the current version of PRISM. Please note that these examples are for fictitious clients.

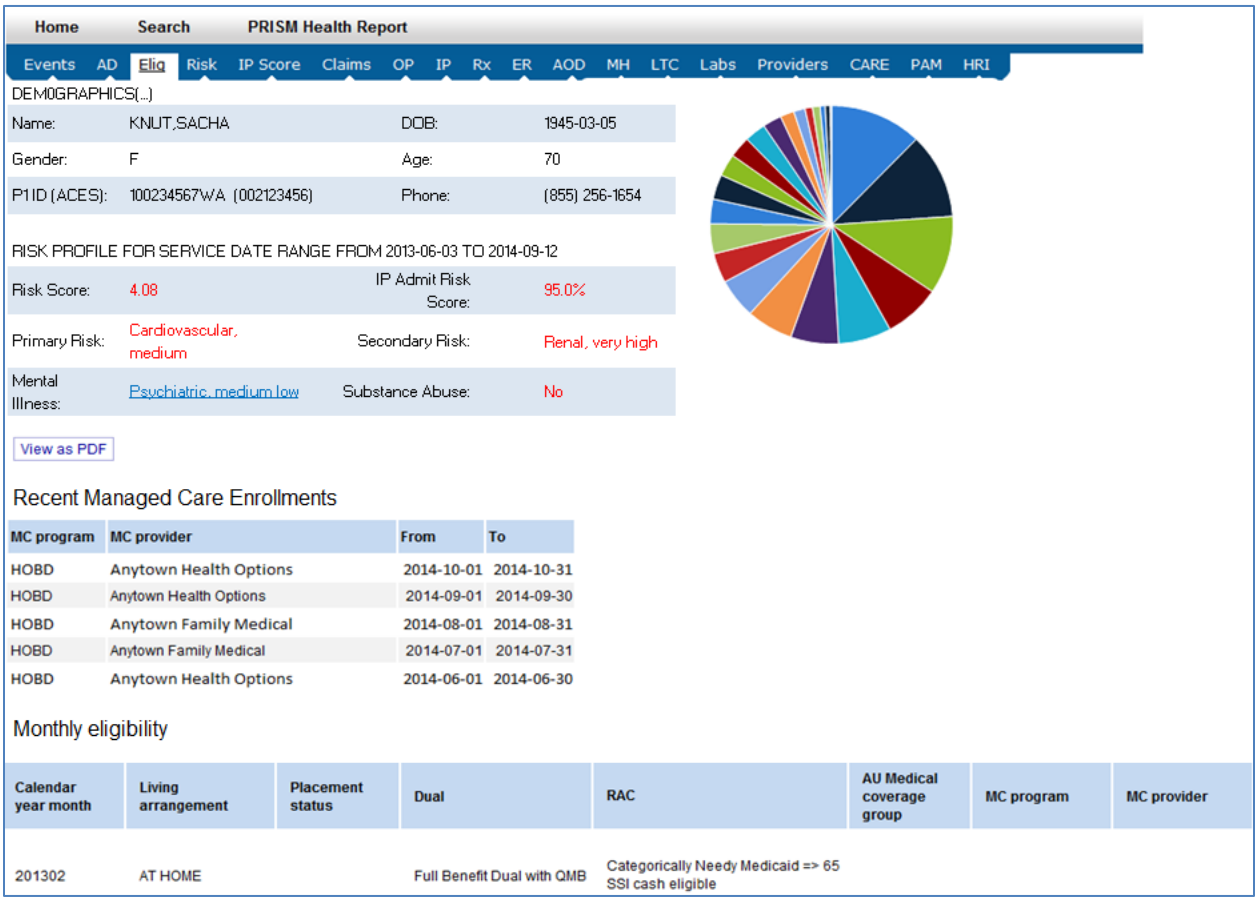
Events



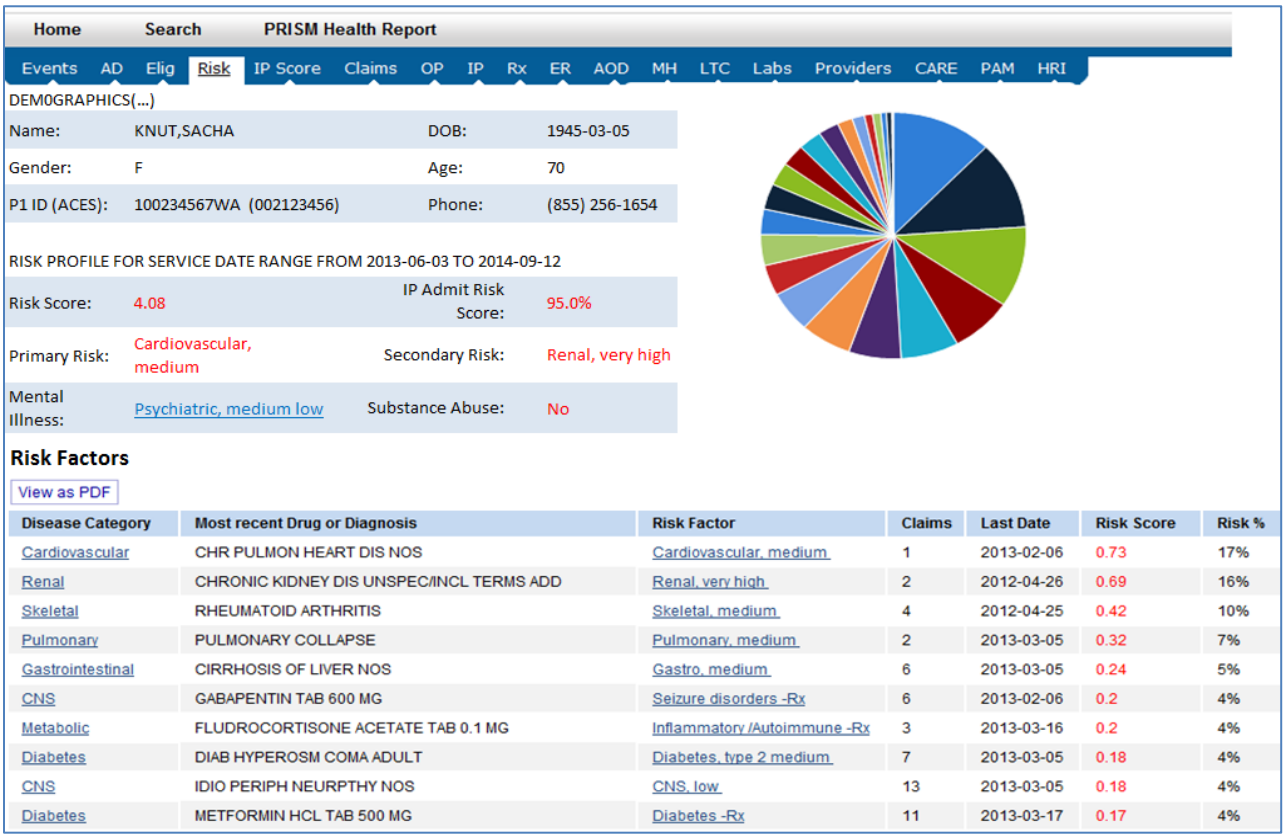
Drug Adherence

Eligibility

and Demographics



Risk Factors



Disease Category	Most recent Drug or Diagnosis	Risk Factor	Claims	Last Date	Risk Score	Risk %
Cardiovascular	CHR PULMON HEART DIS NOS	Cardiovascular, medium	1	2013-02-06	0.73	17%
Renal	CHRONIC KIDNEY DIS UNSPEC/INCL TERMS ADD	Renal, very high	2	2012-04-26	0.69	16%
Skeletal	RHEUMATOID ARTHRITIS	Skeletal, medium	4	2012-04-25	0.42	10%
Pulmonary	PULMONARY COLLAPSE	Pulmonary, medium	2	2013-03-05	0.32	7%
Gastrointestinal	CIRRHOSIS OF LIVER NOS	Gastro, medium	6	2013-03-05	0.24	5%
CNS	GABAPENTIN TAB 600 MG	Seizure disorders -Rx	6	2013-02-06	0.2	4%
Metabolic	FLUDROCORTISONE ACETATE TAB 0.1 MG	Inflammatory /Autoimmune -Rx	3	2013-03-16	0.2	4%
Diabetes	DIAB HYPEROSM COMA ADULT	Diabetes, type 2 medium	7	2013-03-05	0.18	4%
CNS	IDIO PERIPH NEURPTHY NOS	CNS, low	13	2013-03-05	0.18	4%
Diabetes	METFORMIN HCL TAB 500 MG	Diabetes -Rx	11	2013-03-17	0.17	4%

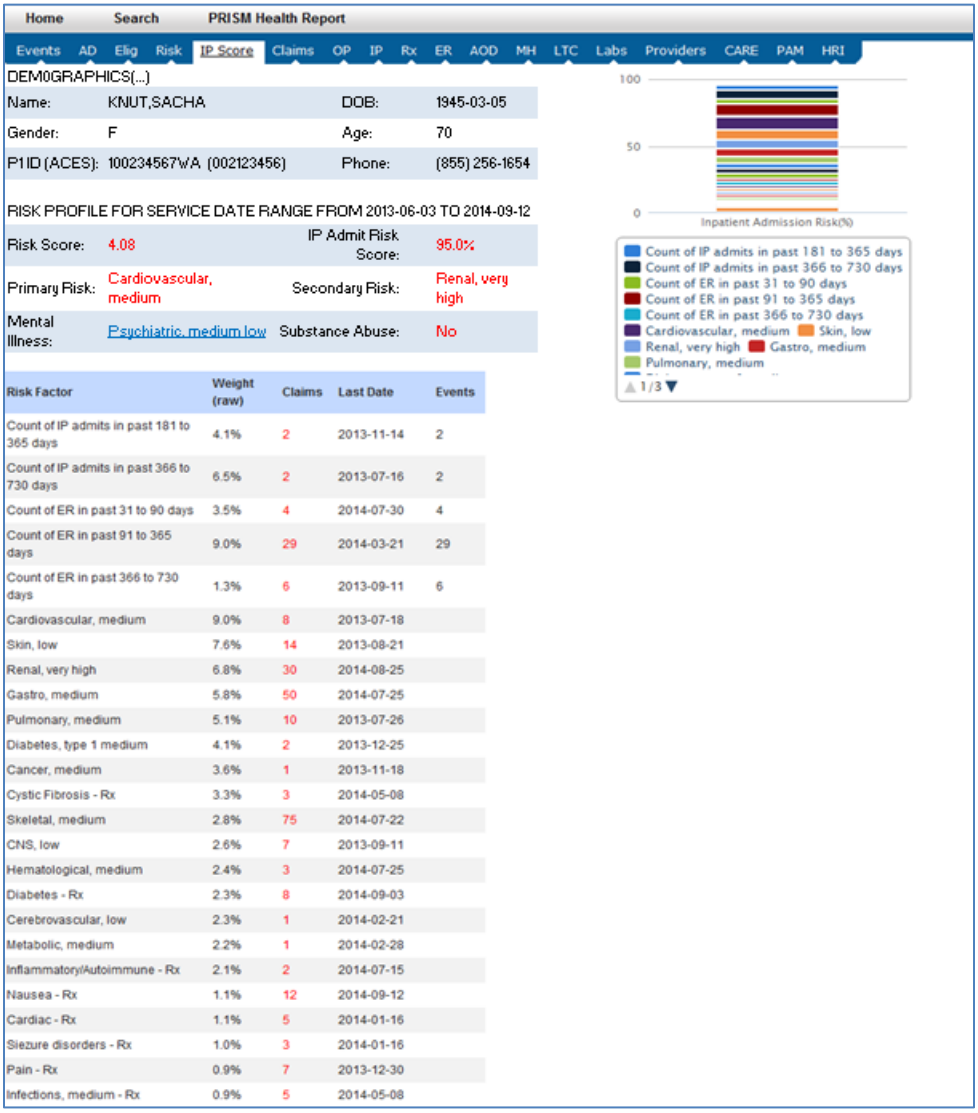
A **Risk Score** estimates the client's expected future medical costs given their risk factors: gender, age, diagnoses and medications. The information is based on fee-for-service and managed care encounter claims data from the past 15 months (24 months for children).

Interpretation: If a client has a risk score of 1.5 that means that their expected medical expenditures in the next year are expected to be 50% greater than the average Medicaid client in the SSI blind/disabled category.

The risk score is only a starting point – Don't take the numeric value too literally. A client with a score of 1.20 will generally be less complex than a client with a score of 7.0, but the differences between 1.2 and 1.3 are likely to be negligible from a care management perspective. The score can vary somewhat every week, based on changes in age or new claims being processed. However, once a Medicaid client is identified as "clinically qualified", they stay qualified regardless of their PRISM score.

A risk score can be broken down into **risk factors**. Risk factors include diagnoses grouped together based on disease category. The diagnosis groups are further broken down by the degree of increased expenditures associated with that group, such as "high cost, medium cost, low cost". The risk factors are provided to assist you in identifying the multitude needs of the client.

IP Score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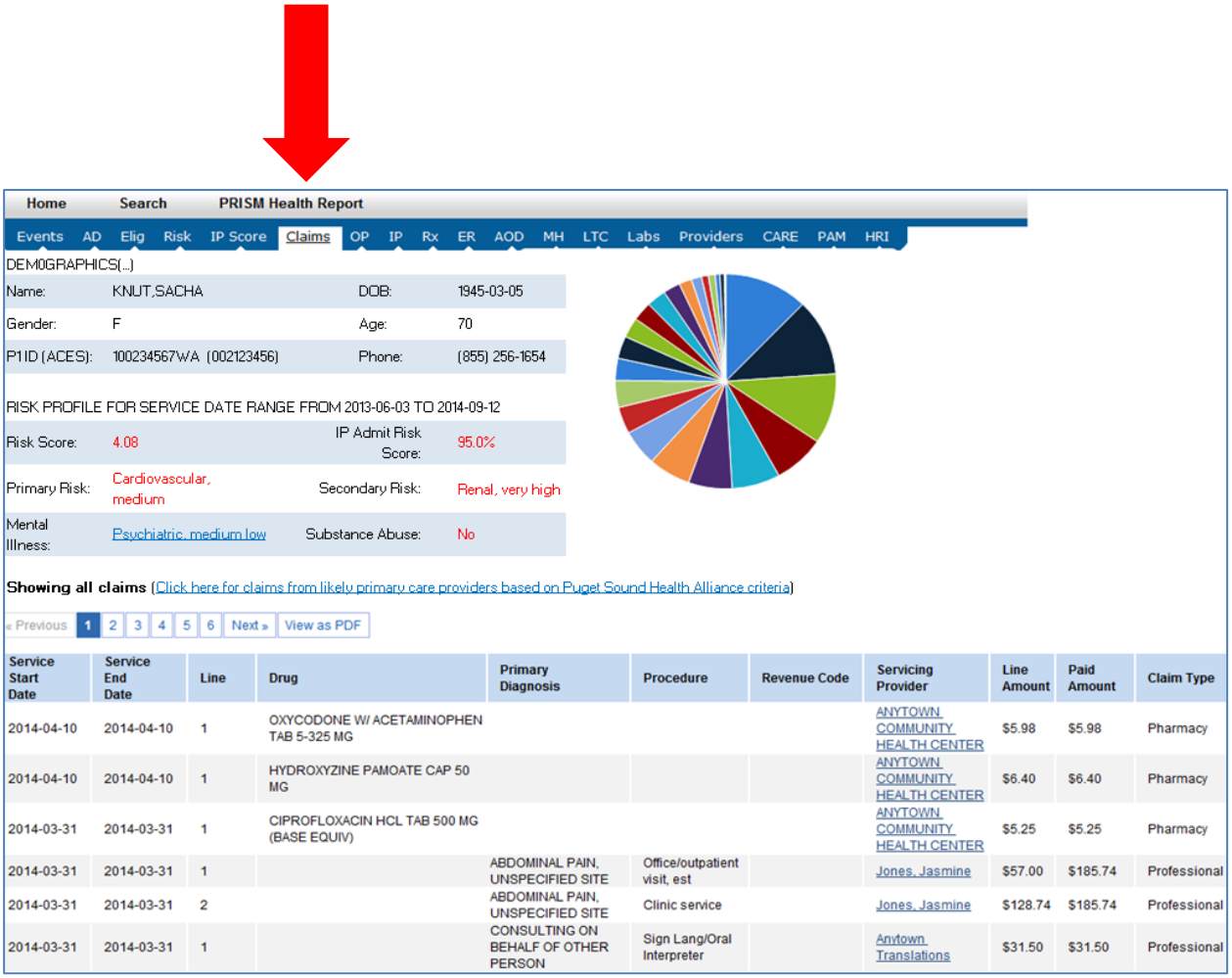
PRISM Health Report
Events AD Elig Risk IP Score Claims OP IP Rx ER AOD MH LTC Labs Providers CARE PAM HRI
DEMOGRAPHICS(...)
Name: KNUT,SACHA
DOB: 1945-03-05
Gender: F
Age: 70
P1 ID (ACES): 100234567WA (002123456)
Phone: (855) 256-1654
RISK PROFILE FOR SERVICE DATE RANGE FROM 2013-06-03 TO 2014-09-12
Risk Score: 4.08
IP Admit Risk Score: 95.0%
Primary Risk: Cardiovascular, medium
Secondary Risk: Renal, very high
Mental Illness: Psychiatric, medium low
Substance Abuse: No
Risk Factor
Weight (raw)
Claims
Last Date
Events
Count of IP admits in past 181 to 365 days 4.1% 2 2013-11-14 2
Count of IP admits in past 366 to 730 days 6.5% 2 2013-07-16 2
Count of ER in past 31 to 90 days 3.5% 4 2014-07-30 4
Count of ER in past 91 to 365 days 9.0% 29 2014-03-21 29
Count of ER in past 366 to 730 days 1.3% 6 2013-09-11 6
Cardiovascular, medium 9.0% 8 2013-07-18
Skin, low 7.6% 14 2013-08-21
Renal, very high 6.8% 30 2014-08-25
Gastro, medium 5.8% 50 2014-07-25
Pulmonary, medium 5.1% 10 2013-07-26
Diabetes, type 1 medium 4.1% 2 2013-12-25
Cancer, medium 3.6% 1 2013-11-18
Cystic Fibrosis - Rx 3.3% 3 2014-05-08
Skeletal, medium 2.8% 75 2014-07-22
CNS, low 2.6% 7 2013-09-11
Hematological, medium 2.4% 3 2014-07-25
Diabetes - Rx 2.3% 8 2014-09-03
Cerebrovascular, low 2.3% 1 2014-02-21
Metabolic, medium 2.2% 1 2014-02-28
Inflammatory/Autoimmune - Rx 2.1% 2 2014-07-15
Nausea - Rx 1.1% 12 2014-09-12
Cardiac - Rx 1.1% 5 2014-01-16
Siezure disorders - Rx 1.0% 3 2014-01-16
Pain - Rx 0.9% 7 2013-12-30
Infections, medium - Rx 0.9% 5 2014-05-08
100
50
0
Inpatient Admission Risk(%)
Count of IP admits in past 181 to 365 days
Count of IP admits in past 366 to 730 days
Count of ER in past 31 to 90 days
Count of ER in past 91 to 365 days
Count of ER in past 366 to 730 days
Cardiovascular, medium
Skin, low
Renal, very high
Gastro, medium
Pulmonary, medium
1 / 3

Claims

Claims and Encounters



Home | Search | PRISM Health Report

Events | AD | Elig | Risk | IP Score | Claims | OP | IP | Rx | ER | AOD | MH | LTC | Labs | Providers | CARE | PAM | HRI

DEMOGRAPHICS(...)

Name:	KNUT,SACHA	DOB:	1945-03-05
Gender:	F	Age:	70
P1ID (ACES):	100234567WA (002123456)	Phone:	(855) 256-1654

RISK PROFILE FOR SERVICE DATE RANGE FROM 2013-06-03 TO 2014-09-12

Risk Score:	4.08	IP Admit Risk Score:	95.0%
Primary Risk:	Cardiovascular, medium	Secondary Risk:	Renal, very high
Mental Illness:	Psychiatric, medium low	Substance Abuse:	No

Showing all claims (Click here for claims from likely primary care providers based on Puget Sound Health Alliance criteria)

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Service Start Date	Service End Date	Line	Drug	Primary Diagnosis	Procedure	Revenue Code	Servicing Provider	Line Amount	Paid Amount	Claim Type
2014-04-10	2014-04-10	1	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG				ANYTOWN COMMUNITY HEALTH CENTER	$5.98	$5.98	Pharmacy
2014-04-10	2014-04-10	1	HYDROXYZINE PAMOATE CAP 50 MG				ANYTOWN COMMUNITY HEALTH CENTER	$6.40	$6.40	Pharmacy
2014-03-31	2014-03-31	1	CIPROFLOXACIN HCL TAB 500 MG (BASE EQUIV)				ANYTOWN COMMUNITY HEALTH CENTER	$5.25	$5.25	Pharmacy
2014-03-31	2014-03-31	1		ABDOMINAL PAIN, UNSPECIFIED SITE	Office/outpatient visit, est		Jones, Jasmine	$57.00	$185.74	Professional
2014-03-31	2014-03-31	2		ABDOMINAL PAIN, UNSPECIFIED SITE	Clinic service		Jones, Jasmine	$128.74	$185.74	Professional
2014-03-31	2014-03-31	1		CONSULTING ON BEHALF OF OTHER PERSON	Sign Lang/Oral Interpreter		Anytown Translations	$31.50	$31.50	Professional

Outpatient

Professional Office, Ambulatory Surgery Center and non-ER Hospital Outpatient Visits

Events | AD | Elig | Risk | IP Score | Claims | OP | IP | Rx | ER | AOD | MH | LTC | Labs | Providers | CARE | PAM | HRI

DEMOGRAPHICS(...)

Name:	KNUT,SACHA	DOB:	1945-03-05
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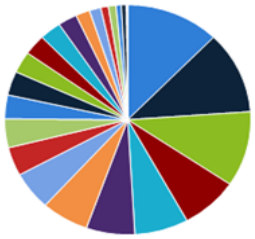
Mental Illness:	Psychiatric, medium low	Substance Abuse:	No



Professional Office, Ambulatory Surgery Center, and non-ER Hospital Outpatient Visits

May include ancillary professional claims associated with an outpatient ER visit

« Previous | 1 | 2 | 3 | 4 | 5 | 6 | Next » | View as PDF

Service Start Date	Service End Date	Line	Drug	Primary Diagnosis	Procedure	Revenue Code	Servicing Provider	Line Amount	Paid Amount	Claim Type
2014-03-31	2014-03-31	1		ABDOMINAL PAIN, UNSPECIFIED SITE	Office/outpatient visit, est		Jones, Jasmine	$57.00	$185.74	Professional
2014-03-31	2014-03-31	2		ABDOMINAL PAIN, UNSPECIFIED SITE	Clinic service		Jones, Jasmine	$128.74	$185.74	Professional
2014-03-31	2014-03-31	1		CONSULTING ON BEHALF OF OTHER PERSON	Sign Lang/Oral Interpreter		Anytown Translations	$31.50	$31.50	Professional
2014-03-17	2014-03-17	1		CHRONIC HYPOTENSION	Office/outpatient visit, est		Jones, Jasmine	$57.00	$185.74	Professional
2014-03-17	2014-03-17	2		CHRONIC HYPOTENSION	Clinic service		Jones, Jasmine	$128.74	$185.74	Professional
2014-03-17	2014-03-17	1		VITAMIN D DEFICIENCY NOS	Routine venipuncture		ANYTOWN PATHOLOGY MEDICAL LAB	$2.31	$34.60	Professional

IP

Inpatient

Home Search PRISM Health Report

Events AD Elig Risk IP Score Claims OP IP Rx ER AOD MH LTC Labs Providers CARE PAM HRI

DEMOGRAPHICS(...)

Name:	KNUT,SACHA	DOB:	1945-03-05
Gender:	F	Age:	70
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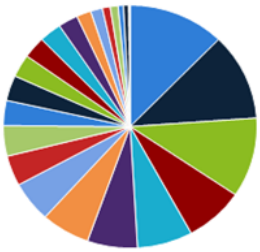
Mental Illness:	Psychiatric, medium low	Substance Abuse:	No



Inpatient

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Claim #	Service Start Date	Service End Date	Primary Diagnosis	Reimbursement	ER	Length of Stay	Diagnosis-Related Group(DRG)	Billing Provider	Provider	E Codes
909145682	2013-03-05	2013-03-08	DIAB HYPEROSM COMA ADULT	$4,570.31	Yes	4 days	294	ANYTOWN REGIONAL MED AND HEART CTR		
911374868	2012-09-29	9/31/2012	URIN TRACT INFECTION NOS	$4,009.14	Yes	3 days	321	Acme Healthy Options Blind/Disabled		
815842865	2012-05-10	2012-05-11	CHEST PAIN NOS	$3,977.16	Yes	2 days	143	ANYTOWN REGIONAL MED AND HEART CTR		
812509004	2012-04-02	2012-04-06	AC PYELONEPHRITIS NOS	$4,805.47	Yes	5 days	320	ANYTOWN REGIONAL MED AND HEART CTR		

RX

Prescriptions filled

Home Search PRISM Health Report

Events AD Elig Risk IP Score Claims OP IP Rx ER AOD MH LTC Labs Providers CARE PAM HRI

DEMOGRAPHICS(...)

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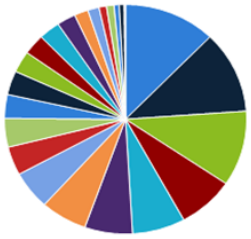
Mental Illness:	Psychiatric, medium low	Substance Abuse:	No



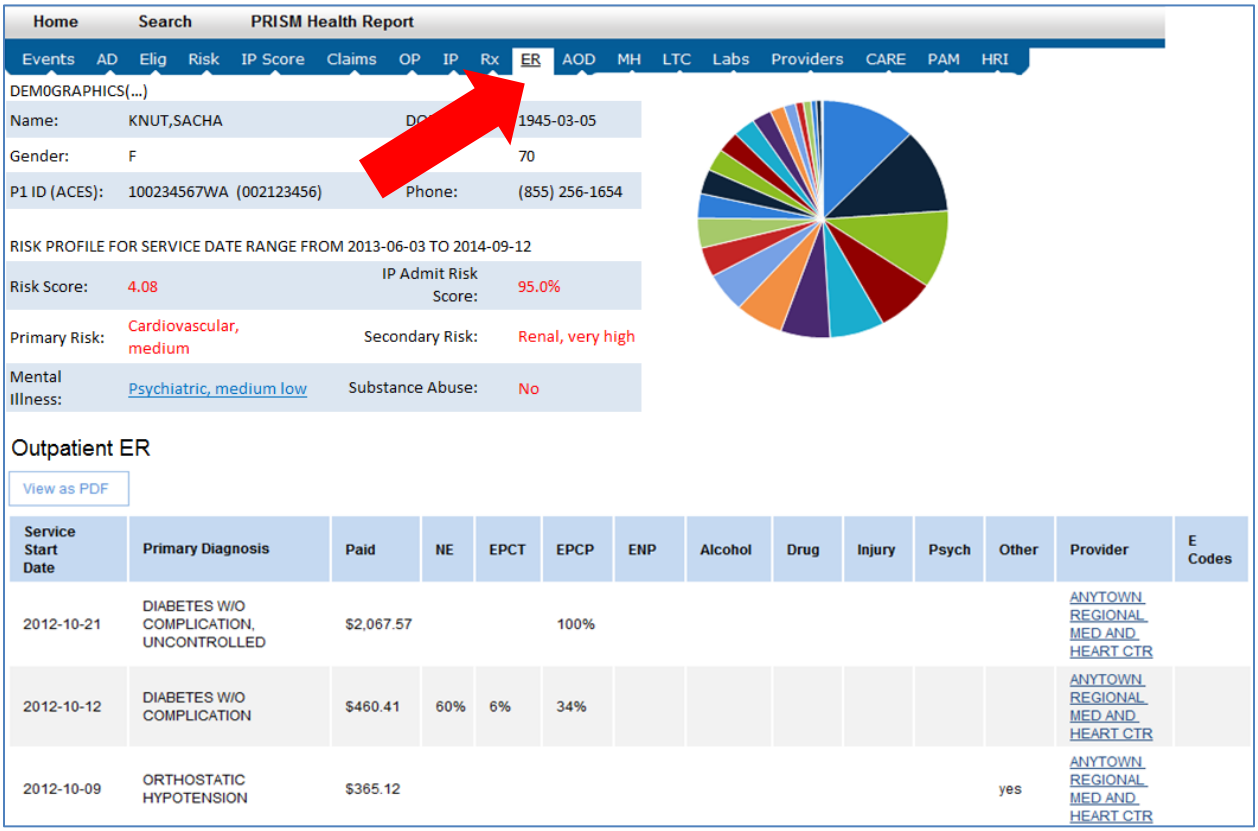
Prescriptions

« Previous 1 2 3 4 5 6 Next » View as PDF

Service Start Date	Generic Drug Name	Drug Class	Quantity	Days Supplied	Reimbursement	Pharmacy	Prescriber	Refill seqence
2014-04-08	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	ANALGESICS,NARCOTICS	30	10	$5.98	ANYTOWN COMMUNITY HEALTH CENTER	Jones, Jasmine	00
2014-04-08	HYDROXYZINE PAMOATE CAP 50 MG	ANTIHISTAMINES - 1ST GENERATION	30	30	$6.40	ANYTOWN COMMUNITY HEALTH CENTER	Jones, Jasmine	00
2014-03-29	CIPROFLOXACIN HCL TAB 500 MG (BASE EQUIV)	QUINOLONES	10	5	$5.25	ANYTOWN COMMUNITY HEALTH CENTER	Jones, Jasmine	00
2014-03-22	GLUCOSE BLOOD TEST STRIP	BLOOD SUGAR DIAGNOSTICS	100	25	$64.40	ANYTOWN COMMUNITY HEALTH CENTER	Jones, Jasmine	01
2014-03-18	SERTRALINE HCL TAB 100 MG	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	30	30	$6.38	ANYTOWN COMMUNITY HEALTH CENTER	Steve R McQueen	00

Emergency Room

Emergency Room Visits that did not result in an inpatient admission



Home Search PRISM Health Report

Events AD Elig Risk IP Score Claims OP IP Rx ER AOD MH LTC Labs Providers CARE PAM HRI

DEMOGRAPHICS(...)

Name:	KNUT,SACHA	DO	1945-03-05
Gender:	F		70
P1 ID (ACES):	100234567WA (002123456)	Phone:	(855) 256-1654

RISK PROFILE FOR SERVICE DATE RANGE FROM 2013-06-03 TO 2014-09-12

Risk Score:	4.08	IP Admit Risk Score:	95.0%
Primary Risk:	Cardiovascular, medium	Secondary Risk:	Renal, very high
Mental Illness:	Psychiatric, medium low	Substance Abuse:	No

Outpatient ER

View as PDF

Service Start Date	Primary Diagnosis	Paid	NE	EPCT	EPCP	ENP	Alcohol	Drug	Injury	Psych	Other	Provider	E Codes
2012-10-21	DIABETES W/O COMPLICATION, UNCONTROLLED	$2,067.57			100%							ANYTOWN REGIONAL MED AND HEART CTR	
2012-10-12	DIABETES W/O COMPLICATION	$460.41	60%	6%	34%							ANYTOWN REGIONAL MED AND HEART CTR	
2012-10-09	ORTHOSTATIC HYPOTENSION	$365.12									yes	ANYTOWN REGIONAL MED AND HEART CTR	

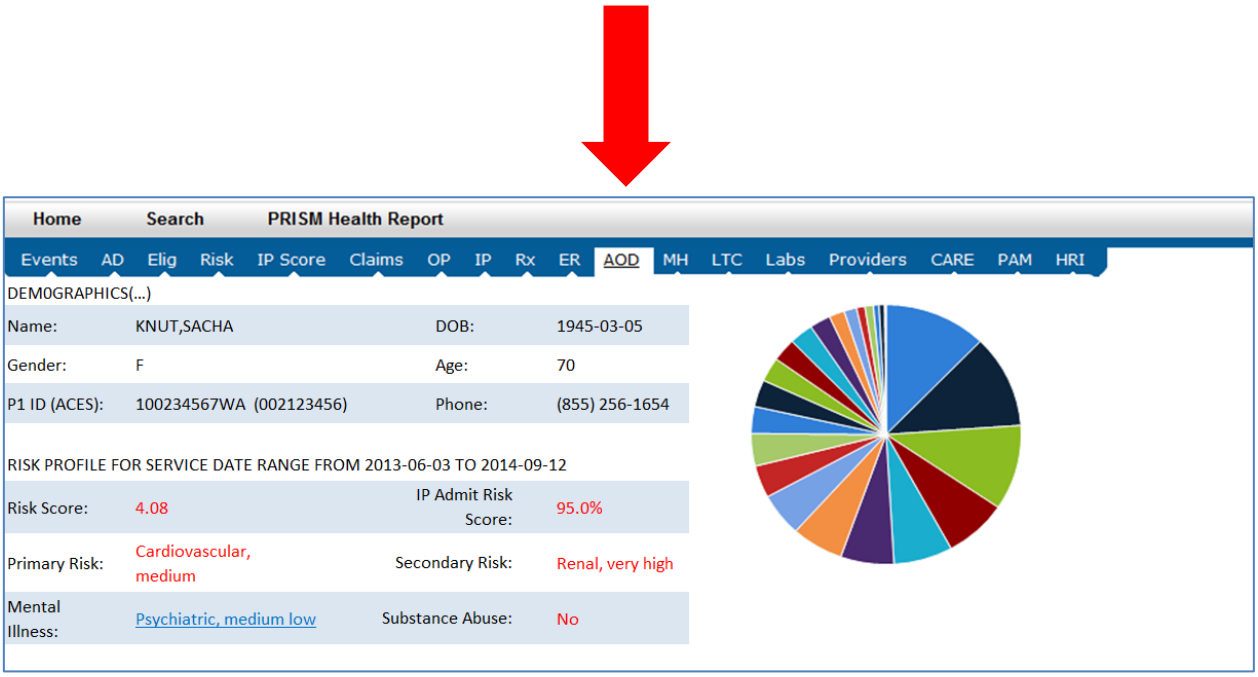
Four columns indicate the probability that the Emergency Room visit is:
NE - Non Emergent. The patient's initial complaint, symptoms, vitals, history and age indicated that medical care was not required within the next 12 hours;
EPCT - Emergent: Primary Care Treatable. Treatment was required within 12 hours and could have been provided outside of the ER;
EPCP - Emergent: Emergency Room Care Needed, Illness Preventable. The health episode could have been avoided with timely primary care treatment; and/or
ENP - Emergent: Emergency Room Care Needed, Not Preventable health episode could not have been avoided.

Interpretation: The first ER visit here, Chest Pain NOS has a 32% probability of being **Emergent, Primary Care Treatable** and a 68% probability of being **Emergent, Emergency Room Care Needed, Not Preventable** based on a study conducted by New York University (http://wagner.nyu.edu//chpsr/index.html?p=62).

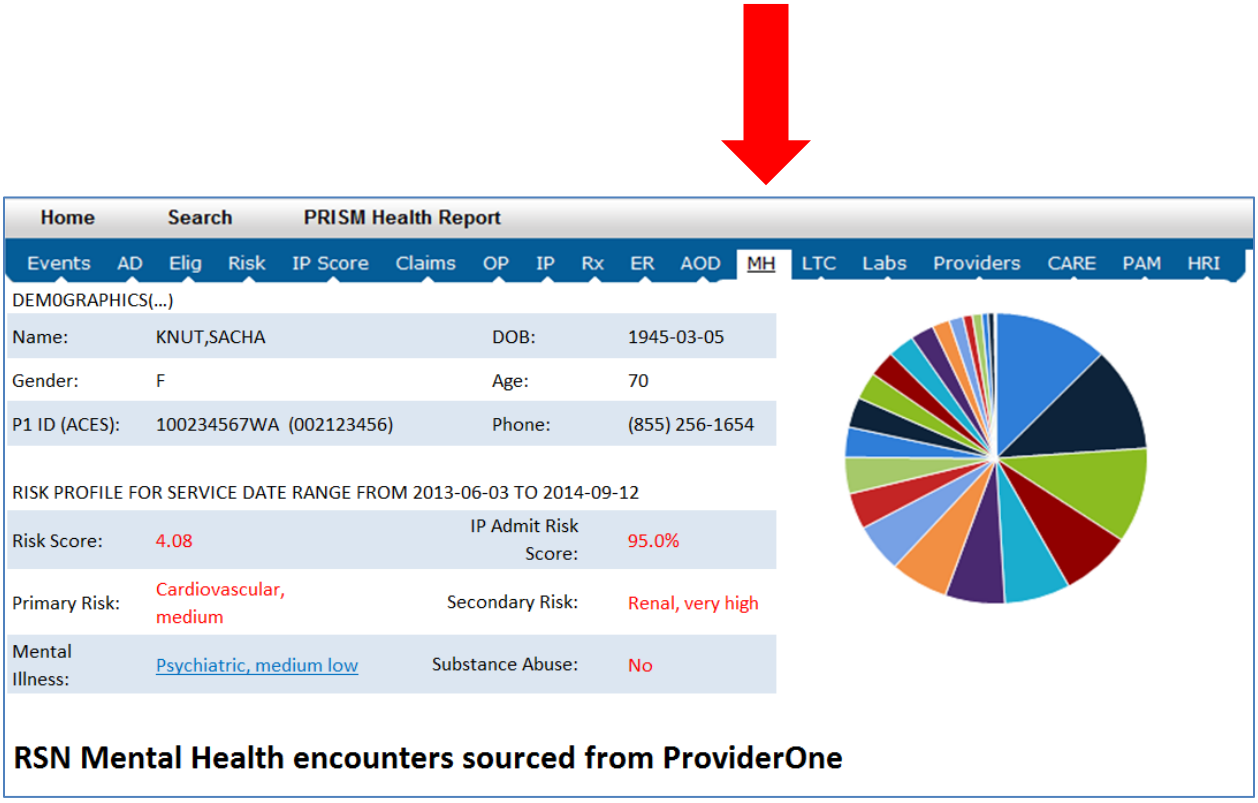
Five (5) types of ER visits do not have a prevention probability assigned to them; they are just assigned a group based on the diagnosis code: Alcohol, Drug (excluding alcohol), Injury, Psych or Other.

These categories can help you quickly scan the list to determine which visits may have been avoidable or determine patterns of ER visits.

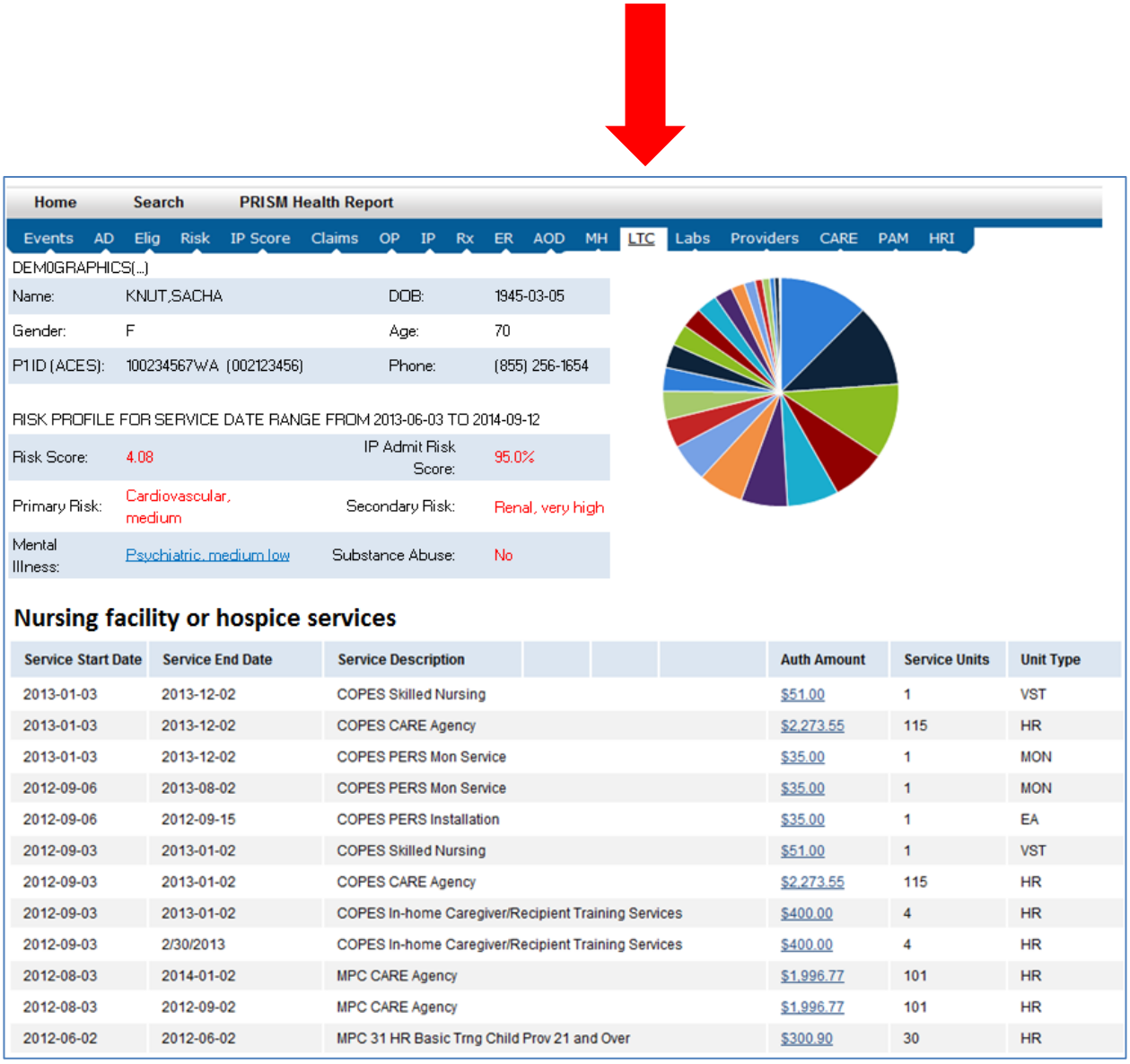
Alcohol or Drug



Mental Health



Long Term Care



Home Search PRISM Health Report

Events AD Elig Risk IP Score Claims OP IP Rx ER AOD MH LTC Labs Providers CARE PAM HRI

DEMOGRAPHICS(...)

Name:	KNUT,SACHA	DOB:	1945-03-05
Gender:	F	Age:	70
P1ID (ACES):	100234567WA (002123456)	Phone:	(855) 256-1654

RISK PROFILE FOR SERVICE DATE RANGE FROM 2013-06-03 TO 2014-09-12

Risk Score:	4.08	IP Admit Risk Score:	95.0%
Primary Risk:	Cardiovascular, medium	Secondary Risk:	Renal, very high
Mental Illness:	Psychiatric, medium low	Substance Abuse:	No

Nursing facility or hospice services

Service Start Date	Service End Date	Service Description	Auth Amount	Service Units	Unit Type
2013-01-03	2013-12-02	COPES Skilled Nursing	$51.00	1	VST
2013-01-03	2013-12-02	COPES CARE Agency	$2,273.55	115	HR
2013-01-03	2013-12-02	COPES PERS Mon Service	$35.00	1	MON
2012-09-06	2013-08-02	COPES PERS Mon Service	$35.00	1	MON
2012-09-06	2012-09-15	COPES PERS Installation	$35.00	1	EA
2012-09-03	2013-01-02	COPES Skilled Nursing	$51.00	1	VST
2012-09-03	2013-01-02	COPES CARE Agency	$2,273.55	115	HR
2012-09-03	2013-01-02	COPES In-home Caregiver/Recipient Training Services	$400.00	4	HR
2012-09-03	2/30/2013	COPES In-home Caregiver/Recipient Training Services	$400.00	4	HR
2012-08-03	2014-01-02	MPC CARE Agency	$1,996.77	101	HR
2012-08-03	2012-09-02	MPC CARE Agency	$1,996.77	101	HR
2012-06-02	2012-06-02	MPC 31 HR Basic Trng Child Prov 21 and Over	$300.90	30	HR

NOTE: Long Term Services and Supports (LTSS) may also be located under the Claims screen.

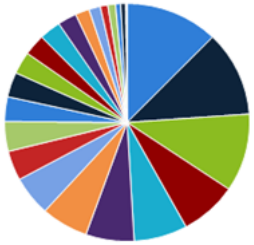
Labs

Home Search PRISM Health Report

Events AD Elig Risk IP Score Claims OP IP Rx ER AOD MH LTC Labs Providers CARE PAM HRI

DEMOGRAPHICS(...)

Name:	KNUT,SACHA	DOB:	1945-03-05
Gender:	F	Age:	70
P1ID (ACES):	100234567WA (002123456)	Phone:	(855) 256-1654



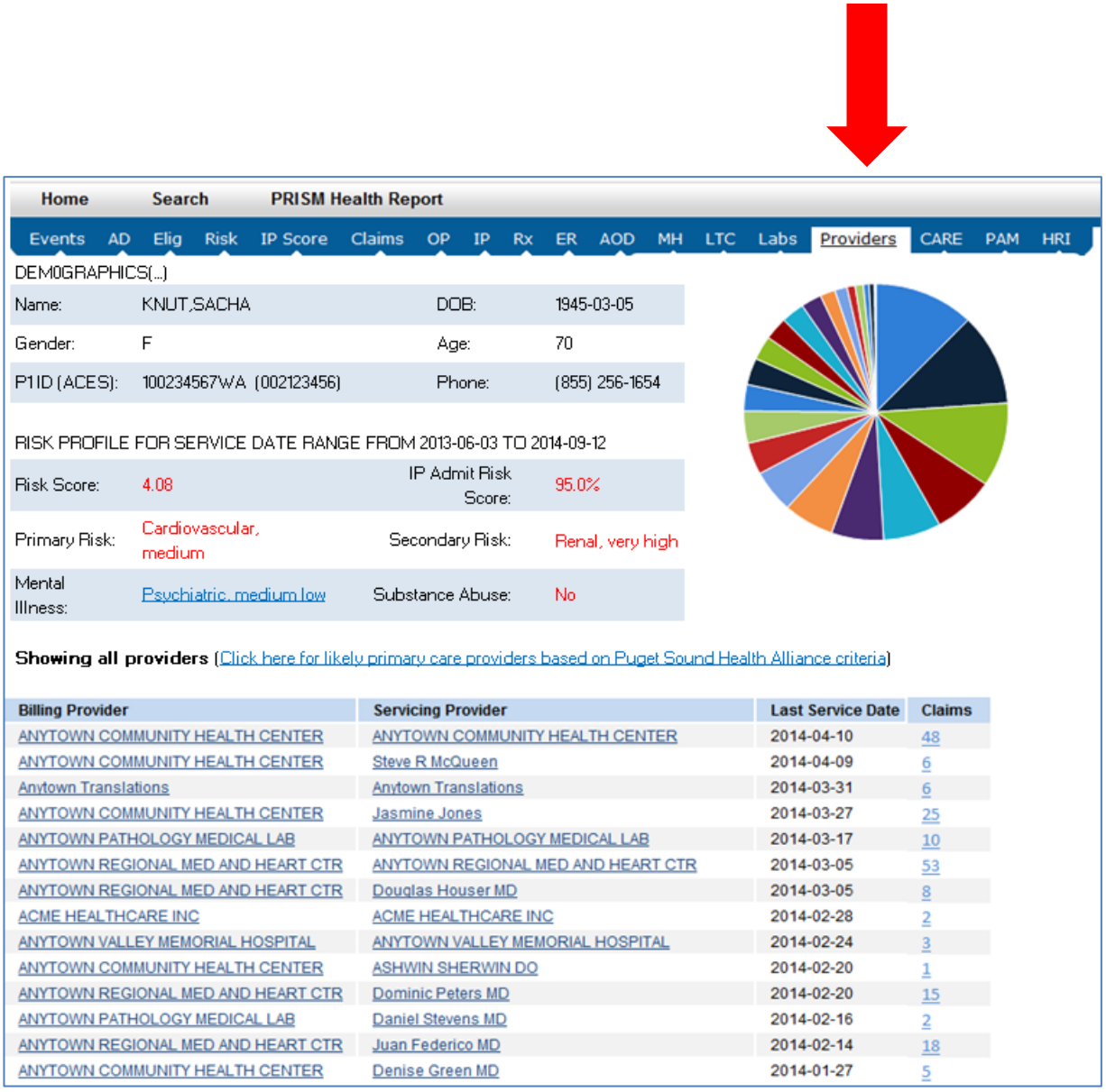
RISK PROFILE FOR SERVICE DATE RANGE FROM 2013-06-03 TO 2014-09-12

Risk Score:	4.08	IP Admit Risk Score:	95.0%
Primary Risk:	Cardiovascular, medium	Secondary Risk:	Renal, very high
Mental Illness:	Psychiatric, medium low	Substance Abuse:	No

← Previous 1 2 3 4 5 6 7 8 9 ... 20 21 Next → View as PDF

Service Start Date	Service End Date	Line	Drug	Primary Diagnosis	Procedure	Revenue Code	Servicing Provider	Line Amount	Paid Amount	Claim Type
2013-01-22	2013-01-22	6		CHEST PAIN NOS	Comprehen metabolic panel	Laboratory-Chemistry	ANYTOWN REGIONAL MED AND HEART CTR	$9.31	$682.59	OPPS
2013-01-22	2013-01-22	7		CHEST PAIN NOS	Assay of troponin, quant	Laboratory-Chemistry	ANYTOWN REGIONAL MED AND HEART CTR	$10.73	$682.59	OPPS
2013-01-22	2013-01-22	8		CHEST PAIN NOS	Natriuretic peptide	Laboratory-Chemistry	ANYTOWN REGIONAL MED AND HEART CTR	$37.02	$682.59	OPPS
2013-01-22	2013-01-22	9		CHEST PAIN NOS	Assay of magnesium	Laboratory-Chemistry	ANYTOWN REGIONAL MED AND HEART CTR	$7.31	$682.59	OPPS
2013-01-22	2013-01-22	4		CHEST PAIN NOS	Routine venipuncture	Laboratory-General Classification	ANYTOWN REGIONAL MED AND HEART CTR	$2.31	$682.59	OPPS
2013-01-22	2013-01-22	5		CHEST PAIN NOS	Prothrombin time	Laboratory-General Classification	ANYTOWN REGIONAL MED AND HEART CTR	$4.28	$682.59	OPPS
2013-01-22	2013-01-22	10		CHEST PAIN NOS	Complete cbc w/auto diff wbc	Laboratory-Hematology	ANYTOWN REGIONAL MED AND HEART CTR	$8.49	$682.59	OPPS
2013-01-22	2013-01-22	11		CHEST PAIN NOS	Thromboplastin time, partial	Laboratory-Hematology	ANYTOWN REGIONAL MED AND HEART CTR	$6.34	$682.59	OPPS
2013-01-24	2013-01-24	8		CHEST PAIN NOS	Comprehen metabolic panel	Laboratory-Chemistry	ANYTOWN REGIONAL MED AND HEART CTR	$9.31	$1,167.16	OPPS

Providers



Home Search PRISM Health Report

Events AD Elig Risk IP Score Claims OP IP Rx ER AOD MH LTC Labs Providers CARE PAM HRI

DEMOGRAPHICS(...)

Name:	KNUT,SACHA	DOB:	1945-03-05
Gender:	F	Age:	70
P1ID (ACES):	100234567WA (002123456)	Phone:	(855) 256-1654

RISK PROFILE FOR SERVICE DATE RANGE FROM 2013-06-03 TO 2014-09-12

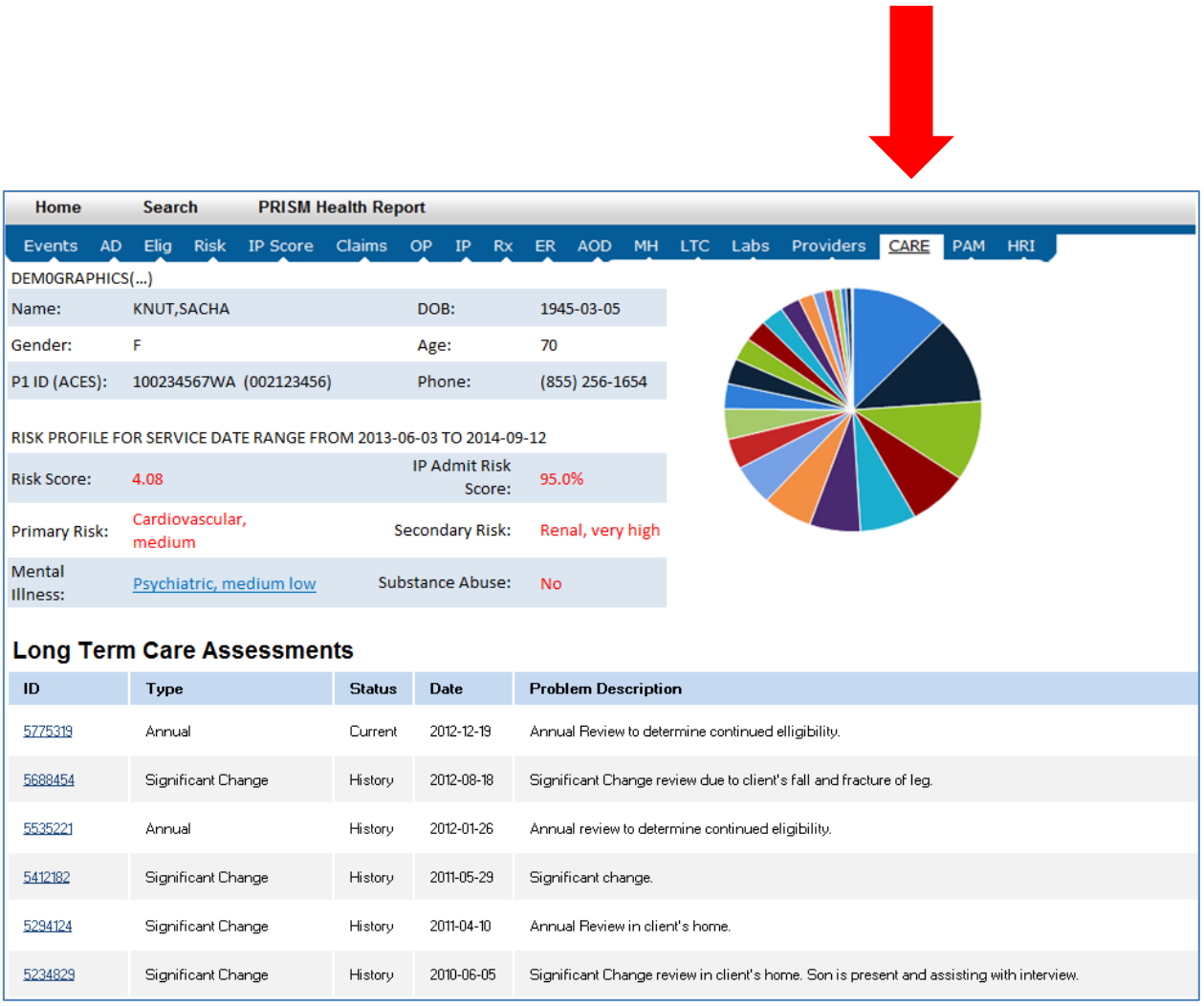
Risk Score:	4.08	IP Admit Risk Score:	95.0%
Primary Risk:	Cardiovascular, medium	Secondary Risk:	Renal, very high
Mental Illness:	Psychiatric, medium low	Substance Abuse:	No

Showing all providers (Click here for likely primary care providers based on Puget Sound Health Alliance criteria)

Billing Provider	Servicing Provider	Last Service Date	Claims
ANYTOWN COMMUNITY HEALTH CENTER	ANYTOWN COMMUNITY HEALTH CENTER	2014-04-10	48
ANYTOWN COMMUNITY HEALTH CENTER	Steve R McQueen	2014-04-09	6
Anytown Translations	Anytown Translations	2014-03-31	6
ANYTOWN COMMUNITY HEALTH CENTER	Jasmine Jones	2014-03-27	25
ANYTOWN PATHOLOGY MEDICAL LAB	ANYTOWN PATHOLOGY MEDICAL LAB	2014-03-17	10
ANYTOWN REGIONAL MED AND HEART CTR	ANYTOWN REGIONAL MED AND HEART CTR	2014-03-05	53
ANYTOWN REGIONAL MED AND HEART CTR	Douglas Houser MD	2014-03-05	8
ACME HEALTHCARE INC	ACME HEALTHCARE INC	2014-02-28	2
ANYTOWN VALLEY MEMORIAL HOSPITAL	ANYTOWN VALLEY MEMORIAL HOSPITAL	2014-02-24	3
ANYTOWN COMMUNITY HEALTH CENTER	ASHWIN SHERWIN DO	2014-02-20	1
ANYTOWN REGIONAL MED AND HEART CTR	Dominic Peters MD	2014-02-20	15
ANYTOWN PATHOLOGY MEDICAL LAB	Daniel Stevens MD	2014-02-16	2
ANYTOWN REGIONAL MED AND HEART CTR	Juan Federico MD	2014-02-14	18
ANYTOWN COMMUNITY HEALTH CENTER	Denise Green MD	2014-01-27	5

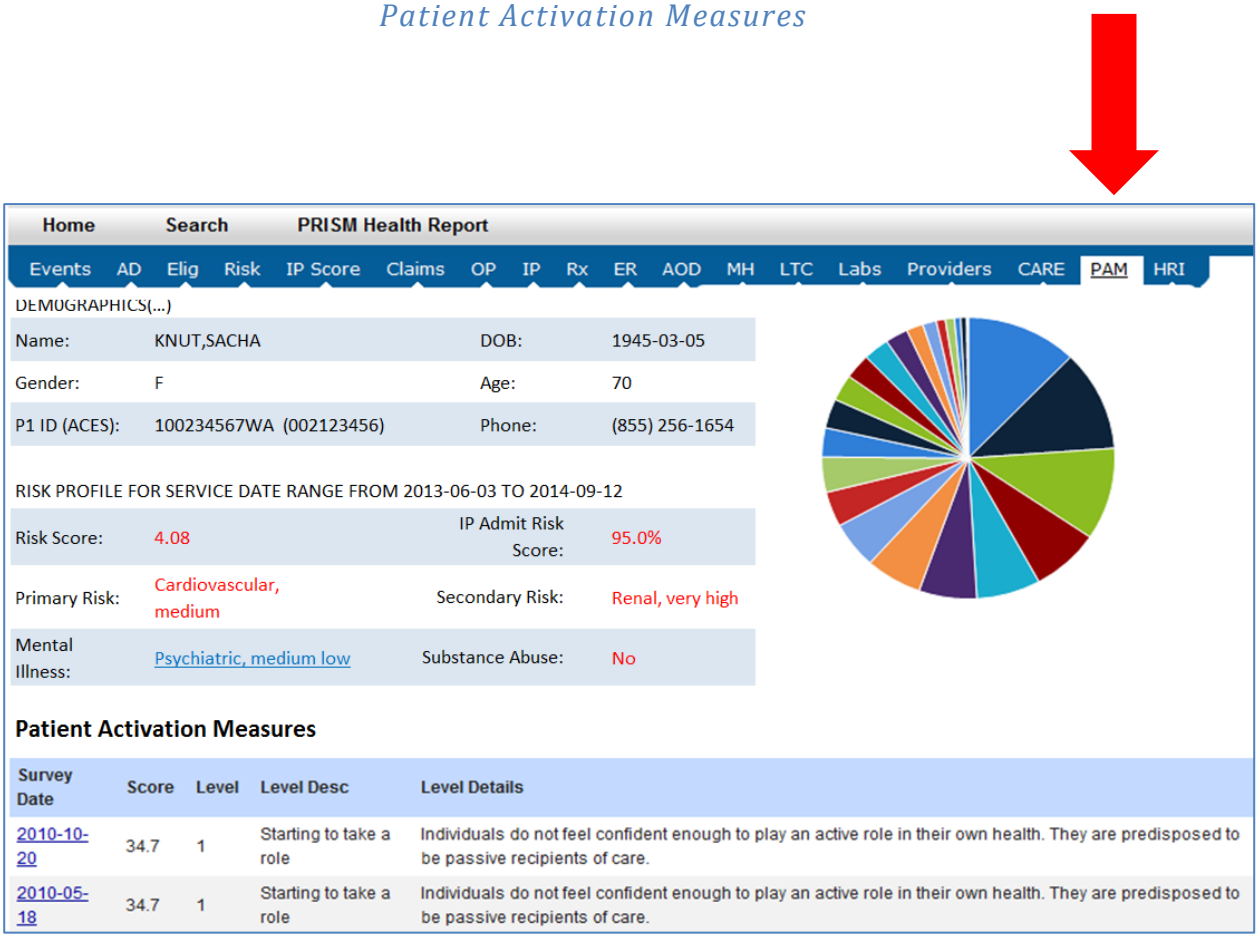
CARE

Long Term Care functional assessments



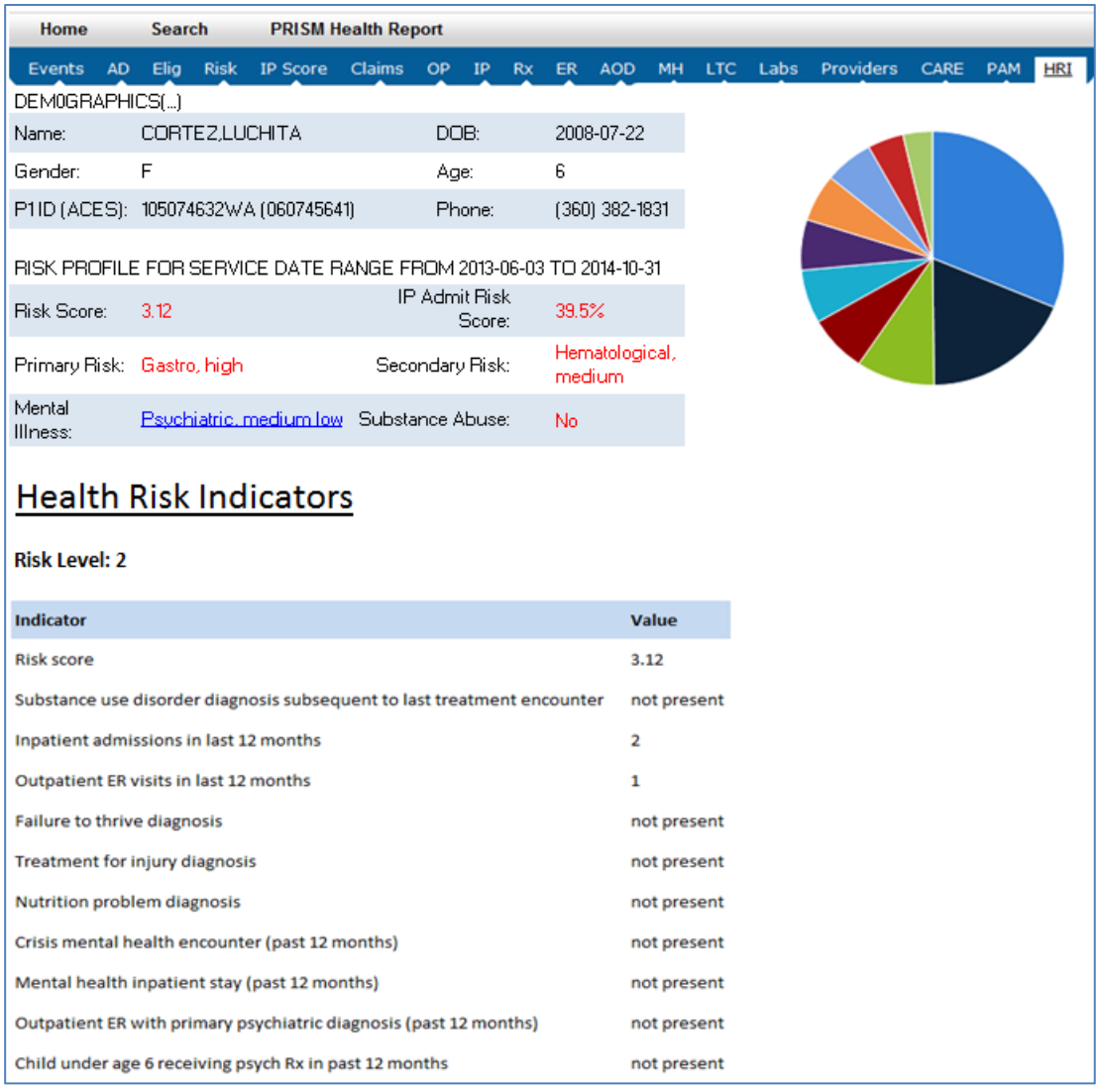
PAM

Patient Activation Measures



HRI

Health Risk Indicators for children only



Home Search PRISM Health Report

Events AD Elig Risk IP Score Claims OP IP Rx ER AOD MH LTC Labs Providers CARE PAM HRI

DEMOGRAPHICS(...)

Name:	CORTEZ,LUCHITA	DOB:	2008-07-22
Gender:	F	Age:	6
P1ID (ACES):	105074632WA (060745641)	Phone:	(360) 382-1831

RISK PROFILE FOR SERVICE DATE RANGE FROM 2013-06-03 TO 2014-10-31

Risk Score:	3.12	IP Admit Risk Score:	39.5%
Primary Risk:	Gastro, high	Secondary Risk:	Hematological, medium
Mental Illness:	Psychiatric, medium low	Substance Abuse:	No

Health Risk Indicators

Risk Level: 2

Indicator	Value
Risk score	3.12
Substance use disorder diagnosis subsequent to last treatment encounter	not present
Inpatient admissions in last 12 months	2
Outpatient ER visits in last 12 months	1
Failure to thrive diagnosis	not present
Treatment for injury diagnosis	not present
Nutrition problem diagnosis	not present
Crisis mental health encounter (past 12 months)	not present
Mental health inpatient stay (past 12 months)	not present
Outpatient ER with primary psychiatric diagnosis (past 12 months)	not present
Child under age 6 receiving psych Rx in past 12 months	not present

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE	FEMALE	UNKNOWN	OTHER	DATE OF BIRTH	PROVIDER ONE CLIENT ID
Jordan	Larson	☐	☒	☐	☐	05/30/1959	111111111WA

HEALTH HOME LEAD ORGANIZATION	HH LEAD ORGANIZATION PHONE
Statewide Lead	206 111-5554

DATE OF HAP: BEGIN	END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE
07/20/2018		07/20/2018	Best CCO	Martha Stewart	306 555-1111

REASON FOR CLOSURE OF THE HAP
- ☐ Beneficiary Opted Out
- ☐ Death
- ☐ Move to a county that does not have Health Home services
- ☐ No longer eligible

REASON FOR TRANSFER OF THE HAP
- ☐ Client choice to change CCO or Lead Organization
- ☐ Eligibility changed (change to/from FFS or MCO)

CLIENT INTRODUCTION

Jordan is a 59 year-old woman who has lived a very active life: bicyling, running, and exploring. She wants to overcome her arthritis problems and become active again.

CLIENT'S LONG TERM GOAL

Jordan wants to go camping on the Olympic Penninsula in the summer of 2019.

DIAGNOSIS (PERTINENT TO HAP)

Osteoarthritis in knees and spine. History of bursitis in right shoulder.

Initial / Annual HAP Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM	07/20/2018	86.3 / 4	
CAM		/	
PPAM		/	
Katz ADL	07/20/2018	4	
PHQ-9	07/20/2018	3	
PSC-17			
BMI	07/20/2018	31	

OPTIONAL SCREENING SCORES

SCREEN	DATE	SCORE	
DAST			
GAD-7			
AUDIT			
FALLS RISK	07/20/2018	5	
PAIN	07/20/2018	7	☐ FLACC ☐ FACES ☒ NUMERIC

ADDITIONAL COMMENTS

Met for first HAP and goal setting. Jordan reports a moderate level of pain due to arthritis. She reports she is afraid of failure due to her painful joints but is ready to work on achieving her long term goal.

Four Month Update Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM	11/30/2018	77.5 / 4	
CAM		/	
PPAM		/	
Katz ADL	11/30/2018	5	
PHQ-9	11/30/2018	3	
PSC-17			
BMI	11/30/2018	30	

OPTIONAL SCREENING SCORES

SCREEN	DATE	SCORE	
DAST			
GAD-7			
AUDIT			
FALLS RISK	11/30/2018	4	
PAIN	11/30/2018	6	☐ FLACC ☐ FACES ☒ NUMERIC

ADDITIONAL COMMENTS

Jordan worked hard in partnership with her personal trainer at the Y. She is beginning to see some progress, especially with weight loss, stamina, pain, and independence with ADLs; she can now transfer by herself.

Eight Month Update Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM	04/25/2019	82.8 / 4	
CAM		/	
PPAM		/	
Katz ADL	04/25/2019	5	
PHQ-9	04/25/2019	2	
PSC-17			
BMI	04/25/2019	29	

OPTIONAL SCREENING SCORES

SCREEN	DATE	SCORE	
DAST			
GAD-7			
AUDIT			
FALLS RISK	04/25/2019	4	
PAIN	04/25/2019	5	☐ FLACC ☐ FACES ☒ NUMERIC

ADDITIONAL COMMENTS

Jordan relates that her pain has decreased. She is able to be more active for longer periods of time. She has established a home exercise program and a program at the Y designed by her trainer. She is planning a brief camping trip in June.

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE	FEMALE	UNKNOWN	OTHER	DATE OF BIRTH	PROVIDER ONE CLIENT ID
Jordan	Larson	☐	☒	☐	☐	05/30/1959	111111111WA

HEALTH HOME LEAD ORGANIZATION	HH LEAD ORGANIZATION PHONE
Statewide Lead	206 111-5554

DATE OF HAP: BEGIN / END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE
07/20/2018	07/20/2018	Best CCO	Martha Stewart	306 555-1111

Initial / Annual HAP

Short Term Goal: **Increase walking distance in neighborhood**
Goal Start Date: **07/20/2018** Goal End Date: **11/19/2018**
Outcome:
☒ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS
07/20/2018	11/19/2018	07/23/2018: 1. Jordan will walk a half of a block daily 07/30/2018: 2. Jordan will add stretching before and after walking 08/06/2018: 3. Martha will call Jordan to ask about her progress and remind her of her next action step. 08/13/2018: 4. Jordan will increase walking to 1 block a day. 09/17/2018: 5. Jordan will increase walking to 2 blocks a day. 10/15/2018: 6. Martha will contact Jordan to see if she wants to increase her walking distance to 3 blocks per day.

Four Month Update

Short Term Goal: **Join the YWCA and get a personal trainer**
Goal Start Date: **11/20/2018** Goal End Date: **03/19/2019**
Outcome:
☒ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS
11/20/2018	03/19/2019	11/20/2018: 1. Martha will contact the YWCA to see if Jordan can get a free or reduced rate for Jordan's membership. She may contact other agencies, such as the Area Agency on Aging, for other suggestions for subsidizing Jordan's membership. She will call Jordan to inform her of the results of her inquiries. 11/26/2018: 2. Jordan will contact the Y to apply for a membership. She will also ask about a personal trainer and schedule an appointment for an assessment and exercise plan. 12/10/2018: 3. Martha will follow up with Jordan to see if she got her membership and set up an

Eight Month Update

Short Term Goal: **Gain better control of arthritis and pain**
Goal Start Date: **03/20/2019** Goal End Date:
Outcome:
☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS
03/20/2019		03/20/2019: 1. Jordan will make an appointment with her rheumatologist and a pain specialist. 03/29/2019: 2. Martha will contact Jordan to see if she needs assistance preparing for her visits. She will encourage and assist her as needed to write down her medications and questions for both specialist appointments. She will get the dates for the appointments and ensure that Jordan has transportation and an escort (possibly her paid caregiver) for both appointments.

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE	FEMALE	UNKNOWN	OTHER	DATE OF BIRTH	PROVIDER ONE CLIENT ID
Jordan	Larson	☐	☒	☐	☐	05/30/1959	111111111WA

HEALTH HOME LEAD ORGANIZATION	HH LEAD ORGANIZATION PHONE
Statewide Lead	206 111-5554

DATE OF HAP: BEGIN / END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE
07/20/2018	07/20/2018	Best CCO	Martha Stewart	306 555-1111

Initial / Annual HAP

Short Term Goal: **Increase walking distance to 1 block a day**
Goal Start Date: **07/20/2018** Goal End Date: **11/22/2018**
Outcome:
☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS

Four Month Update

Short Term Goal: **Join the YWCA and get a personal trainer**
Goal Start Date: **11/20/2018** Goal End Date: **03/19/2019**
Outcome:
☒ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS
11/20/2018	03/19/2019	**appointment with the trainer.** **12/17/2018:** **4. Jordan will meet with the trainer and begin her prescribed exercise program. She will continue her walking and stretching program as weather permits at home or at the Y.** **01/03/2019:** **Melody will provide an exercise and walking tracker for Jordan to complete during their January visit and they will review it at each monthly visit.**

Eight Month Update

Short Term Goal: **Gain better control of arthritis and pain**
Goal Start Date: **03/20/2019** Goal End Date:
Outcome:
☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS
03/20/2019		**04/25/2019:** **3. Martha will visit Jordan to find out how her appointments went with the two specialists. They will review the HAP to see if any revisions are needed to her existing goal or if a new goal is needed based on what her doctors precribe. Jordan will complete the required screenings and the pain and falls assessment to see if there has been any improvement.**

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE	FEMALE	UNKNOWN	OTHER	DATE OF BIRTH	PROVIDER ONE CLIENT ID
Jordan	Larson	☐	☒	☐	☐	05/30/1959	111111111WA

HEALTH HOME LEAD ORGANIZATION	HH LEAD ORGANIZATION PHONE
Statewide Lead	206 111-5554

DATE OF HAP: BEGIN / END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE
07/20/2018	07/20/2018	Best CCO	Martha Stewart	306 555-1111

Initial / Annual HAP

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS

Four Month Update

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS

Eight Month Update

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE	FEMALE	UNKNOWN	OTHER	DATE OF BIRTH	PROVIDER ONE CLIENT ID
Jordan	Larson	☐	☒	☐	☐	05/30/1959	111111111WA

HEALTH HOME LEAD ORGANIZATION	HH LEAD ORGANIZATION PHONE
Statewide Lead	206 111-5554

DATE OF HAP: BEGIN / END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE
07/20/2018	07/20/2018	Best CCO	Martha Stewart	306 555-1111

Initial / Annual HAP

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS

Four Month Update

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS

Eight Month Update

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE	FEMALE	UNKNOWN	OTHER	DATE OF BIRTH	PROVIDER ONE CLIENT ID
Jordan	Larson	☐	☒	☐	☐	05/30/1959	111111111WA

HEALTH HOME LEAD ORGANIZATION	HH LEAD ORGANIZATION PHONE
Statewide Lead	206 111-5554

DATE OF HAP: BEGIN / END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE
07/20/2018	07/20/2018	Best CCO	Martha Stewart	306 555-1111

Initial / Annual HAP

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS

Four Month Update

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

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START DATE	COMPLETION DATE	ACTION STEPS

Eight Month Update

Short Term Goal:

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Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

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Initial / Annual HAP

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Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

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Robert "Bobby"	Smith	☒	☐	☐	☐	04/07/1969	999999999WA

HEALTH HOME LEAD ORGANIZATION	HH LEAD ORGANIZATION PHONE
Always There	360 111 -1111

DATE OF HAP: BEGIN	END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE
08/15/2017		08/15/2017	Ever So Helpful	Melody Petrianado	360 111-2222

REASON FOR CLOSURE OF THE HAP
- ☐ Beneficiary Opted Out
- ☐ Move to a county that does not have Health Home services
- ☐ Death
- ☐ No longer eligible

REASON FOR TRANSFER OF THE HAP
- ☐ Client choice to change CCO or Lead Organization
- ☐ Eligibility changed (change to/from FFS or MCO)

CLIENT INTRODUCTION

Bobby is 48 years old and lives in his own apartment. He hears voices and sometimes yells at them when he is scared. Neighbors have complained to the landlord about his loud voice.

CLIENT'S LONG TERM GOAL

Bobby wants to be able to breath better when he gets scared.

DIAGNOSIS (PERTINENT TO HAP)

Schizophrenia and Chronic Obstructive Pulmonary Disease (COPD)

Initial / Annual HAP Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM	08/15/2017	32.2 / 1	
CAM		/	
PPAM		/	
Katz ADL	08/15/2017	6	
PHQ-9	08/15/2017	12	
PSC-17			
BMI	08/15/2017	26	

OPTIONAL SCREENING SCORES

SCREEN	DATE	SCORE	
DAST			
GAD-7	08/15/2017	14	
AUDIT			
FALLS RISK			
PAIN			☐ FLACC ☐ FACES ☐ NUMERIC

ADDITIONAL COMMENTS

Bobby's PHQ-9 and GAD-7 scores indicate a need for a mental health assessment. A Peer Support Program is recommended. He reports that his biggest concern is going to see a doctor so he can "get his breathing checked".

Four Month Update Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM		/	
CAM		/	
PPAM		/	
Katz ADL			
PHQ-9			
PSC-17			
BMI			

OPTIONAL SCREENING SCORES

SCREEN	DATE	SCORE	
DAST			
GAD-7			
AUDIT			
FALLS RISK			
PAIN			☐ FLACC ☐ FACES ☐ NUMERIC

ADDITIONAL COMMENTS

Eight Month Update Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM		/	
CAM		/	
PPAM		/	
Katz ADL			
PHQ-9			
PSC-17			
BMI			

OPTIONAL SCREENING SCORES

SCREEN	DATE	SCORE	
DAST			
GAD-7			
AUDIT			
FALLS RISK			
PAIN			☐ FLACC ☐ FACES ☐ NUMERIC

ADDITIONAL COMMENTS

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

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HEALTH HOME LEAD ORGANIZATION	HH LEAD ORGANIZATION PHONE
Always There	**360 111 -1111**

DATE OF HAP: BEGIN / END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE
08/15/2017	**08/15/2017**	**Ever So Helpful**	**Melody Petrianado**	**360 111-2222**

Initial / Annual HAP

Short Term Goal: **Get a doctor (primary care physician).**

Goal Start Date: **08/15/2017** Goal End Date:

Outcome:

☐ Completed ☐ No longer pertinent – life or health change

☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS
08/15/2017		**08/21/17:** **1.Melody will refer Bobby to a Mental Health Peer Support Program and will provide the Peer Support Specialist with the names of three doctors offices near Bobby's home.** **09/05/17:** **2.The Peer Support Specialist will meet Bobby and drive him by the three doctors offices. Bobby will choose the clinic he likes the best.** **09/11/17:** **3. Melody will call Bobby and ask him to select a doctor from the clinic he chooses.** **09/13/17:** **4. Melody will schedule an appointment with a doctor at the clinic of Bobby's choice.**

Four Month Update

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

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START DATE	COMPLETION DATE	ACTION STEPS

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Short Term Goal:

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08/15/2017	**08/15/2017**	**Ever So Helpful**	**Melody Petrianado**	**360 111-2222**

Initial / Annual HAP	Four Month Update	Eight Month Update
Short Term Goal: **Get a doctor (primary care physician).** Goal Start Date: **08/15/2017** Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue	Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue	Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS
		09/13/17: **5. Melody will call Bobby and the Peer Support Specialist to inform them of the date and time of the doctor appointment.** **09/15/17:** **6. Melody will contact the clinic to tell staff that Bobby will make a number of visits to the waiting room over the next two weeks.** **09/18/17:** **7. Twice a week for two weeks Bobby and the Peer Support Specialist will sit in the waiting room of the clinic increasing the length of time he sits in the clinic at each visit. At the first visit Bobby will try to sit in the waiting room for ten minutes.**						

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

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08/15/2017	**08/15/2017**	**Ever So Helpful**	**Melody Petrianado**	**360 111-2222**

Initial / Annual HAP

Short Term Goal: **Get a doctor (primary care physician).**

Goal Start Date: **08/15/2017** Goal End Date:

Outcome:

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START DATE	COMPLETION DATE	ACTION STEPS
		10/02/17: **8. Bobby will go to the clinic and his new doctor will meet him in the waiting room for an introduction.** **10/04/17:** **9. Bobby will wait in the waiting room with his Peer Support Specialist and then go in to the exam room for a brief period of time. During this time his doctor will come in to the exam room to meet Bobby.**

Four Month Update

Short Term Goal:

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Initial / Annual HAP	Four Month Update	Eight Month Update
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START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS
		10/10/2017: **10. The Peer Support Specialist with transport Bobby to his first appointment and his doctor will do a brief exam.** **10/11/2017:** **11. Melody will call Bobby after his appointment to check in. Together they will discuss what he learned from his doctor and what he would like to do next.**						

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08/15/2017	**08/15/2017**	**Ever So Helpful**	**Melody Petrianado**	**360 111-2222**

Initial / Annual HAP	Four Month Update	Eight Month Update
Short Term Goal:	Short Term Goal:	Short Term Goal:
Goal Start Date: Goal End Date:	Goal Start Date: Goal End Date:	Goal Start Date: Goal End Date:
Outcome:	Outcome:	Outcome:
☐ Completed ☐ No longer pertinent – life or health change	☐ Completed ☐ No longer pertinent – life or health change	☐ Completed ☐ No longer pertinent – life or health change
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START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS

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Initial / Annual HAP	Four Month Update	Eight Month Update
Short Term Goal:	Short Term Goal:	Short Term Goal:
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START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS

Katz Index of Independence in Activities of Daily Living

Katz Index of Independence in Activities of Daily Living

ACTIVITIES POINTS (1 OR 0)	INDEPENDENCE: (1 POINT) **NO** supervision, direction or personal assistance	DEPENDENCE: (0 POINTS) **WITH** supervision, direction, personal assistance or total care
BATHING POINTS:_____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING POINTS:_____	**(1 POINT)** Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING POINTS:_____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING POINTS:_____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE POINTS:_____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder.
FEEDING POINTS:_____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS = _____ 6 = High (*patient independent*) 0 = Low (*patient very dependent*)

Slightly adapted from Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. *The Gerontologist*, 10(1), 20-30.
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Link to Katz ADL video:

https://consultgeri.org/try-this/general-assessment/issue-2

Running time is 28:25 minutes

DEPRESSION SCREENING AND SUICIDE

GUIDE SHEET

OVERVIEW

According to the National Institute of Mental Health, research suggests that people who have depression and another medical illness tend to have more severe symptoms of both illnesses. They may have more difficulty adapting to their co-occurring illness and more medical costs than those who do not have depression. *The National Institute of Mental Health has identified the follow **risk factors** for depression:

1. Personal or family history of depression
2. Major life changes, trauma, or stress
3. Certain physical illnesses and medications

Depression, even in the most severe cases, can be treated. **Symptoms of depression** include:

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities
- Decrease energy, fatigue, being "slowed down"
- Difficulty sleeping, early-morning awakening, or oversleeping
- Appetite and/or weight changes
- Restlessness, irritability
- Persistent physical symptoms
- Difficulty concentrating, remembering, or making decisions
- Aches or pains, headaches, cramps, or digestive problems without a clear physical cause and/or that do not ease even with treatment
- Thoughts of death or suicide, suicide attempts

Washington State has a goal to reduce hospitalizations due to suicide attempts and deaths due to suicide. This guide sheet provides information about depression screening and suicide and was created for Health Home Care Coordinators.

YOUR ROLE AS A CARE COORDINATOR

One service Care Coordinators (CCs) provide to clients is the opportunity to complete the **Patient Health Questionnaire – 9 (PHQ-9)**. The PHQ-9 is a screening assessment for depression. There are nine questions regarding mood and thoughts during the past two weeks.

How to administer and score the PHQ-9:

The CC may ask the client the nine questions, the client may complete the assessment, or a reliable surrogate may answer the questions. The nine questions are scored using four options:

1. Not at all (scoring = 0 points)
2. Several days (scoring = 1 point)
3. More than half the days (scoring = 2 points)
4. Nearly every day (scoring = 3 points)

*_Chronic Illness and Mental Health: Recognizing and Treating Depression_. Bethesda, MD: National Institute of Mental Health. **Retrieved November 21, 2017 from https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health/nih-15-mh-8015_151898.pdf**

The points are **added up** to determine the total score with a maximum of **27 points**. Clients and surrogates retain the *right to decline* to complete the assessment. Document in the client file who was asked to complete the PHQ-9, the date, and the reason (if provided) that the PHQ-9 was not completed. If the CC has concerns about potential depression for a client who has not completed the screening they should ask the client if they may consult with their primary care or behavioral health provider. The screening assessment should be offered to the client or surrogate at least one time during each four month activity period. Scores of 10 or higher may indicate the need for more frequent screenings. CCs should use their professional judgment to determine when to offer additional screenings.

Before you complete face-to-face visits and administer any screenings:

- Know and follow your agency's policies related to responding to potential suicide.
- Effective April 2018 designated mental health professionals (DMHPS) were renamed designated crisis responders (DCRs). Research your area's Designated Crisis Responders (DCRs) and keep these phone numbers with you while visiting clients.
    - Use this link to locate DCRs in your area: https://www.hca.wa.gov/assets/billers-and-providers/designated-crisis-responders-contact-list.pdf

ITS ABOUT THE CONVERSATION

First, ask for permission to have a conversation about depression:

CCs might consider opening the conversation about possible depression:

- For example: "Depression often occurs with other diseases, such as _____. I have a few questions I would like to ask to see if this might be happening with you. Would you be willing to talk with me about this?"

If the client answers **yes to the ninth question** on PHQ related to suicide

***SAMHSA recommends asking these four questions about suicidal ideation:**

- **Past Suicide Attempt**: "Have you ever attempted to harm yourself in the past?"
- **Suicide Plan**: "Have you had thoughts about how you might actually hurt yourself?" (This could include thoughts of timing, location, lethality, availability of means, and preparatory acts.) If yes, "Do you have the means to follow it through?"
- **Probability (Perceived)**: "How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?"
- **Preventive (Protective) Factors**: "Is there anything that would prevent or keep you from harming yourself?"

If the client responds "**no or in a manner indicating they are not at risk**" to the above questions then no further immediate action is needed. The client should be referred for an evaluation to determine what is causing the elevated suicide question on the PHQ and a plan set up to address whatever the identified issue is. Document the responses in the client file.

If a client responds "**yes or in a manner that is concerning**" to having a suicide plan with high probability then a DCR should be contacted to evaluate the person further. Having a history of suicide attempts is a concern if the attempts are recent or in addition with having a plan and the intent to carry it out. Use of the Columbia Suicide Severity Rating Scale may be more objective and easier to determine who is a concern and who needs an immediate referral to a DCR.

Determine who else needs to be notified (family, caregiver, or provider/s). You can break confidentiality due to a safety concern.

Document the responses and any actions taken.

* *Older Americans Behavioral Health Issue Brief 4: Preventing Suicide in Older Adults.* (2012). Rockville, MD: Substance Abuse and Mental Health Services Administration. **Retrieved November 21, 2017 from https://www.ncoa.org/wp-content/uploads/Older-Americans-Issue-Brief-4_Preventing-Suicide_508.pdf**

NEXT STEPS

- Make sure the client has signed the Participation Authorization and Information Sharing Consent form indicating consent to disclose mental health information.
- For immediate crisis intervention call 9-1-1. Have the client's address and phone number available for your report.
- Stay with the client until a family member, client representative, DCR, emergency responder, or law enforcement arrives.
- Consult with your supervisor either on the phone for emergencies or in person for non-emergencies. Document the results of the screening and all actions taken.
- Follow up with phone calls or face-to-face visits with the client, family members, or client representative to discuss outcomes from hospitalizations and/or treatment and counseling. Using a person-centered approach review the Health Action Plan with the client to see if it could be revised to include goals and actions steps to better manage depressive symptoms.

RESOURCES

Chronic Illness and Mental Health: Recognizing and Treating Depression: https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health

Columbia-Suicide Severity Rating Scale (C-SSRS): http://cssrs.columbia.edu/

Evaluation and Triage Card: Safe-T Card: https://adaa.org/sites/default/files/SMA09-4432.pdf

National Suicide Prevention Lifeline: 1-800 273-8255 (TALK)

Patient Health Questionnaire – 9 (PHQ-9): https://www.phqscreeners.com/

SAMHSA Older Americans Behavioral Health Issue Brief 4: Preventing Suicide in Older Adults: https://acl.gov/sites/default/files/programs/2016-11/Issue%20Brief%204%20Preventing%20Suicide.pdf

Depression and the Patient Health Questionnaire (PHQ-9)

Begin this discussion by asking the individual one or more of following questions:

- How do you feel about life in general?
- How are your spirits generally?
- Do you find yourself avoiding being with people? If yes, why is that?

Then ask the individual if you can ask him/her some specific questions about how they have been feeling over the last two weeks? If the individual you are assessing can read, give them the PHQ-9 and ask them to complete the screening.

An alternative method of administering the PHQ-9 is to provide an index card with the following responses on it. Tell them to answer each question you ask them, using the following scale:

- Not at all (Scoring = 0 Points)
- Several days (Scoring = 1 Point)
- More than half the days (Scoring = 2 Points)
- Nearly every day (Scoring = 3 Points)

If they cannot read, you will have to repeat the scale to them after each question is asked, so they can make their choice. Proceed by asking the following questions:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless
- Trouble falling or staying asleep, or sleeping too much
- Feeling tired or having little energy
- Poor appetite or overeating
- Feeling bad about yourself, or that you are a failure, or have let yourself or your family down
- Trouble concentrating on things, such as reading the newspaper or watching television
- Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual
- Thoughts that you would be better off dead, or of hurting yourself in some way.

A score of (10) or more indicates possible depression on the PHQ-9.

Discuss with this individual that from their responses to the questions you just asked, it appears they may be suffering from depression. If needed, reassure him/her that Depression is a serious illness, not a moral weakness. Inform him/her that there are many effective ways to treat depression. Ask the individual if they are interested in a referral for diagnosis and/or treatment. The referral may be to the individual's primary health care

provider or a mental health professional. Discuss with the appropriate caregiver (family, AFH, Assisted Living Facility, etc.) if necessary. When the client's depression score is 10 or more, document your discussion about a referral; if the client chooses to seek assistance for any problem identified then document the date you referred the client and who is responsible to follow through. If the client or others are responsible, the care coordinator should contact the client within 30 days of the referral and document the outcome.

Surrogate Report of Depression Symptoms: A surrogate report of Depressive Symptoms is to be used when the care coordinator concludes that a surrogate would be a more reliable reporter of the client's mood and emotional state or when the client refuses to answer the questions. It may also be used when a client has Alzheimer's disease* or other types of Dementia that has progressed to a point where the client cannot relate pertinent information. 30% of individuals who have Alzheimer's disease also suffer with major depression. Many of these individuals have symptoms that cause significant distress and dysfunction to both the individual and the caregiver. Clients with these conditions are not able to reliably respond to the questions themselves in the PHQ-9 depression screen above. Research has shown that family (or other primary) caregivers are reliable informants in reporting depressive symptoms.

As an introduction to this issue, ask the family (or primary) caregiver if they have observed the individual you are assessing as having persistent sadness or crying, a sleep impairment or a change in their appetite. Then ask the caregiver if you can ask him/her some specific questions about how the individual they are caring for may have been feeling over the last two weeks? Proceed by following the process below.

- If the caregiver can read, give them the index card with the following responses on it. Telling them they are to answer each question you ask them, using the following scale:

  - Not at all (Scoring = 0 Points)
  - Several days (Scoring = 1 Point)
  - More than half the days (Scoring = 2 Points)
  - Nearly every day (Scoring = 3 Points)

- If they are unable to read, you will have to repeat the scale to them after each question is asked, so they can make their choice.

Here is some additional information regarding depression and its impact on clients with chronic health problems.

The National Institute of Mental Health (NIMH) commissioned the Harris survey. The survey showed that: Lack of energy, recurrent thoughts of death and difficulty concentrating were viewed by half of the medical providers polled as natural components of aging rather than symptoms of depression. Tragically, accordingly to data cited in a recent NIMH report, 70 % of elderly people who commit suicide visit their family doctors within a month of their death, and 39% have a medical encounter within one week of killing themselves, yet their depression remains undiagnosed and untreated. 25 % of elderly individuals experience

periods of persistent sadness that lasts two weeks or longer and more than 20% report persistent thoughts of death and dying. 20% of clients in nursing home are depressed. More than ½ of the people polled, 75 years or older, believed that depression is a natural part of the aging process. Additionally, 93% of all adults polled said they believed depression is a normal side effect for those suffering from a medical condition. These individuals believed there was little that could be done to impact this.

Depression is one of the most common and potentially dangerous complications of every chronic illness. It is particularly common in those with:

- **Recent heart attacks**
- **Hospitalized cancer patients**
- **Recent stroke survivors**
- **People with multiple sclerosis**
- **Parkinson's Disease and**
- **Diabetes**

Depression caused by chronic illness often aggravates the illness, especially if the condition causes pain, fatigue or disruption in social life. Depression makes pain hurt more. Depression impairs the immune system, which can hurt the body's efforts to combat chronic illness.

Note: The highest rate of completed suicide among all population groups is in older white men who become excessively depressed and drink heavily following the death of their spouse.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Body Mass Index Table

	Normal						Overweight					Obese										Extreme Obesity																
BMI	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	**40**	**41**	**42**	**43**	**44**	**45**	**46**	**47**	**48**	**49**	**50**	**51**	**52**	**53**	**54**
Height (inches)	**Body Weight (pounds)**																																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report*.

Body Mass Index Tools and Calculators

BMI Tools Online
http://www.cdc.gov/healthyweight/assessing/bmi/index.html

BMI Calculator for Children and Teens (2-19)
https://www.cdc.gov/healthyweight/bmi/calculator.html

BMI Calculator for Adults (20 and older)
https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

ALCOHOL USE QUESTIONS (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:	 12 oz. beer	 5 oz. wine	 1.5 oz. liquor (one shot)	
		Place an X in one box that best describes your answer to each question.		
In the past 12 months…	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	○ Never	○ Monthly or less	○ 2 to 4 times a month	○ 2 to 3 times a week	○ 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	○ 1 or 2	○ 3 or 4	○ 5 or 6	○ 7 to 9	○ 10 or more
3. How often do you have 5 or more drinks on one occasion?	○ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	○ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	○ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	○ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	○ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	○ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily
9. Have you or someone else been injured because of your drinking?	○ No		○ Yes, but not in the last year		○ Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	○ No		○ Yes, but not in the last year		○ Yes, during the last year
Add scores for each column, then add across this row.					
				TOTAL	

Date_____

SCORING:

Each response from the AUDIT has a score ranging from 0 to 4. The top of each column has a number. That number equals the score value for responses in that column. After a patient has completed the AUDIT, add up each column score, and then sum all five columns for the patient's score. Below are the scoring guidelines for the AUDIT.

Guidelines for Interpretation for AUDIT

Score	Risk Level	Intervention
0-6 (Female) 0-7 (Male)	Zone I	Feedback and alcohol education
7-15 (Female) 8-15 (Male)	Zone II	Brief intervention
16-19	Zone III	Brief intervention plus brief therapy
20-40	Zone IV	Brief intervention plus referral to chemical dependency treatment

Babor TF, Higgins-Biddle JC , Saunders JB, Monteiro MG. *AUDIT: The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. 2nd Edition.* World Health Organization. 2001

DRUG USE QUESTIONS (DAST-10)

Using drugs can affect your health and your daily life. Please help us assist you by answering the questions below.

Drugs include marijuana, solvents like paint thinners, tranquilizers like Valium, barbiturates, cocaine, stimulants like speed, hallucinogens such as LSD, or narcotics like heroin. Drug use also includes using prescription or over-the-counter medications more than directed.

In the past 12 months...	1	0
1. Have you used drugs other than those required for medical reasons?	O Yes	O No
2. Do you abuse more than one drug at a time?	O Yes	O No
3. Are you unable to stop using drugs when you want to?	O Yes	O No
4. Have you ever had blackouts or flashbacks as a result of drug use?	O Yes	O No
5. Do you ever feel bad or guilty about your drug use?	O Yes	O No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	O Yes	O No
7. Have you neglected your family because of your use of drugs?	O Yes	O No
8. Have you engaged in illegal activities in order to obtain drugs?	O Yes	O No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	O Yes	O No
10. Have you had medical problems as a result of your drug use (such as: memory loss, hepatitis, convulsions, or bleeding)?	O Yes	O No
TOTAL		

Date_____

Score 1 point for each question answered "YES", except for questions (3) for which a "NO" answer received 1 point and (0) for a "YES". Add up the points and interpretations are as followed:

DAST – 10 SCORE	Risk Level	Suggested Action
0	No problems reported	Encouragement and education
1-2	Moderate Level	Brief intervention
3-5	High Level	Brief intervention plus brief therapy
6-10	Substantial Level	Brief intervention plus referral to chemical dependency treatment

Guidelines for Interpretation of AUDIT Scores

Score	Risk Level	Suggested Action
0-6 (Female) 0-7 (Male)	Little or no risk	Feedback and alcohol education
7-15 (Female) 8-15 (Male)	Moderate level	Brief intervention
16-19	High level	Brief intervention plus brief therapy
20-40	Substantial level	Brief intervention plus referral to chemical dependency treatment

Guidelines for Interpretation of DAST-10 Scores

Score	Risk Level	Suggested Action
0	No problems reported	Encouragement and education
1-2	Moderate level	Brief intervention
3-5	High level	Brief intervention plus brief therapy
6-10	Substantial level	Brief intervention plus referral to chemical dependency treatment

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  **~5% alcohol**	12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz.  **~7% alcohol**	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz.  **~12% alcohol**	a 750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  **~40% alcohol**	a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39 *Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

http://pubs.niaaa.nih.gov/publications/Practitioner/pocketguide/pocket_guide2.htm

wasbirt·pci PHQ-9 Depression Scale

Over the Last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	O 0	O 1	O 2	O 3
2. Feeling down, depressed, or hopeless	O 0	O 1	O 2	O 3
3. Trouble falling or staying asleep, or sleeping too much	O 0	O 1	O 2	O 3
4. Feeling tired or having little energy	O 0	O 1	O 2	O 3
5. Poor appetite or overeating	O 0	O 1	O 2	O 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	O 0	O 1	O 2	O 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	O 0	O 1	O 2	O 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	O 0	O 1	O 2	O 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	O 0	O 1	O 2	O 3

10. If you checked off any problems on this questionnaire so far, how difficult have these problems made if for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
O 0	O 1	O 2	O 3

GAD-7 Anxiety Scale

Over the Last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	O 0	O 1	O 2	O 3
2. Not being able to stop or control worrying	O 0	O 1	O 2	O 3
3. Worrying too much about different things	O 0	O 1	O 2	O 3
4. Trouble Relaxing	O 0	O 1	O 2	O 3
5. Being so restless that it's hard to sit still	O 0	O 1	O 2	O 3
6. Becoming easily annoyed or irritable	O 0	O 1	O 2	O 3
7. Feeling afraid as if something awful might happen	O 0	O 1	O 2	O 3

8. If you checked off any problems on this questionnaire so far, how difficult have these problems made if for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
O 0	O 1	O 2	O 3

IF total PHQ-9 ≥ 10
OR
IF total GAD-7 ≥ 10

This could indicate a clinically significant problem and should trigger an initial clinical assessment and consideration for follow up, referral to mental health program or enrollment in the Mental Health Integration Program

NOTE: On the PHQ-9, if the patient responds to question 9 with any answer other than "not at all," a suicide risk assessment needs to be completed.

My Falls-Free Plan

Name: _____ **Date:** _____

As we grow older, gradual health changes and some medications can cause falls, but many falls can be prevented. Use this to learn what to do to stay active, independent, and falls-free.

Check "Yes" if you experience **this** (even if only **sometimes**)	No	Yes	What to do if you checked "Yes"
Have you had **any falls in the last six months**?			☐ Talk with your doctor(s) about your falls and/or concerns. ☐ Show this checklist to your doctor(s) to help understand and treat your risks, and protect yourself from falls.
Do you take **four or more** prescription or over-the-counter medications daily?			☐ Review your medications with your doctor(s) **and** your pharmacist at each visit, and with each new prescription. ☐ Ask which of your medications can cause drowsiness, dizziness, or weakness as a side effect. ☐ Talk with your doctor about anything that could be a medication side effect or interaction.
Do you have **any difficulty walking or standing**?			☐ Tell your doctor(s) if you have any pain, aching, soreness, stiffness, weakness, swelling, or numbness in your legs or feet—**don't ignore** these types of health problems. ☐ Tell your doctor(s) about **any** difficulty walking to discuss treatment. ☐ Ask your doctor(s) if physical therapy or treatment by a medical specialist would be helpful to your problem.
Do you use a **cane, walker, or crutches**, or have to hold onto things when you walk?			☐ Ask your doctor for training from a physical therapist to learn what type of device is best for you, and how to safely use it.
Do you have to **use your arms to be able to stand up from a chair**?			☐ Ask your doctor for a physical therapy referral to learn exercises to strengthen your leg muscles. ☐ Exercise at least two or three times a week for 30 min.
Do you ever feel **unsteady on your feet, weak, or dizzy**?			☐ Tell your doctor, and ask if treatment by a specialist or physical therapist would help improve your condition. ☐ Review all of your medications with your doctor(s) or pharmacist if you notice **any** of these conditions.
Has it been **more than two years since you had an eye exam**?			☐ Schedule an eye exam every two years to protect your eyesight and your balance.
Has your **hearing gotten worse with age**, or do your family or friends say you have a hearing problem?			☐ Schedule a hearing test every two years. ☐ If hearing aids are recommended, learn **how** to use them to help protect and restore your hearing, which helps improve and protect your balance.
Do you usually **exercise less than two days a week**? (for 30 minutes total each of the days you exercise)			☐ Ask your doctor(s) what types of exercise would be good for improving your strength and balance. ☐ Find some activities that you enjoy and people to exercise with two or three days/week for 30 min.
Do you drink **any alcohol** daily?			☐ Limit your alcohol to one drink per day to avoid falls.
Do you have **more than three chronic health conditions**? (such as heart or lung problems, diabetes, high blood pressure, arthritis, etc. Ask your doctor(s) if you are unsure.)			☐ See your doctor(s) as often as recommended to keep your health in good condition. ☐ Ask your doctor(s) what you should do to stay healthy and active with your health conditions. ☐ Report any health changes that cause weakness or illness as soon as possible.

The more "Yes" answers you have, the greater your chance of having a fall. **Be aware of what can cause falls, and take care of yourself to stay independent and falls-free!**

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Reviewed by: _____

Four Things You Can Do to Prevent Falls:

① **Speak up.**
Talk openly with your healthcare provider about fall risks and prevention. Ask your doctor or pharmacist to review your medicines.

② **Keep moving.**
Begin an exercise program to improve your leg strength and balance.

③ **Get an annual eye exam.**
Replace eyeglasses as needed.

④ **Make your home safer.**
Remove clutter and tripping hazards.

1 in 4 people 65 and older falls each year.

Prevent falls to stay injury-free and independent.

Learn More

Contact your local community or senior center for information on exercise, fall prevention programs, and options for improving home safety, or visit:

- cdc.gov/falls
- www.stopfalls.org

For more information, visit www.cdc.gov/steadi

This brochure was produced in collaboration with the following organizations: VA Greater Los Angeles Healthcare System, Geriatric Research Education & Clinical Center (GRECC), and the Fall Prevention Center of Excellence.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

2023

Stay Independent

Learn more about fall prevention.

STEADI
Stopping Elderly Accidents, Deaths & Injuries

Check Your Risk for Falling

Circle "Yes" or "No" for each statement below			Why it matters
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.

Total _____

Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.

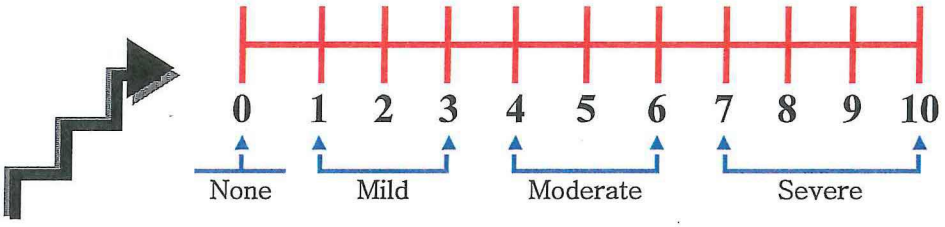
To check your risk online, visit: www.bit.ly/3o4RiW8

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. J Safety Res; 2011: 42(6)493-499). Adapted with permission of the authors.

NATIONAL INSTITUTES OF HEALTH
WARREN GRANT MAGNUSON CLINICAL CENTER

PAIN INTENSITY INSTRUMENTS
JULY 2003

0 – 10 Numeric Rating Scale (page 1 of 1)



Indications: Adults and children (> 9 years old) in all patient care settings who are able to use numbers to rate the intensity of their pain.

Instructions:

1. The patient is asked any one of the following questions:
   - What number would you give your pain right now?
   - What number on a 0 to 10 scale would you give your pain when it is the worst that it gets and when it is the best that it gets?
   - At what number is the pain at an acceptable level for you?
2. When the explanation suggested in #1 above is not sufficient for the patient, it is sometimes helpful to further explain or conceptualize the Numeric Rating Scale in the following manner:
   - 0 = No Pain
   - 1-3 = Mild Pain (nagging, annoying, interfering little with ADLs)
   - 4–6 = Moderate Pain (interferes significantly with ADLs)
   - 7-10 = Severe Pain (disabling; unable to perform ADLs)
3. The interdisciplinary team in collaboration with the patient/family (if appropriate), can determine appropriate interventions in response to Numeric Pain Ratings.

Reference

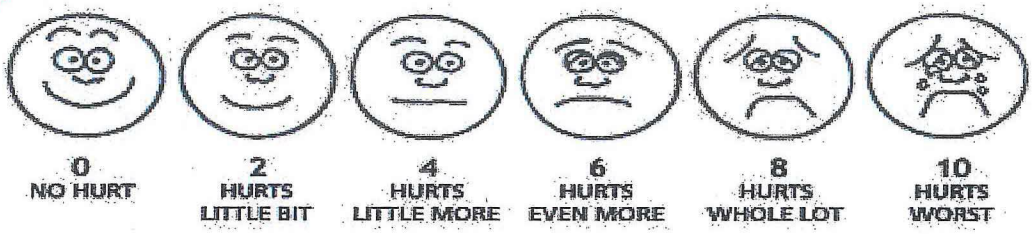
McCaffery, M., & Beebe, A. (1993). Pain: Clinical Manual for Nursing Practice. Baltimore: V.V. Mosby Company.

NATIONAL INSTITUTES OF HEALTH
WARREN GRANT MAGNUSON CLINICAL CENTER

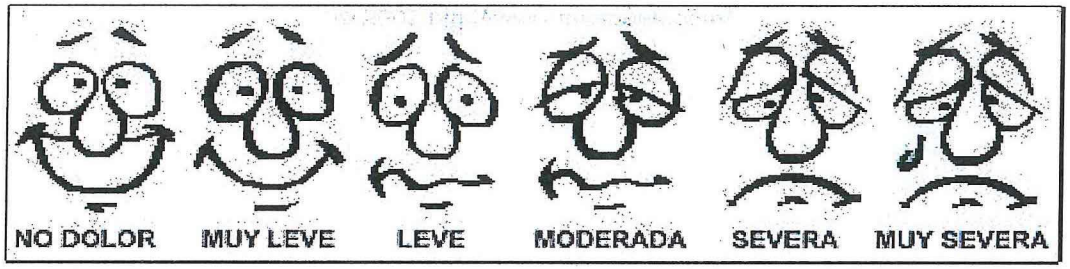
PAIN INTENSITY INSTRUMENTS
JULY 2003

Wong–Baker Faces Pain Rating Scale (page 1 of 1)

English



Español



Indications: Adults and children (> 3 years old) in all patient care settings.

Instructions:

1. Explain to the patient that each face is for a person who feels happy because he has no pain (hurt or, whatever word the patient uses) or feels sad because he has some or a lot of pain.
2. Point to the appropriate face and state, "This face is . . . "
   - 0 -1 – "very happy because he doesn't hurt at all."
   - 2 - 3 – "hurts just a little bit."
   - 4 - 5 – "hurts a little more."
   - 6 - 7 – "hurts even more."
   - 8 - 9 – "hurts a whole lot."
   - 10 – "hurts as much as you can imagine, although you don't have to be crying to feel this bad."
3. Ask the patient to choose the face that best describes how he feels. Be specific about the pain location and at what time pain occurred (now or earlier during a procedure?).
4. The interdisciplinary team in collaboration with the patient/family (if appropriate), can determine appropriate interventions in response to Faces Pain Ratings.

Reference

Wong, D. and Whaley, L. (1986). Clinical handbook of pediatric nursing, ed., 2, p. 373. St. Louis: C.V. Mosby Company.

FLACC Behavioral Pain Assessment Scale

CATEGORIES	SCORING		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown; withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs; frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to; distractable	Difficult to console or comfort

How to Use the FLACC

In patients who are awake: observe for 1 to 5 minutes or longer. Observe legs and body uncovered. Reposition patient or observe activity. Assess body for tenseness and tone. Initiate consoling interventions if needed.

In patients who are asleep: observe for 5 minutes or longer. Observe body and legs uncovered. If possible, reposition the patient. Touch the body and assess for tenseness and tone.

Face

- Score 0 if the patient has a relaxed face, makes eye contact, shows interest in surroundings.
- Score 1 if the patient has a worried facial expression, with eyebrows lowered, eyes partially closed, cheeks raised, mouth pursed.
- Score 2 if the patient has deep furrows in the forehead, closed eyes, an open mouth, deep lines around nose and lips.

Legs

- Score 0 if the muscle tone and motion in the limbs are normal.
- Score 1 if patient has increased tone, rigidity, or tension; if there is intermittent flexion or extension of the limbs.
- Score 2 if patient has hypertonicity, the legs are pulled tight, there is exaggerated flexion or extension of the limbs, tremors.

Activity

- Score 0 if the patient moves easily and freely, normal activity or restrictions.
- Score 1 if the patient shifts positions, appears hesitant to move, demonstrates guarding, a tense torso, pressure on a body part.
- Score 2 if the patient is in a fixed position, rocking; demonstrates side-to-side head movement or rubbing of a body part.

Cry

- Score 0 if the patient has no cry or moan, awake or asleep.
- Score 1 if the patient has occasional moans, cries, whimpers, sighs.
- Score 2 if the patient has frequent or continuous moans, cries, grunts.

Consolability

- Score 0 if the patient is calm and does not require consoling.
- Score 1 if the patient responds to comfort by touching or talking in 30 seconds to 1 minute.
- Score 2 if the patient requires constant comforting or is inconsolable.

Whenever feasible, behavioral measurement of pain should be used in conjunction with self-report. When self-report is not possible, interpretation of pain behaviors and decisions regarding treatment of pain require careful consideration of the context in which the pain behaviors are observed.

Interpreting the Behavioral Score

Each category is scored on the 0–2 scale, which results in a total score of 0–10.

0 Relaxed and comfortable
1–3 Mild discomfort
4–6 Moderate pain
7–10 Severe discomfort or pain or both

From Merkel, S. I., Voepel-Lewis, T., Shayevitz, J. R., & Malviya, S. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. Pediatric Nursing, 23(3), 293–297. The FLACC scale was developed by Sandra Merkel, MS, RN, Terri Voepel-Lewis, MS, RN, and Shobha Malviya, MD, at C. S. Mott Children's Hospital, University of Michigan Health System, Ann Arbor, MI. Used with permission.

Health Home Program
Washington

Health Action Plan (HAP) Assessment Guide

Note: All screening tools (required and additional) may be found in the 2-day training manual at: https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/duals/Trainers%20Manual/2%20Day%20training%20Manual.pdf and the Care Coordinator Toolkit at: https://www.dshs.wa.gov/altsa/stakeholders/washington-health-home-program-core-training

Assessment	Age	When to Offer	Notes & Considerations	Translations & Resources
PAM®	18+	Required	Required if CAM not present and client is 18 years or older.	Multiple languages available. Visit Phreesia/Insignia website.
CAM®	18+	Required	Required if PAM not present and client is 18 years or older. Caregivers may be informal or formal caregivers	Multiple languages available. Visit Phreesia/Insignia website.
P-PAM®	Under 18	Required	Required if client is less than 18 years of age. If client is 18 years or older, field is not required on HAP and no data is accepted. Parents include: Biological, adoptive, or foster.	Multiple languages available. Visit Phreesia/Insignia website.
Katz ADL	18+	Required	If a client indicates that they are	https://hign.org/consultgeri/try-this-series/katz-index-independence-activities-daily-living-adl

			dependent and could use assistance with two or more ADLs consider a discussion about applying for LTSS (or follow-up with case manager on changes if client already has LTSS). If client is less than 18 years of age, field is not required on HAP and no data is accepted. For minors, discuss any need for ADLs with parent/ guardian and if referrals are needed (e.g. DDA)	
PHQ-9	18+	Required	Score of 10 or higher indicates potential depression. Have discussion with client. Do they receive treatment, is a referral needed, share elevated scores with PCP or BH provider.	Multiple languages available https://www.phqscreeners.com/select-screener

			"Yes" on question 9 (suicide) would result in action	
PSC-17	4-17	Required	Completed by parent/guardian. A child age 13 and over may self-administer the screening. Total score of 15 or higher, or any subscale score exceeding the cut-off should lead to referral to behavioral health provider or back to PCP for further assessment. Subscales • Internalizing- anxiety & mood disorder, cut-off score 5 • Attention- hyperactivity, attention deficit, cut-off score 7 • Externalizing – conduct problems, oppositional behavior, cut-off score 7	Multiple languages available https://www.massgeneral.org/psychiatry/treatments-and-services/pediatric-symptom-checklist/

BMI	2+	Required	Anything below 18.5 or 25 and above as score considered outside of healthy	BMI tools online http://www.cdc.gov/healthyweight/assessing/bmi/index.html BMI Calculator for Children and Teens (2-19) https://www.cdc.gov/healthyweight/bmi/calculator.html BMI Calculator for Adults Adult BMI Calculator | Healthy Weight, Nutrition, and Physical Activity | CDC
DAST	16+	When indicated	Score of 1 and above may indicate a need for intervention. If there is an elevated score, the focus is getting clients to the appropriate professional or resource.	English https://sbirt.publichealthcloud.com/resources/links/DAST-10%20Revised.pdf Spanish (some differences including 6 month lookback & 4 more items https://elcentro.sonhs.miami.edu/research/measures-library/dast-10/dast-10_spa.pdf DBHR: https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/substance-use-treatment#type-of-services
GAD-7	12+	When indicated	Score of 10+ may indicate anxiety. Discuss with client, notify PCP or BH provider of elevated score	Multiple languages available https://www.phqscreeners.com/select-screener
AUDIT	14+	When indicated	A score of 8 or more may indicate a need for intervention. If there is an elevated score, the focus is getting clients to the appropriate	Multiple languages available https://auditscreen.org/translations • DBHR: https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/substance-use-treatment#type-of-services • AUDIT : the Alcohol Use Disorders Identification Test : guidelines for use in primary health care (who.int)

			professional or resource.	• Drinking Levels Defined | National Institute on Alcohol Abuse and Alcoholism (NIAAA) (nih.gov) • Screening, Brief Intervention, and Referral to Treatment (SBIRT) | SAMHSA • Alcohol Use Disorders Identification Test (AUDIT) | SAMHSA • How to Start Drinking Less | CDC
Falls Risk	18+	When indicated	0 to 2 indicates a low risk for falls 2 to 4 indicates a moderate risk for falls 4 or more indicates a high risk for falls	English version My Falls-Free Plan (wa.gov) • Fall Prevention Resources Fall Prevention Resources | Washington State Department of Health • Check for Safety (CDC) https://www.cdc.gov/steadi/pdf/check_for_safety_brochure-a.pdf • What YOU Can Do To Prevent Falls (CDC) https://www.cdc.gov/steadi/pdf/STEADI-Brochure-WhatYouCanDo-508.pdf • AARP HomeFit Guide is a room by room guide to modifying homes for safety (AARP) http://www.aarp.org/livable-communities/info-2014/aarp-home-fit-guide-aging-in-place.html
FLACC (Behavioral pain assessment scale	When self report not possible. For ages 2 months to 7 years, or if an individual is not able to communicate pain level	When indicated	A score of 4 or above indicates a moderate level of pain that may interfere with activities of daily living. Discuss results with client, notify PCP of elevated score.	Find English version on the Care Coordinator toolkit
Wong-Baker FACES®	Use with adults and children 3	When indicated	A score of 4 or above indicates a moderate level of	Multiple languages available http://www.wongbakerfaces.org/faces-download/

(pain rating scale)	years and older		pain that may interfere with activities of daily living. Discuss results with client, notify PCP of elevated score.	
Numeric (pain scale)	Adults and children 9 years and older	When indicated	A score of 4 or above indicates a moderate level of pain that may interfere with activities of daily living. Discuss results with client, notify PCP of elevated score.	Find English version on the Care Coordinator toolkit

Health Home Program
Washington

Sample Telephone Outreach Script

Note: this is a sample outreach script that may be used or edited for first telephone contacts with your clients. Use of this script is not required.

Hi _____, this is _____ with _____, here in _____ (county or town). Am I speaking with _____?

I am calling because you can now receive a free additional program as a part of your Medicaid health insurance. Do you have a minute so I can tell you about it?

Good, the program I am calling about is the Health Home Program. The program helps clients to support them so they can better manage the health care they receive and increase wellness. What has made the program so successful is the support we offer. You do not need to come to appointments; we can meet you in your own home or another place of your choice, such as an office in your community or coffee shop.

Some of the things we have helped clients with is applying for housing and accessing resources such as low-cost or free services like dental care and eyeglasses.

Would you like to schedule a time for me to meet with you so I can tell you more about the program?

Are there days or times that work better for you? (Offer an appointment day and time.)

This is the address I have for you _____.

Would you like me to meet you at this address?

Are there any other phone numbers I can reach you at?

Is there someone else, like a family member, that you would like to be at the visit?

Do I have your permission to contact them?

May I have their contact information?

Thanks for your time today. I look forward to meeting you on _____ at _____.

If something comes up and you need to reschedule you can reach me at _____. My name is _____. I can wait if you want to write this information down.

Thank you for scheduling a visit. Do you have any questions I can answer now? Okay, goodbye.

Qualified Health Home Lead Requested Disenrollment – Due Diligence

When a Qualified Health Home Lead, Care Coordination Organization or Care Coordinator is unable to contact a client, the Lead and HCA must follow standardized procedures to disenroll the client from the Health Home program

Due Diligence Process:

Qualified Health Home Leads (Lead) and HCA must follow these procedures when processing client disenrollments. The Lead must ensure Due Diligence is followed to contact the client. All contacts and attempted contacts must be documented in the client's case file.

Step 1. Mail an HCA approved welcome letter prior to calling the client. If the letter is returned, the Lead/CCO must check alternate databases or resources to secure an updated address and mail a second welcome letter to the new address.

Step 2. HCA requires at least three (3) calls be attempted and documented. The calls must be made on different days of the week and at different times of the day. At least one call must be made each month for two (2) months following the initial attempts.

Step 3. If the client cannot be contacted after 90 days from the effective date of enrollment and the above procedures have been followed, the Health Home Lead may request disenrollment of the client from the Health Home Program according to the Disenrollment Process below.

For Previously Engaged Clients: The due diligence process may begin after one month of attempted contacts to meet the monthly face- to-face home visit requirement. Example: Face-to-face meeting with client in August, unable to contact client in September, begin the due diligence process in October starting with Step 2 above.

NOTE: Do not send the **HCA Opt-out Form** unless specifically requested by the client.

Disenrollment Process:

- **CCO or Lead** - If the CCO is unable to connect with the client following the above activities, inform the Lead.
- **Lead -** If the Lead determines the client should be disenrolled from the Health Home program, the Lead will:
    - Send the Health Home Disenrollment letter to the last known address of the client giving the client at least ten (10) business days to reply. Place a copy into the clients file.
    - If the client contacts the Lead and wants to participate in the program before the disenrollment is effective, the Lead must reassign them via a "warm hand-off" to a CC.
    - If there is no response to the letter, fill out the Health Home Due Diligence Registry, which is to be submitted monthly to HCA via secure email. Note that the Health Home Due Diligence Registry does not replace the required documentation in the client's case file
- **HCA -** When HCA receives the Health Home Due Diligence Registry from the Lead, the client's Health Home segment will be ended and enrollment terminated.

NOTE: A Due Diligence Disenrollment from the Health Home program is not considered an Opt-Out. If the client asks to be reenrolled and meets Health Home eligibility criteria, they will be reenrolled. If after one year the client meets the Health Home eligibility criteria, they may be passively reenrolled.

Decisional Balance Scale

Value/Benefit of Staying the Same	Value/Benefits of Changing
Disadvantage/Consequence of Staying the Same	Disadvantage/Consequence of Changing

Questions to Consider

How important is it for you right now to...? On a scale from 0 - 10... what number would you give yourself?

0_____10

CONVICTION/IMPORTANCE SCALE

If you did decide to change, how confident are you that you would succeed? On a scale from 0 - 10... what number would you give yourself?

0_____10

CONFIDENCE SCALE

If you did decide to change, how ready are you to make this change? On a scale from 0 - 10... what number would you give yourself?

0_____10

READINESS SCALE

Washington State Health Care Authority

Washington State Department of Social & Health Services
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Non-Emergency Medical Transportation (NEMT) for Health Home Services
REQUEST FORM

Date:_____

TO NEMT Broker:_____**FAX #:** _____

NEMT Broker Look-up: https://www.hca.wa.gov/assets/billers-and-providers/BrokerByCounty.pdf

FROM (Care Coordination Organization): _____

Name of Care Coordinator:_____ **Phone #** _____

Health Home Lead Agency: (Check one)

____AAADSW
____Amerigroup
____Community Choice – Action Health Partners
____Community Health Plan of WA
____Coordinated Care
____Full Life Care
____Molina
____Northwest Regional Council
____Olympic AAA
____Pierce County Human Services (AAA)
____Pierce County ACH
____SE WA AAA
____United Health Care

Section I - Client Information

Last Name_____**First Name**_____

ProviderOne ID Number_____**DOB:**_____

Transportation Date (mm/dd/yyyy) and ***Appointment Time**:_____

Pick-up Address (exact address/entrance):_____

Drop-off Address (exact address/entrance):_____

ROUND TRIP (Circle one): YES / NO

Special Needs (e.g. escort; oxygen, wheelchair/oversize wheelchair; etc.): _____

_____

Section II – Certification:

____ Client is Medicaid Eligible_____Client is enrolled with the Health Home Lead selected above
____ Client needs transportation to an alternate location to receive health home services

Care Coordinator Signature/Date:_____/_____

Washington State Health Care Authority

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NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) FOR HEALTH HOME CLIENTS

Beginning April 1, 2015, transportation may be provided to Health Home clients for services when the client is homeless or lives in an unhealthy or unsafe environment. A Care Coordinator may request a non-emergency medical transportation to alternate locations to conduct care coordination services such as developing the Health Action Plan (HAP), obtaining consent to participate, or to administer health assessments.

TO USE NEMT SERVICES:

1. Only the Care Coordinator can request NEMT for the Health Home client. The client must behaviorally and medically stable and safe to transport.

2. The Care Coordinator must identify an alternate location where he/she may meet the client in person. Examples of acceptable alternate locations include but are not limited to:
    - A medical office or behavioral health setting or
    - A community based social or health services location such as senior center, community services office, Area Agency on Aging, or local health department.

3. The Care Coordinator must ensure the availability of the alternate location prior to scheduling the transportation.

4. NEMT for clients can only be used when providing a qualifying Health Home service and is limited to the following distance standards:
    - Within 10 miles of the client's residence in urban or suburban areas or
    - Within 25 miles of the client's residence in rural areas.

    Exceptions may be made to the distance criteria on a case-by-case basis in remote areas of the state and by approved by HCA. To request an exception, the Health Home Lead Entity with whom the client is enrolled must request the approval by sending an email to healthhomes@hca.wa.gov and include the client's name and ProviderOne ID as well as the reason for the exception.

5. The Care Coordinator must complete the Request Form for Non-Emergency Medical Transportation (NEMT) for Health Home Services and fax to the NEMT broker and maintain a copy in the client file for audit purposes.

A list of contracted regional transportation brokers can be found at https://www.hca.wa.gov/assets/billers-and-providers/ContractedBrokers.pdf.

UPDATED 12.27.2021

Washington State Health Care Authority

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NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) FOR HEALTH HOME CLIENTS

FREQUENTLY ASKED QUESTIONS (FAQs)

Beginning April 1, 2015, transportation may be provided to Health Home clients for services when the client is homeless or lives in an unhealthy or unsafe environment. A Care Coordinator may request a non-emergency medical transportation to alternate locations to conduct care coordination services such as developing the Health Action Plan (HAP), obtaining consent to participate, or to administer health assessments.

WHAT IS THE HEALTH HOME PROGRAM?
The Health Home program is a care coordination service available to eligible Medicaid clients of all ages including Medicaid clients who also receive Medicare. To receive services, clients must have a chronic condition and be at risk for a second, as demonstrated by a PRISM risk score of 1.5 or greater. The program focuses on care coordination between the client's medical, behavioral, and social needs providers.

WHO IS THE CARE COORDINATOR?
A Care Coordinator is the person who provides Health Home services. The Care Coordinator works with clients to help them identify and meet their goals for self-management, improving health, and providing comprehensive care management.

WHY WOULD A HEALTH HOME CLIENT NEED NEMT?
Health Home care coordination is person-centered and based on the development of the Health Action Plan (HAP) by the Care Coordinator and the client. The development of the HAP, as well as some ongoing Health Home services, require face-to-face visits that usually takes place in the client's home. If a client is homeless or lives in an unhealthy environment, the Care Coordinator may identify an alternate location for the face-to-face visit. In these instances, the client may need transportation to the alternate location.

WHO CAN REQUEST NEMT?
Only a client's Care Coordinator can request NEMT services from a transportation broker for providing Health Home services. Clients may not schedule this service. The Care Coordinator must contact the NEMT broker available in the client's county of residence and submit a NEMT Health Home Services Request Form. The list of transportation brokers is available at https://www.hca.wa.gov/assets/billers-and-providers/ContractedBrokers.pdf.

WHAT ARE ACCEPTABLE ALTERNATE LOCATIONS TO USE NEMT FOR HEALTH HOME SERVICES?
The Care Coordinator must identify an alternate location where the client may be met in person. Examples of acceptable alternate locations include but are not limited to:

- A medical office or behavioral health setting or
- A community based social or health services location such as senior center, community services office, Area Agency on Aging, or local health department.

WHAT ARE THE DISTANCE STANDARDS FOR TRANSPORTATION OF HEALTH HOME CLIENTS?
NEMT for Health Home services is limited to the following distance standards:

- Within 10 miles of the client's residence in urban or suburban areas or
- Within 25 miles of the client's residence in rural areas.

Exceptions may be made to the distance criteria on a case-by-case basis in remote areas of the state and be approved by HCA. To request an exception, the Health Home Lead Entity with whom the client is enrolled must request the approval by sending an email to healthhomes@hca.wa.gov and include the client's name and ProviderOne ID as well as the reason for the exception. HCA will notify the Health Home Lead Entity and the transportation broker of approved exceptions to the distance standards.

HOW DOES THE CARE COORDINATOR KNOW WHEN THE NEMT IS SCHEDULED?

The NEMT broker will contact both the Care Coordinator and the client when the request for the trip is approved and scheduled.

WHERE CAN I FIND MORE INFORMATION?
Health Home services website: https://www.hca.wa.gov/billers-providers-partners/programs-and-services/health-home-resources

HCA Transportation website: https://www.hca.wa.gov/billers-providers-partners/programs-and-services/transportation-services-non-emergency

Transportation brokers: https://www.hca.wa.gov/assets/billers-and-providers/ContractedBrokers.pdf

Email questions to: healthhomes@hca.wa.gov

Health Home Program
Washington

Dear Administrator or Staff,

I am a Health Home Care Coordinator with _____.

I am here because one of your residents is eligible for the **Health Home Program**. The program is voluntary and is provided at no cost to eligible Medicaid and Medicaid/Medicare clients. The state identified one or more of your residents who are eligible to receive my services.

The Health Home Program **helps residents** who have one or more chronic diseases. These residents are at risk for other health problems and higher medical costs.

Care Coordinators help your resident(s) create a Health Action Plan, which includes personalized health goals. I can **assist you** by providing Health Home activities such as:

1. **Teaching** your resident about their health
2. **Coaching** family members to support your resident and you
3. **Referring** your resident to services outside of routine care
4. **Helping** you with care transitions when your resident returns from a hospital or nursing facility

Your resident may receive monthly visits and phone calls as part of their Health Home services. I look forward to working with you **to support** your resident in reaching their health goals.

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Optional Use by Facility

Resident Name	**ID#**

Best Practices Residential Facilities

- Follow facility sign in/out procedure
- Attempt to adhere to reasonable visiting hours
- Understand basic workings of Residential facilities and roles of staff
- Prearrange visits and private space for meetings
- Provide Residential Introduction Letter to staff
- Provide your business card (if available)
- Wear appropriate organization identification
- Attain contact information of staff
- Be mindful of staff's duties and time. They have multiple residents they tend to
- Do not go into resident rooms without asking the resident first. Always knock first and wait for response before entering their room. Residents may be in shared rooms
- Ask the client, when applicable, if they would like you to attend their annual CARE assessment
- Notify, when applicable, your client's HCS/AAA/DDA worker for care coordination
- Bring general Health Home program educational materials to leave with resident and facility staff as applicable

Best Practices Skilled Nursing Facilities

- Follow facility sign in/out procedure
- Attempt to adhere to reasonable visiting hours
- Understand basic workings of Skilled Nursing Facilities. It is helpful to know when client is scheduled for therapy or medical visits, meal times, shift changes, activities and other schedules that may impact having quality time with your client
- Prearrange visits and private space for meetings
- Provide Residential Introduction Letter to staff
- Provide your business card (if available)
- Wear appropriate organization identification
- Attain contact information of staff
- Be mindful of staff's duties and time. This is a nursing/rehab facility which operates 24 hours per day and which staff have multiple residents they tend to
- Do not go into resident rooms without asking the resident and nursing home staff first. Always knock first and wait for response before entering room. Residents may be in shared rooms
- Ask the client, when applicable, if they would like you to attend their care conference or other multidisciplinary team meeting
- Notify, when applicable, your client's HCS/AAA/DDA worker for care coordination
- Bring general Health Home program educational materials to leave with resident and facility staff as applicable

Washington State Health Care Authority

Interpreter Service Program Overview

Interpreter Service (IS) is a program available through Health Care Authority (HCA) for Medicaid health care providers and their Medicaid clients. The program allows the providers to gain access to skilled and qualified spoken language access providers (LAPs) and sign language interpreters for Apple Health (Medicaid) clients who have limited English proficiency (LEP) and may be Deaf, DeafBlind, or hard of hearing. HCA offers access to an in-person spoken language contract, an over-the-phone and video remote spoken language contract, and a sign language contract. The IS program works with Universal Language Service for all spoken language contracts and the Office of Deaf and Hard of Hearing (ODHH) for the sign language contract.

Medicaid providers are required to ensure appropriate language access is provided to their Medicaid clients according to Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA).

How to request an Interpreter or LAP?

- Request spoken language LAPs through our contract with Universal Language Service.
- Request sign language interpreters through the Department of Enterprise Services (DES) Office of Deaf and Hard of Hearing (ODHH) master contract utilizing the online request system.

Who is eligible to utilize HCA's Interpreter Services contracts?

Apple Health Medicaid providers are eligible to request an interpreter when:

- They have a national provider identification number (NPI)
- They are actively enrolled as an Apple Health Medicaid enrolled health care provider
- The services are for an eligible Apple Health Medicaid client

What services are available through Universal Language Service?

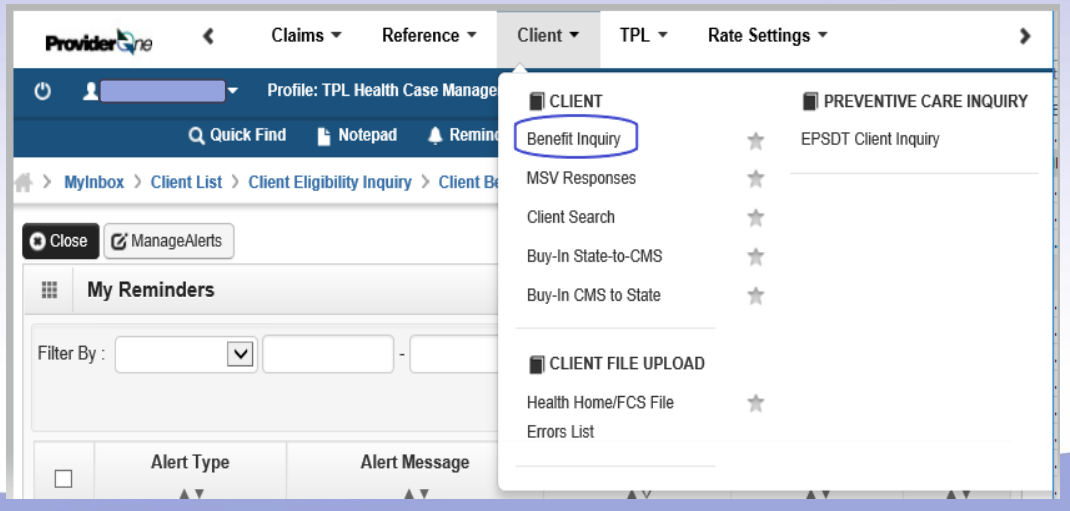
- Universal Language Service offers in-person, over-the-phone, and video remote interpreting. All appointments are offered to DSHS certified, authorized, and recognized LAPs. Medicaid providers can schedule a service request online through the Universal Language Service portal.
- It is the responsibility of the provider to verify eligibility, but Universal Language Service will verify the eligibility when accepting the request for interpreter services.
- LAPs are paid directly by Universal Language Service so there is no paperwork for providers.

What services are available through DES/ODHH?

- ODHH offers interpreter services with certified, authorized, and recognized sign language and tactile interpreters.
- Increased ability to best match interpreters with Deaf, DeafBlind, and Hard of Hearing clients.
- Accepts requests through the online request system.

For more information on Interpreter Services please visit the Interpreter Services webpage.
Contact us at: interpreterservices@hca.wa.gov

Go to Client and select Benefit Inquiry



We will review a few screens in ProviderOne Benefit Inquiry that show how to identify clients that are eligible for the Health Home program.

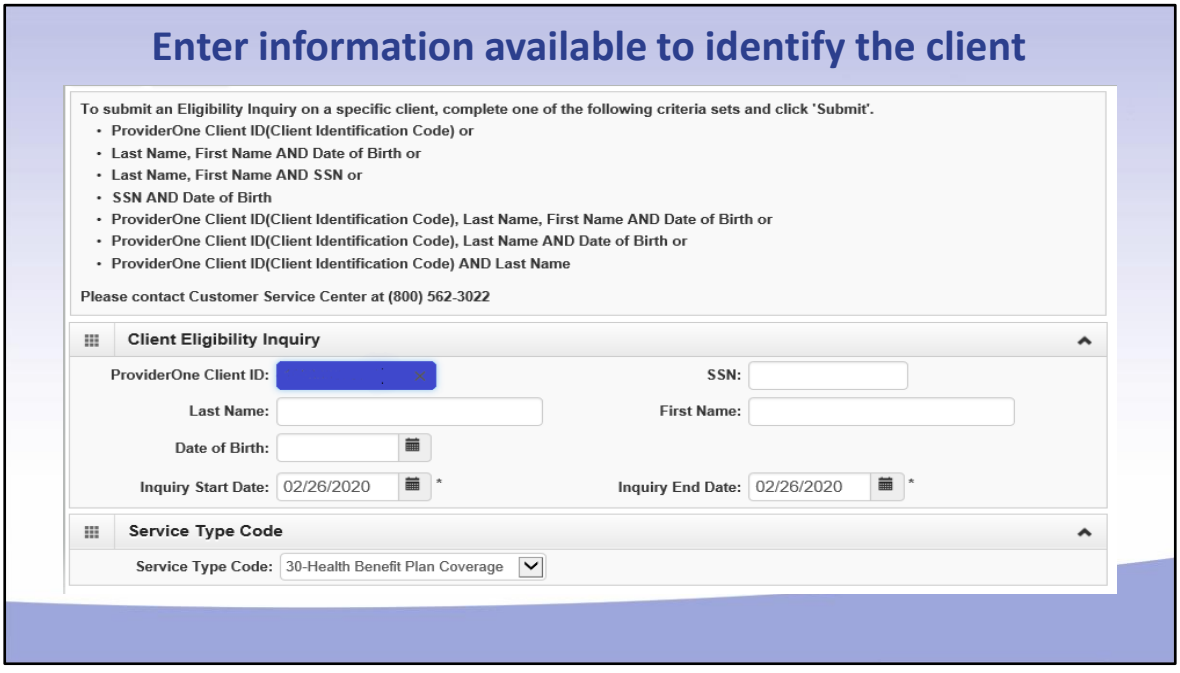
At the end of this module there will be a handout of these screens for future reference.

Some of you may not receive access to ProviderOne. Check with your agency and Lead if you will be gaining access.

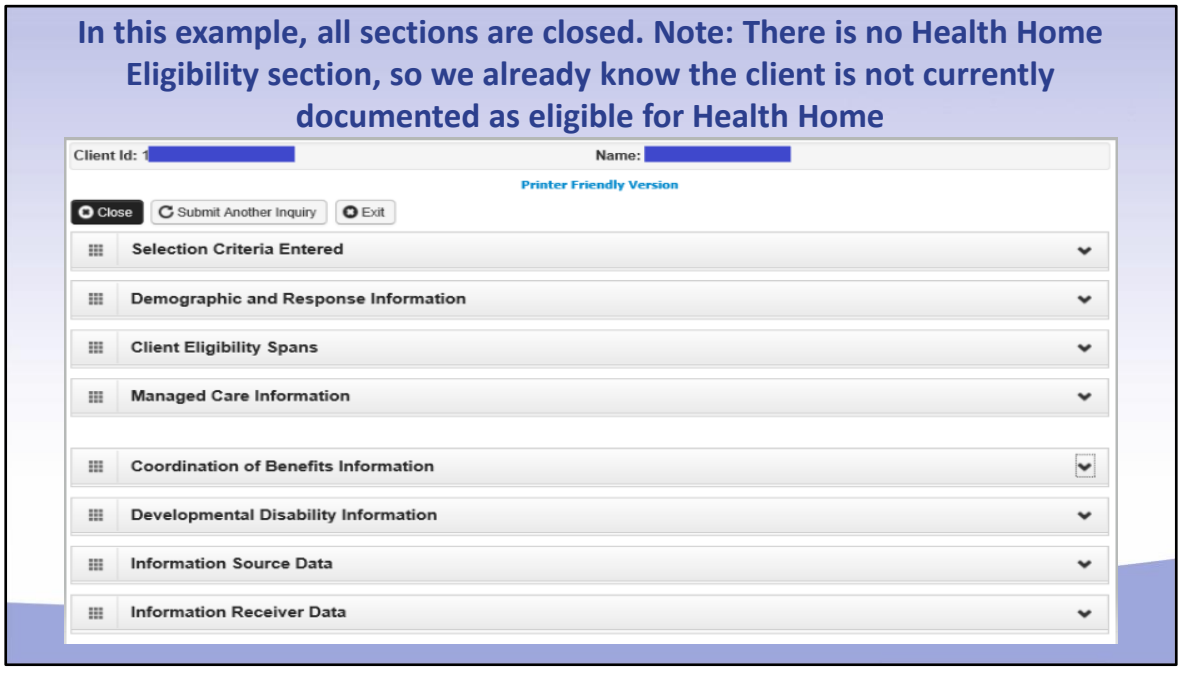
In many cases you will not be able to tell for sure that a client is eligible, but by understanding the Benefit Inquiry screen you will be able to answer some eligibility questions.

Go to the Client tab in ProviderOne and select Benefit Inquiry.

Enter information available to identify the client

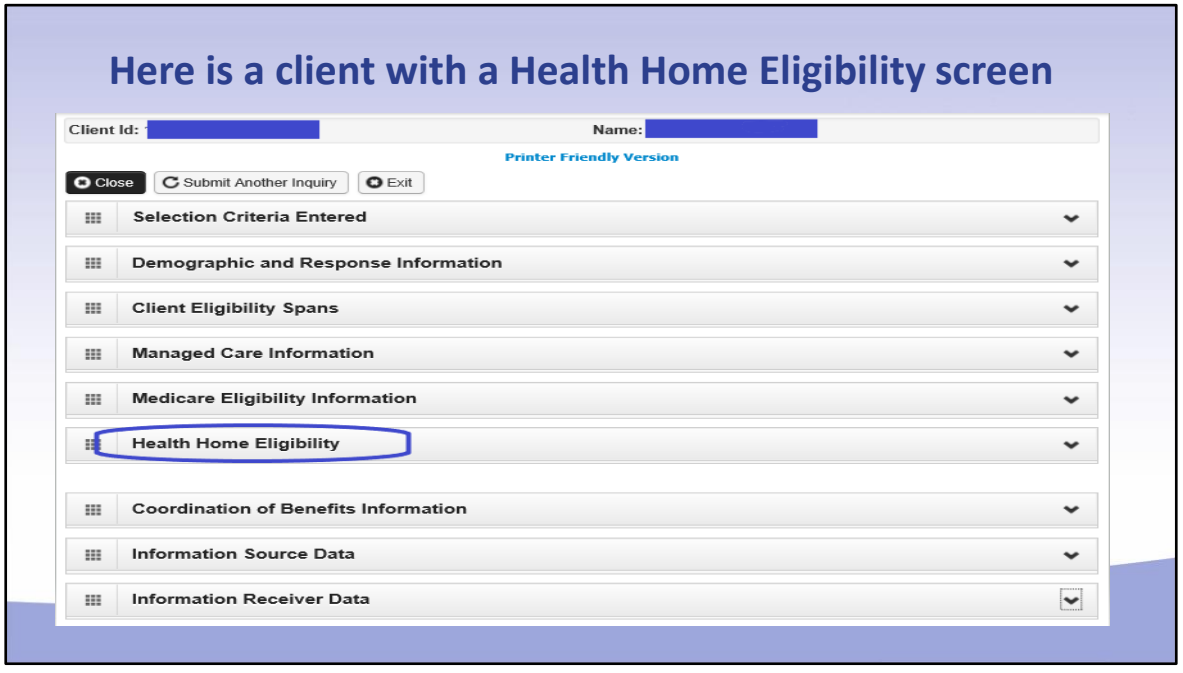


Enter what information that you have available to identify the client.



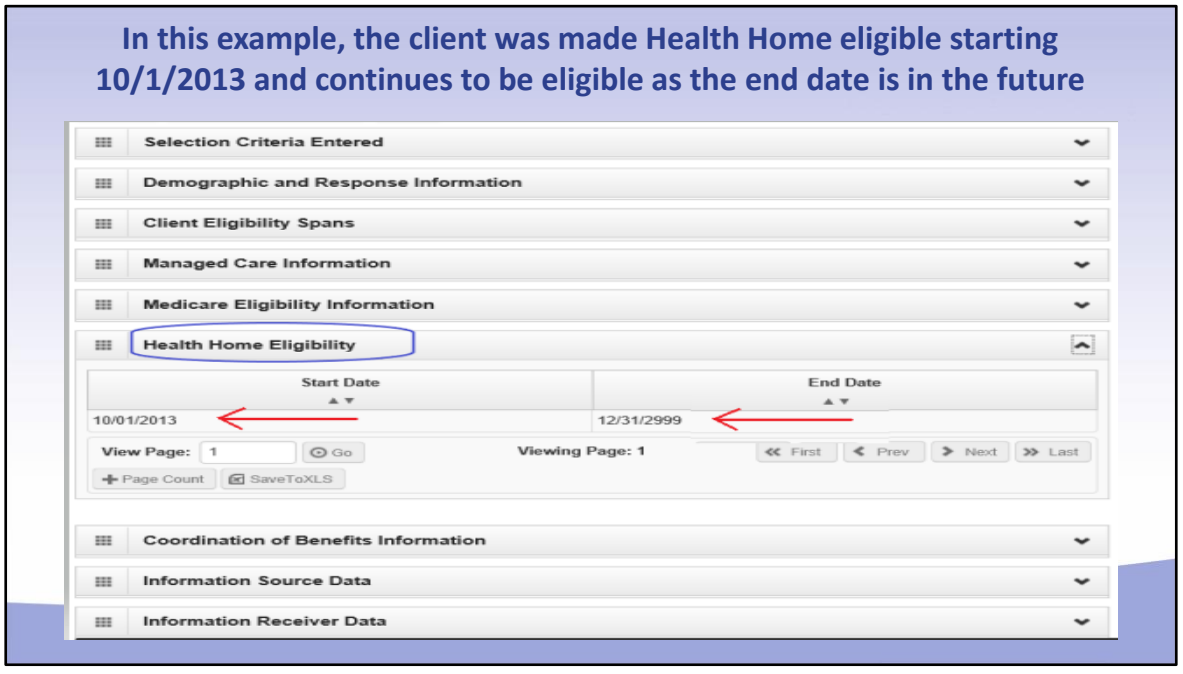
In this example, all sections are closed so that you can see this client does not have a Health Home section.

This means that the client has not been identified as Health Home eligible or they are not currently eligible. A client could however be identified as eligible in the future.



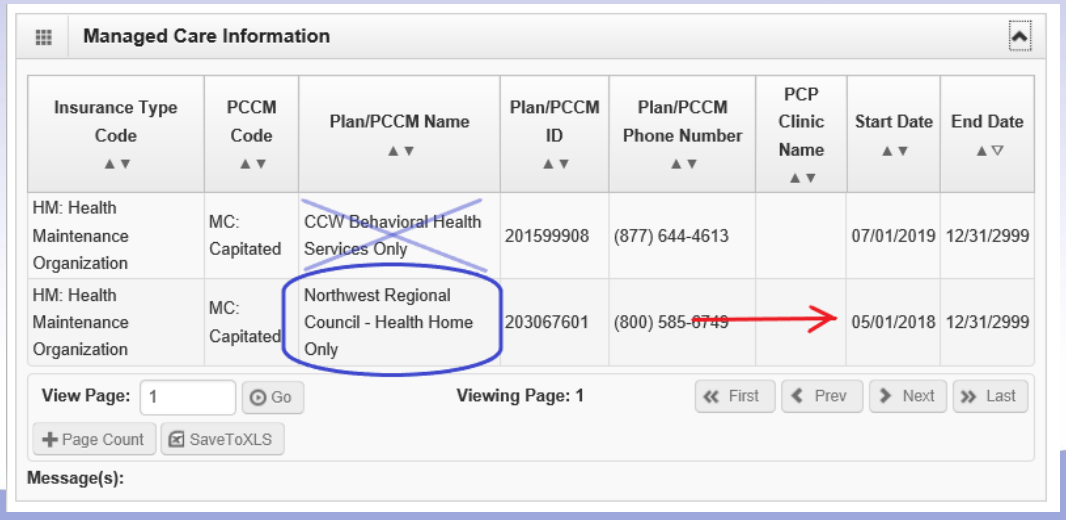
Here is a client with a Health Home eligibility screen and has a Health Home segment entered into their profile.

Although this tab is titled Health Home Eligibility, It takes more than just a Health Home segment to make a client eligible.



In this example, the client was made Health Home eligible starting 10/1/2013 and continues to be eligible as the end date is in the future.

Same client continued



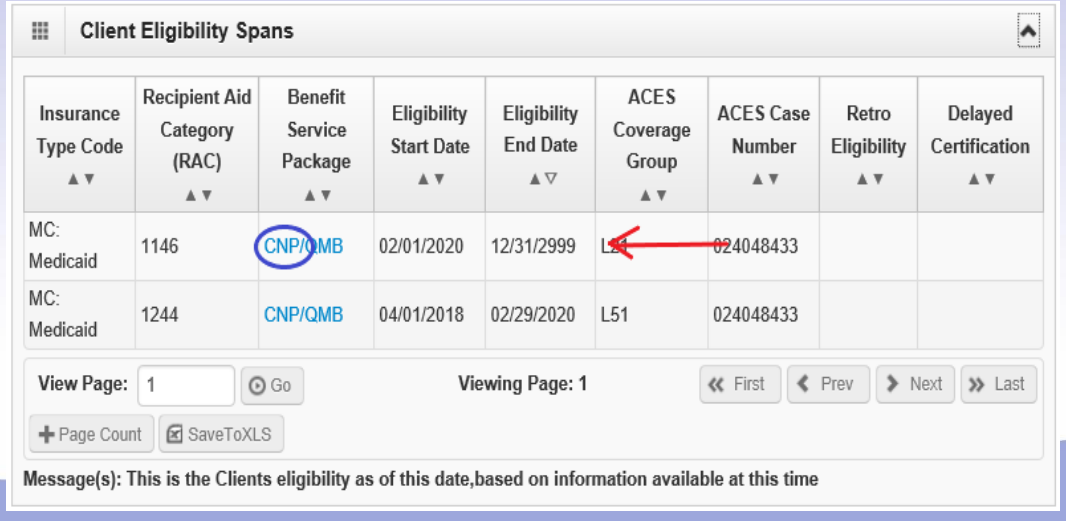
Let us look at other information on this client.

In the Managed Care Information section, we see that the client is receiving Health Home services through *Northwest Regional Council – Health Home Only* program. Note that the start date is in the past and the end date is in the future.

Health Home services are never received through a Behavioral Health Services Only contract such as the one listed here. This is also true with Employment, Housing PACE and PCCM programs.

There must be a separate line that mentions Health Home. There may also be different organizations providing different services such as in this example.

Same client continued

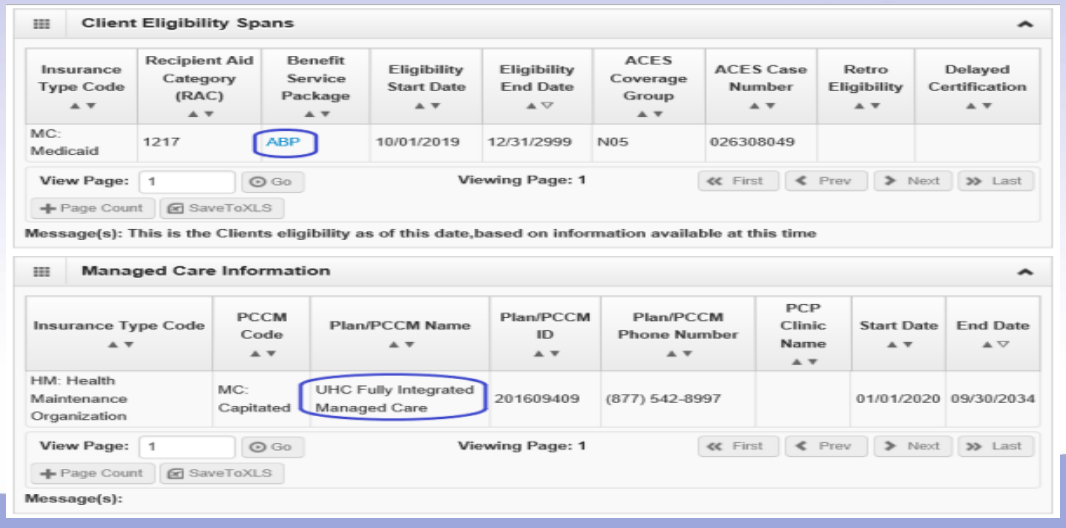


Here is the *Client Eligibility Spans* information for the same client.

For a non-managed care Fee-For-Service client to be Health Home eligible they must have a CNP or ABP Benefit Service Package (Categorically Needy or Alternative Benefit Program). If eligible, they may be enrolled with a Health Home Only provider.

Also, note the start and end date.

Managed Care Client example



Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1217	ABP	10/01/2019	12/31/2999	N05	026308049		

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Message(s): This is the Clients eligibility as of this date,based on information available at this time

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	UHC Fully Integrated Managed Care	201609409	(877) 542-8997		01/01/2020	09/30/2034

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Message(s):

Here is an example of a client in Apple Health managed care (Fully Integrated Managed Care) with a Benefit Services Package of ABP. Managed care clients may also be CNP.

PRISM Data Fields – CARE

The **P**redictive **R**isk **I**ntelligence **S**yste**M** contains valuable information designed to support care management interventions for high-risk clients. It includes information from medical, social service, behavioral health and long term care payments including assessment data from CARE. Information includes Medicare and Medicaid claims, in-patient stays, Emergency Department utilization, and risk factors. The lookback period for data is 15 months for adults and 24 months for children. The following shows the types of data CARE exports to PRISM.

Long Term Care Assessments: In PRISM, the entire CARE assessment is not available, however it will show the history of assessments. It lists the type (annual, interim, sig change, initial), status (current, pending, history), Date assessment was done, and the Problem Description. The Problem description is taken verbatim from "reason for assessment" on the CARE Assessment Main screen. When the PRISM user selects a particular assessment from the list, the following information will display:

Behaviors: The number of behaviors are displayed and when the PRISM user clicks on this section, it shows the name of behavior, type of behavior, status (current/past), intervention, alterability, and description.

Fall: Provides the number of falls listed and when the PRISM user clicks on this section, it shows site (e.g. bedroom, outside), and when occurred (e.g. within 30 days, past 31-180 days).

Pain: The number provided is not the client's pain level but rather the amount of impacts listed for pain. When the PRISM user clicks in this section, it specifies the pain impacts (e.g. depression, activity limited, sleep loss, etc.).

Limitations: The number listed is the amount of limitations that are on the assessment. When the PRISM user clicks on it, it shows each limitation from all screens.

Client: Shows ADSA ID, name, reporting unit and housing (does not pull the address).

Worker: Shows current HCS/AAA/DDA case manager and their phone number per overview screen.

PCP: Shows name, address and start date of any PCP's listed as PCP in contact role. Will show previous PCP's with end date.

Other details: The following areas show only the noted response and no further information:

ADL Score (0-28): Does not list the ADL's but only shows the score (0-28);

Depression Score: Lists the depression score by number. CARE uses the Patient Health Questionnaire (PHQ), PHQ-2/PHQ-9, a validated depression screening tools to assist in the assessment process. The PHQ-0 is also used in MDS 3.0 and will allow for comparisons across healthcare settings. A score of 10 or more indicates possible depression and the case manager is to document a discussion regarding possible referral;

CPS Score (0-6): Lists the CPS score (0-6). The Cognitive Performance Scale (CPS) is made up of the following elements taken from the assessment:

- Is client comatose?
- Can client feed her/himself?
- Can client make her/him understood?
- Rate how client makes decisions
- Short term memory OK? Or MMSE delayed recall (missing one or more)

The following table contains the average relationship between a client's CPS and MMSE score.

Score meaning	Cognitive performance scale
Intact	0
Borderline Intact	1
Mild Impairment	2
Moderate Impairment	3
Moderate to Severe Impairment	4
Severe Impairment	5
Very Severe Impairment	6

Overall Self-Sufficiency: Lists what was selected on Independence and Improvement screen (e.g. No change, Deterioration, Improved);

Self Rated Health Status: Lists what was selected on the Indicators/Health Indicators screen (e.g. good, fair, poor). This question is an excellent indicator of a client's health status. A client's perspective of his/her health can be a very good predictor of what his/her health status will be;

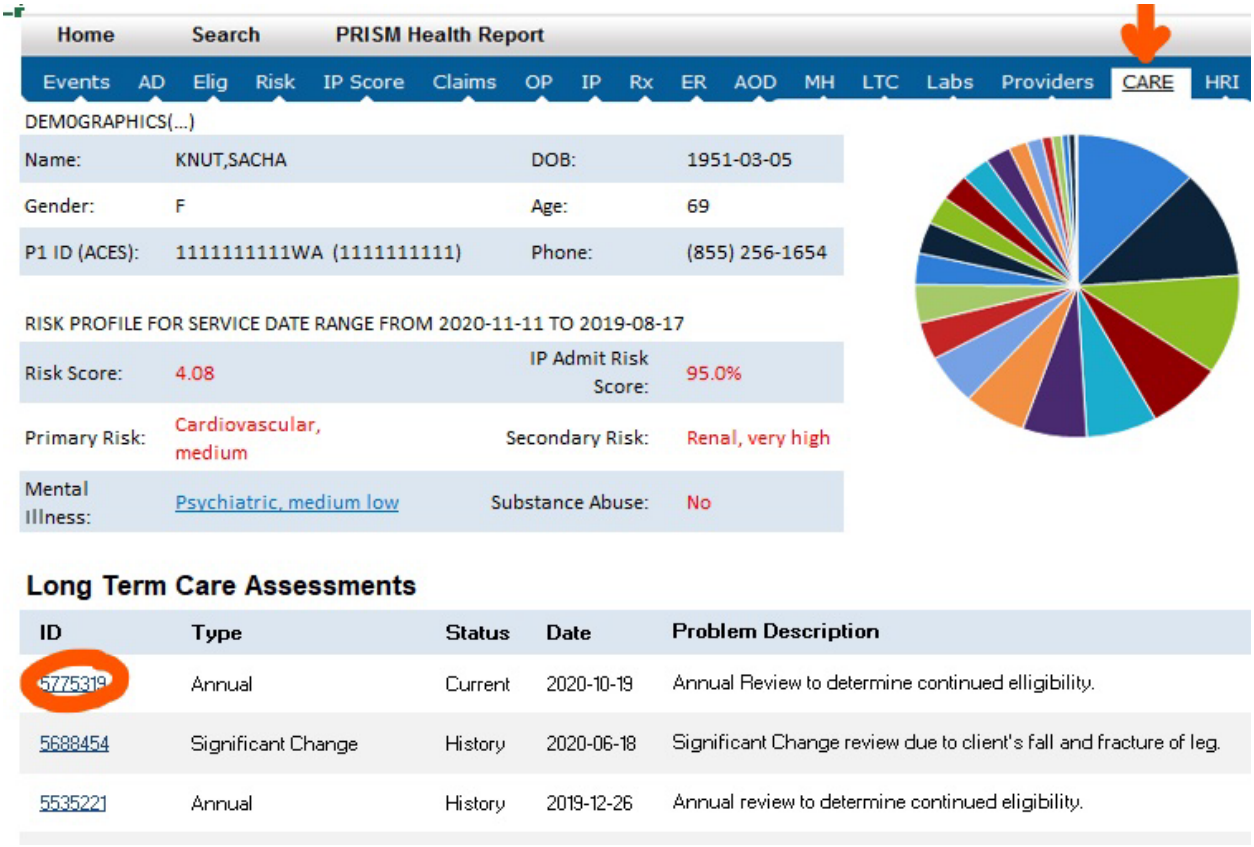
Residential Group: From the Care Plan screen lists the Classification such as A High, B Low, etc. This is the clinical grouping that the client falls into based upon clinical complexity, Cognitive Performance Scale (CPS) score, moods/behavior, and ADL score; and

In Home Group: Same as Residential Group.

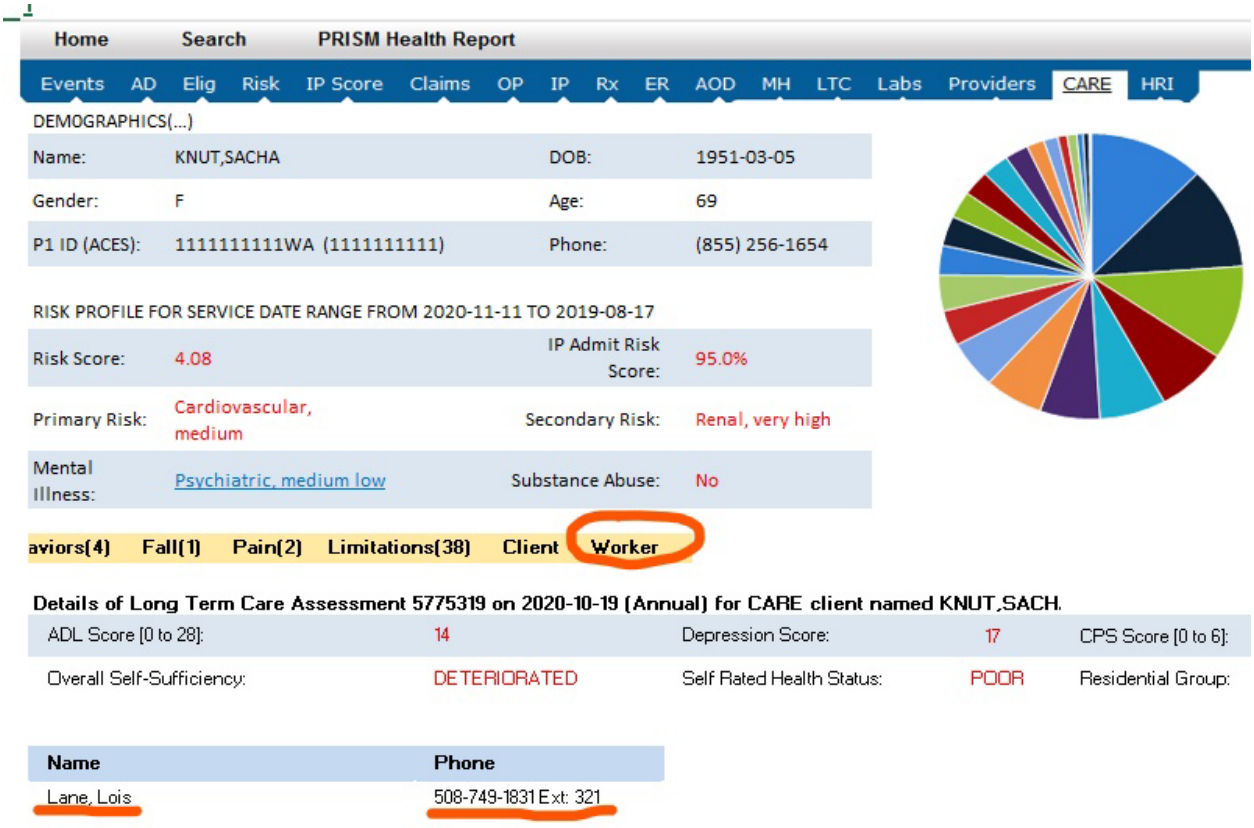
Finding Case Manager Contact Information in PRISM

If a Care Coordinator is having difficulty getting in contact with a client, they may want to see if there is a case manager assigned who may have current contact information. Speaking with case managers may also help with coordinating services for clients.

To find if there is a case manager with HCS/AAA/DDA go to the CARE tab in PRISM. If there is an assessment, it will show under “Long Term Care Assessments”. Assessments will be listed as current, pending or history. If there is no assessment, or if the most recent assessment is listed as “history”, the client may not have a current case manager.



When the PRISM user selects a particular assessment from the list, the following information will be displayed



Click on “Worker”. Once you do, the current HCS/AAA/DDA case manager and their phone number will be shown.

CARE COORDINATOR ADVANCE CARE PLANNING (ACP) GUIDE SHEET

OVERVIEW

Determining our preferences for health care, medical emergencies, disability, and end of life care poses a challenge not only for ourselves but also for our clients, parents, caregivers, and family members.

Advance Care Planning (ACP) is a process in which an individual explores their goals, values, and beliefs and considers what health care they would want in their future, including wishes and preferences for care at the end of life. It involves choosing a health care agent who can communicate their wishes if they can no longer speak for themselves, and having conversations with their loved ones about their choices.

An Advance Directive (AD) is a legal document that includes two parts: a health care directive for documenting client treatment wishes and a durable power of attorney for health care used to name their selected health care agent (HCA).

YOUR ROLE AS A CARE COORDINATOR

One service Care Coordinators (CCs) are required to provide is the opportunity for clients to consider and discuss ACP. While CCs do not draft ADs for their clients they should assist clients and their families in accessing legal assistance if they wish to complete an AD. A discussion about ACP must be offered within the first year of the client's agreement to participate in the Health Home program. CCs are expected to simply begin the conversation to determine the client's interest in ACP. This offer of assistance and any actions taken should be documented in the client's case record.

ITS ABOUT THE CONVERSATION

CCs might consider opening the conversation in the following ways:

First, ask for permission:

- Introduce ACP as a statewide initiative. We are talking with our clients about the importance of ACP and ADs to help them and their families learn how to plan for future health care decisions. Would you mind if we talked a bit about this?

Second, consider these questions to assist the client in thinking about ACP:

- You may have received information about ACP. Tell me what you understand about this type of planning? *[The CC should confirm knowledge or provide clarification about ACP and ADs.]*
- Do you have any concerns about this planning? What experiences have you had with family or friends who have become seriously ill or injured? *[The CC should be prepared to listen for experiences that will help the client think about their personal goals and values regarding decision making. Promote dialogue by asking "what did you learn from that experience?" "What else did you learn?"]*

- Do you have questions about the role of an HCA? *[The CC should be prepared to review the qualities of an HCA including – does the HCA accept their role; does the HCA accept the client's goals, values, and preferences; does the HCA agree to follow their wishes even if they do not agree with them; and can the HCA make decisions in difficult moments?]*

SUMMARY OF THE THREE DECISIONS FOR ACP

Summarize the three decisions that need to be made as part of ACP:

- Who your health care decision maker or HCA should be;
- What cultural, religions, spiritual, or personal beliefs you have that might impact your decisions, and discuss these with your HCA and loved ones; and
- What health care would you like to receive if you have a sudden illness or injury?

NEXT STEPS

- Offer assistance with getting more information about ACP or connecting them to someone who could help them complete an AD.
- If the client is interested in incorporating ACP or the development of an AD in to their Health Action Plan ask the following questions:
  - Would they like to set a short term goal of pursuing an AD?
  - What action steps are necessary?
  - Who will complete them and by when?
  - Who else should be involved?
  - Who should be informed that they are pursuing an AD?
  - Who should receive copies of any documents created?

RESOURCES

Health Home Care Coordinators Toolkit website located at:

https://www.dshs.wa.gov/altsa/stakeholders/chronic-disease-and-education-materials

Next Step in Care
Family Caregivers & Health Care Professionals Working Together

Family Caregiver Guide

Hospital-to-Home Discharge Guide

In the Hospital: Planning for Discharge

The best time to start planning for discharge is just after your family member is admitted. While it may seem too soon to think about going home, planning gives you more time to prepare.

A good way to start planning for discharge is by asking the doctor how long your family member is likely to be in the hospital. The doctor may know this when the admission is planned, such as for surgery or tests. But the doctor may not know how long your family member will be in the hospital if the admission was not planned, such as for an emergency or sudden illness. When patients leave the hospital they might be discharged to:

- Home, with no needed services
- Home, with help needed from a family caregiver
- Home, with help needed from a home care agency
- A rehabilitation setting (such as a short-term unit in a nursing home or rehab facility)

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Know Who Is on the Discharge Team

Many people help plan a hospital discharge, and they are often referred to as a "team." The team members include:

- **A doctor**. He or she authorizes (approves) the hospital discharge.
- **A nurse or social worker**. This person coordinates the discharge, making sure that everything happens when it should. He or she also takes care of many details about hospital discharge.
- **You, the family caregiver**. You likely are the one who knows your family member best.

Tell the nurse or social worker that you are the family caregiver. Meet with this person as soon as you can to talk about discharge. This is a good time to discuss:

- How much time you can devote to being a family caregiver
- Whether you will provide all or some of the needed care
- Whether you can continue to work at your job or must take time off
- Whether you have any health problems or other limitations, such as not being able to lift heavy weights
- Whether you have other commitments, such as caring for young children
- All your other questions and concerns about being a family caregiver

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Your family member should not leave the rehab facility until there is a safe and adequate discharge plan. This means that the plan meets your family member's needs and that you can do what's expected of you.

Help Decide about Discharge

You may feel pressure from the hospital team to take your family member home. Your family member might also pressure you to go home as soon as possible. Being home might be better for everyone involved. But it needs to make sense for both your family member and you. This means that the home to which your family member will be discharged is safe, has a telephone, and does not need a lot of repair. It also means thinking about how to pay for care and balance caregiving with your other commitments.

This is a lot to think about. You may need time to figure out how to manage it all. **Tell the team if you are not ready or able to care for your family member after discharge. They will try to help you solve the problem(s).**

Appeal a Hospital Discharge Decision (if needed)

Sometimes the hospital makes a discharge plan you do not want, agree with, or feel is safe. You have the right to appeal (ask for another review) this decision. By law, the hospital must let you know how to appeal and explain what will happen. Make sure the hospital provides you with contact information for the Beneficiary and Family Centered Care-Quality Improvement Office (BFCC-QIO) that reviews such appeals. You can find a list by state at http://www.nextstepincare.org/Links_and_Resources/Federal/Medicare_Appeals/.

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Next Step: Getting Ready to Go Home

There is a lot to think about as you get ready for your family member's transition from hospital to home. Here are some important issues to keep in mind:

Equipment and Supplies

Make sure to get all the needed equipment and supplies. Find out what the hospital or home care agency provides and what you must get. Here are some good questions to ask:

- Does my family member need a hospital bed, shower chair, commode, oxygen supply, or other equipment? If so, where do I get these items?
- What supplies do I need? This may be diapers, disposable gloves, and skin care items.
- Do I get these from the hospital or a home care agency, or will I need to buy them?
- Where can I find these supplies if I have to buy them?
- Will my family member's insurance pay for them?

Home Space

Your family member's home should be comfortable and safe, and a good place for care. Ask the hospital team if you need to do anything special to get ready. This might be to:

- Make room for a hospital bed or other large equipment.
- Move out items that can cause falls such as area rugs and electric cords.
- Arrange a safe place to store medications.
- Create a place to sit near your family member.
- Have a place for important information, such as a bulletin board, notebook, or a drawer

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Health Care Tasks

You will likely do certain tasks as part of giving care. It is important that you know how to do these safely. **Try to learn as much as you can while your family member is still in the hospital.** You can do this by watching hospital staff as they do these tasks and asking them to watch as you try these tasks yourself.

Sometimes, hospital staff will not teach these tasks until the day of discharge. This may not be a good time to learn if you feel rushed or overwhelmed. Learn what you can, and ask who to call if you have questions at home.

You might be told to call someone from the hospital, a home care nurse, or other health care professional.

Speak up if you are afraid of doing certain tasks (such as wound care) or cannot help with personal hygiene (like helping your family member take a shower or go to the bathroom). Some caregivers are okay with changing their family member's diapers while others feel very uncomfortable about doing this task. Think about your own feelings as well as your family member's. **The hospital team needs to know what tasks you can and cannot do so they can plan for any needed help.**

Special Foods

Ask the hospital team if there are certain foods your family member can or cannot eat. This might include specific foods such as milk or meat, or general types of food, such as very soft food or liquids. If your family member needs any special foods, try to buy them before discharge when it is easier to shop.

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Medication

One of your jobs as a caregiver may be "medication management" — making sure your family member takes the right medication, at the right time, and in the right amount. Here are some questions to ask that can help you do this job well:

- What new medications will my family member take?
- For all new medications, how long should he or she take them?
- Should this medication be taken with meals? At certain times each day?
- Does the medication have any side effects?
- Can it be taken with other medications?
- Is this new medication listed in the *Medication Management Form,* along with my family member's other prescriptions, over-the-counter medications, vitamins, and herbal supplements?
- Do I get this medication from my pharmacy or the hospital?
- Will my family member's insurance pay for these medications? If not, are there other medications that work just as well and cost less?

A Medication Management Guide and a form that can help you organize your family member's medication information, are available on www.nextstepincare.org.

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At Home: Giving Care

Know Who to Call and What to Do

You may have a lot of questions during the first few days at home. **Make sure you have phone numbers for people on the hospital team, as well as any home care agency involved with your family member's care.**

Make sure you know what to do for your family member's care. This includes knowing:

- Are there any symptoms that you must report right away, such as fever, intense pain, or shortness of breath? If you notice these symptoms, who do you call, and what should you do?
- Are there limits or restrictions on what your family member can do? For example, your family member might not be able to take a bath, lift heavy things, or walk up or down stairs.
- Is it safe to leave your family member alone? If not, what should you do, for instance, when you need to go work?

Arrange for Follow-Up Care

Your family member may have one or more new health care professionals once he or she is home. Even if no new health care professionals are involved**, your family member should have a follow-up visit with his or her doctor.**

Here are some questions you can ask about follow-up care before leaving the hospital:

- What health professionals does my family member need to see?
- Who should I call to make these appointments?
- Where will the appointments be? In an office, at home, or somewhere else?
- What should I do if I cannot get an appointment within a certain time?
- How will my family member's doctor learn what happened in the hospital?

You should find out about local resources. Many communities have resources that can help you and your family member, such as: Help with transportation or financial assistance, and friendly volunteer visits for your family member, counseling, support groups, and respite care (time away from caregiving) for family caregivers.

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Being a caregiver is a big job whether your family member is in the hospital, getting ready to go home, or already at home. You need to take care of yourself, not just your family member. This means paying attention to your feelings as well as physical health. It also means taking time for yourself—even for just a short while each day.

Plan for Routine Care

Even though all days are not the same, it helps when you have a plan for routine care. This means knowing what tasks are done each day and who will do them. If you are working with a home care agency, find out what jobs they and you will each need to do.

Paying for Care

You will have to deal with your family member's hospital bills at some point. **Make sure to read these bills closely, and make sure that your family member received all the listed services. Let the hospital or insurance company know if there are any problems.**

Dealing with these bills can be difficult, and some caregivers ask other family members to help. You may also have to deal with other financial and insurance issues. Each time you speak with a representative about these issues, write down who you spoke with, and what you discussed. Sometimes you may hear that Medicare or other insurance will not pay for a needed service. If so, check the facts for yourself.

Here are some ways:

- Talk with the hospital team who planned your family member's discharge. They may be able to arrange ways of paying for home care services.
- Call your State Health Insurance Assistance Program (SHIP). You can find contact information for SHIP programs in other states by going to the Medicare website at www.medicare.gov/contacts/static/allStateContacts.asp
- If your family member has Medicare, you can contact the Medicare Rights Center. You can call 800-333-4114 and ask to speak to with a Medicare specialist. You can also check online at www.medicarerights.org

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DISCHARGE PREPARATION CHECKLIST

Patient: _____

Before I leave the care facility, the following tasks should be completed:

- ☐ I have been involved in decisions about what will take place after I leave the facility.
- ☐ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.
- ☐ I have the name and phone number of a person I should contact if a problem arises during my transfer.

- ☐ I understand what my medications are, how to obtain them and how to take them.
- ☐ I understand the potential side effects of my medications and whom I should call if I experience them.
- ☐ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ☐ I understand how to keep my health problems from becoming worse.

- ☐ My family or someone close to me knows that I am coming home, is available to care for me and knows what I will need once I leave the facility.
- ☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.
- ☐ I have what I need at home (medication, equipment, home modifications).

This tool was developed by Eric Coleman, MD, MPH, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation.

Robert Wood Johnson Foundation

CAREABOUT YOURCARE

MY CARE TRANSITION PLAN

I was in the hospital because:

Patient: Date:

Dates of hospitalization:

If I have the following problems...

I should:

My next appointments:

With

Address

Date/Time Phone

With

Address

Date/Time Phone

With

Address

Date/Time Phone

Things to talk to my doctor about at my next visit:

Important contact information:

My primary doctor

Name Phone

My hospital doctor

Name Phone

My hospital nurse

Name Phone

My care coordinator/care manager

Name Phone

My visiting nurse or home health care provider

Name Phone

My pharmacy

Name Phone

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CAREABOUT YOURCARE

Patient: Last updated:

Note what the medication does. For example: **lowers blood pressure** or **for pain relief**

Include any special instructions for the medication, such as **take with food** or **stop taking on 1/14**

Use the grid below to write down the amount you take in each time slot (for example, 1 in the morning and 1 ½ at bedtime).

My daily medications list:

Name	What it does	How to take	Amount to take and when to take			
			Morning	Noon	Evening	Bedtime

As-needed medications:

Name	What it does	How to take	How much and how often

Harrison Medical Center Teach Back Education Tool

*Teach-back should be used with **ALL** patients to ensure that they understand information, changes, and instructions.*

Teach back is not just repeating back or saying "Yes, I understand".

*It is having patients **demonstrate** they understand what is required in **their own words**, **related to their life.** This is a way for us to confirm their understanding and identify areas of need.*

Teach Back Questions to ask your patient:

- **How would you explain that to** *(your wife, your children)?*
- **Tell me what you know about** *(your diabetes, asthma)?*
- **How would you know** *(when to call the doctor, if you, had an infection)?*
- **Show me how you would** (take this insulin, use your inhaler) ?
- **What would you do if** *(you are on insulin but you get sick, have chest pain)?*
- **Who would you call if** *(you have a temp over 102, your arm swells)?*
- **What are 2 side effects of your medication?**

TEACH BACK TIPS

- Do not ask "Do you understand?"
- Ask your patients to repeat *in their own words* what they need to do when they leave the hospital/the doctor's office.
- Let the patient know that you will be asking them questions after you review the information with them (they will pay more attention☺).
- Use phrase like: "I want to be sure that I did a good job explaining"

Follow-up Call by Clinical Staff

Hello Mr. /Ms. _____ I am (caller's name), a (title) from (name of facility). I am calling to see how you are doing after your discharge and if there is anything I can do to help you. We will also review your medications during this call. Can you bring all of your medications including non-prescription medicines and herbal supplements to the telephone, please?

HEALTH STATUS:

1. Before you left the hospital, your main medical problem during your hospital stay was explained to you. Can you explain to me your main problem or diagnosis?
    a. ***Yes*** *– Confirm the patient's knowledge of the discharge diagnosis.*
    b. ***No*** *– Use this opportunity to provide patient education about the discharge diagnosis.*
2. Do you have any questions for me about your diagnosis?
    a. ***Yes*** *– Explain again.*
    b. ***No*** *– Continue.*
3. Since you left the hospital, do you feel your main problem has improved, worsened or not changed? What does your family or caregiver think?
    a. ***Worsened*** *– Refer to an appropriate provider.*
    b. ***Improved/No change*** *– Continue.*
4. Have you experienced any new medical problems since you left the hospital?
    a. ***Yes*** *– Ask what has happened?*
    b. ***No*** *– Continue.*

WARNING SIGNS:

- What did the medical care team tell you to watch out for to make sure you are okay? *Review specific symptoms to watch out for and things to do for this diagnosis e.g. weigh self, blood sugar, blood pressure, peak flow chart, etc.*
- Do you have any questions about what to do if a problem arises?

FOLLOW-UP:

1. Can you please tell me what appointments are scheduled? Who is it with? If it is a lab/test, what is it for? When is it? Are you going to be able to make it to your appointment?
    a. ***Yes*** *– Continue.*
    b. ***No*** *– Help with the issues or get appointment rescheduled.*

Note: *If there is no appointment scheduled already, set up an appointment based on the discharging provider's request and according to the triage grid.*

2. Please remember to bring ***all*** your medications, including non-prescription medicines and herbal supplements, with you to your visit.

MEDICATIONS:_____

What questions do you, your family, or caregiver have regarding your medications?

EDUCATION PROVIDED:_____ _____

Do you have any other questions for me?

ADDITIONAL ACTIONS TAKEN_____

Adapted from Project RED

Tool 10.2: Follow-up Call by Non-Clinical Staff

Hello Mr. /Ms. _____ I am (caller's name), a (title) from (name of facility). I am calling to see how you are doing after your discharge and if there is anything I can do to help you.

FOLLOW-UP:

1. Can you please tell me what appointments are scheduled? Who is it with? If it is a lab/test, what is it for? When is it? Are you going to be able to make it to your appointment?
    a. ***Yes*** *– Continue.*
    b. ***No*** *– Help with the issues or get appointment rescheduled.*

Note: *If there is no appointment scheduled already, set up an appointment based on the discharging provider's request and according to the triage grid*.

2. Please remember to bring ***all*** your medications, including non-prescription medicines and herbal supplements, with you to your visit.

WARNING SIGNS:

- What did the medical team tell you to watch out for to make sure you are okay?
- Do you have any questions about what to do if a problem arises?
    a. ***Yes*** *– Continue.*
    b. ***No/Have questions*** *– Refer to a clinician.*

HEALTH CARE STATUS:

- Before you left the hospital, someone spoke to you about your main problem during your hospital stay. Can you explain to me your main problem or diagnosis?
    a. ***Yes*** *– Continue.*
    b. ***No*** *– Refer to a clinician.*
- Since you left the hospital, do you feel your main problem has improved, worsened or not changed? What does your family or caregiver think?
    a. ***Worsened*** *– Refer to a clinician.*
    b. ***Improved/No change*** *– Continue.*

  Have any new medical problems occurred since you left the hospital?
    a. ***Yes*** *– What has happened? Refer to a clinician.*
    b. ***No*** *– Continue.*

MEDICATIONS:_____

What questions do you/your family or caregiver have regarding your medications?
(Refer to a clinician if there are questions)

EDUCATION PROVIDED:_____

Do you have any other questions that I can forward to the clinical team?

ADDITIONAL ACTIONS TAKEN: _____

Adapted from Project RED

Washington State Department of Social & Health Services

Transforming lives

Behavioral Health Treatment and Resources

How do people with Medicaid coverage access mental health and/or substance use disorder treatment?

Washington Medicaid enrollees have access to **two** types of benefits:

1. **Through Apple Health:** All clients eligible for a Fully Integrated Managed Care (FIMC) or Behavioral Health Services Only (BHSO) are eligible for Behavioral Health services. This includes Mental Health and Substance Use Disorder (SUD) benefits and services. These programs are managed by the Health Care Authority (HCA) through contracts with the Managed Care Organizations (MCO). To access this service through Apple Health plans:
    - If your client is already enrolled in an Apple Health managed care plan, they may contact their plan directly.
    - If your client is **not** enrolled in an Apple Health managed care plan, or they don't know how to reach their plan, they can call the HCA at 1-800-562-3022 for help with finding a mental health provider that accepts Medicaid insurance. **Please see our next section on** "How do American Indians and Alaska Natives (AI/AN) access Medicaid-covered substance use disorder treatment services?"

2. **Through BH-ASOs:** This benefit is for those who need **additional mental health and substance use disorder services** not covered by the Apple Health plan, See page three for a complete list of these services. To access these services, clients may:
    - Contact the BH-ASO for their region directly.
    - Contact a BH-ASO contracted treatment agency directly.
    - Contact the 24-hour, free and confidential Washington Recovery Help Line at 1-866-789-1511 (TTY 1-206-461-3219) or visit www.waRecoveryHelpLine.org. They will be referred to a BH-ASO that will connect them with a provider.

How do American Indians and Alaska Natives (AI/AN) access Medicaid-covered substance use disorder treatment services?

- The State will assign to the Fee-For-Service (FFS) program for SUD services all individuals who self-identify as AI/AN when they:
    - Apply or recertify for Medicaid; or
    - Submit a subsequent change in the HealthPlanFinder website; or
    - Contact the HCA Medical Customer Service Center.

- Medicaid-enrolled AI/ANs will be able to request Substance Use Disorder (SUD) treatment services from any SUD provider enrolled with Medicaid as a FFS provider.

- In the FFS program, these services do not require BH-ASO or State authorization. SUD providers must continue to meet all requirements of their state-issued license or certification in order to maintain their status as a Medicaid FFS provider.

- BH-ASO fact sheet: https://www.hca.wa.gov/assets/program/bhaso-fact-sheet.pdf
- BH-ASO map: https://www.hca.wa.gov/assets/free-or-low-cost/19-0040-bh-aso-map.pdf
- Link to HCA website on BH-ASO: https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/apple-health-managed-care
- Link to County Crisis Line phone numbers: https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-crisis-lines
- 19-0036 Service Area Map. https://www.hca.wa.gov/assets/free-or-low-cost/service_area_map.pdf
- Welcome to Washington Apple Health BHSO booklet: www.hca.wa.gov/assets/free-or-low-cost/19-049.pdf

MCO Contacts:

Amerigroup RealSolutions in healthcare	Customer Service	1-800-600-4441
	Website	www.amerigroup.com
	Provider Line	1-800-454-9790
	Provider Website	http://washington.joinagp.com
COMMUNITY HEALTH PLAN of Washington	Customer Service	1-800-440-1561
	Website	www.chpw.org
	Provider Line	1-800-440-1561
	Provider Website	www.chpw.org/for-providers
coordinatedcare	Customer Service	1-877-644-4613
	Website	www.coordinatedcarehealth.com
	Provider Line	1-877-644-4613
	Provider Website	https://www.coordinatedcarehealth.com/providers.html
MOLINA HEALTHCARE	Customer Service	1-800-869-7165
	Website	www.molinahealthcare.com
	Provider Line	1-800-869-7165
	Provider Website	https://www.molinahealthcare.com/providers/wa/medicaid/pages/home.aspx
UnitedHealthcare Community Plan	Customer Service	1-877-542-8997
	Website	www.uhccommunityplan.com
	Provider Line	1-877-542-9231
	Provider Website	www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home.html

Washington State Health Care Authority

Behavioral health administrative service organization (BH-ASO) fact sheet

What is a BH-ASO?

The Health Care Authority (HCA) is transforming health care by focusing on the whole person, and ensuring care is coordinated and delivered where and when a person needs it. By January 2020, all regions of the state will transition to an integrated system for physical health, mental health, and substance use disorder (SUD) services in the Washington Apple Health (Medicaid) program. This is called integrated managed care (IMC).

Under the IMC program, most services for Apple Health clients are provided through managed care organizations. However, some services in the community, such as services for individuals experiencing a mental health crisis, must be available to all individuals, regardless of their insurance status or income level.

For this reason, HCA will contract with a BH-ASO to provide these services within a region.

What services will the BH-ASO provide?

Certain services must be available to anyone, regardless of their insurance status or income level. The following services may be provided by the BH-ASO to anyone in the region who is experiencing a mental health or SUD crisis:

- A 24/7/365 regional crisis hotline for mental health and SUD crises.
- Mental health crisis services, including the dispatch of mobile crisis outreach teams, staffed by mental health professionals and certified peer counselors.
- Short-term SUD crisis services for people intoxicated or incapacitated in public.
- Application of mental health and SUD involuntary commitment statutes, available 24/7/365, to conduct Involuntary Treatment Act assessments and file detention petition.

What services will the BH-ASO provide to people who are low income, uninsured, and/or not eligible for Apple Health?

The BH-ASO may provide certain mental health services and SUD services (referred to as behavioral health services) to people not enrolled in or eligible for Apple Health. For some services, such as services funded through the federal Substance Abuse Block Grant or Mental Health Block Grant, individuals may need to meet other priority population requirements to be considered eligible.

The BH-ASO may provide the following services to individuals who are not eligible for Apple Health:

- Mental health evaluation and treatment services for individuals involuntarily detained or who agree to a voluntary commitment.
- Residential SUD treatment services for individuals involuntarily detained as described in state law.
- Outpatient behavioral treatment services, in accordance with a Less Restrictive Alternative court order.
- Within available resources, the BH-ASO may provide non-crisis behavioral health services, such as outpatient SUD and/or mental health services, or residential SUD and/or mental health services to low-income individuals not eligible for Apple Health and who meet other eligibility criteria.

What other administrative functions will the BH-ASO manage in the region?

Within the region, the BH-ASO may:

- Provide a behavioral health ombudsman to assist individuals with grievances and appeals.
- Manage the block grants based on locally approved block grant plans.
- Manage Criminal Justice Treatment Account funds and Juvenile Drug Court funds.
- Oversee committees formerly led by the regional behavioral health organization, such as the Behavioral Health Advisory Board, Wraparound with Intensive Services, Children's Long-term Inpatient Program, and Family Youth System Partner Round Table.

Visit the HCA website to learn more about the integration of physical and behavioral health.

OLDER AMERICANS BEHAVIORAL HEALTH
Issue Brief 6: Depression and Anxiety: Screening and Intervention

Introduction and Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA) and Administration on Aging (AoA) recognize the value of strong partnerships for addressing behavioral health issues among older adults. This Issue Brief is part of a larger collaboration between SAMHSA and AoA to support the planning and coordination of aging and behavioral health services for older adults in states and communities. Through this collaboration, SAMHSA and AoA have developed Issue Briefs and archived webinars in the areas of suicide, anxiety, depression, and alcohol and prescription drug use and misuse among older adults, and are partnering to get these resources into the hands of aging and behavioral health professionals.

This Issue Brief is intended to help health care and social service organizations develop strategies to serve older adults with depression and anxiety, by providing:

- **Information** on the prevalence, risk factors, and impact of depression and anxiety in older adults;
- **Recommendations** on screening, assessment, and early intervention and treatment strategies; and
- **Recommendations** and **Resources** to help aging services, behavioral health, and primary care providers develop effective depression and anxiety services for older adults.

Depression in Older Adults

Depression is not a normal part of aging. It is a medical problem that affects many older adults and can often be successfully treated. Symptoms of depression include: depressed mood, loss of interest or pleasure in activities, disturbed sleep, weight loss or gain, lack of energy, feelings of worthlessness or extreme guilt, difficulties with concentration or decision making, noticeable restlessness or slow movement, and frequent thoughts of death or suicide or an attempt of suicide.[1]

Up to 5% of older adults in the community meet diagnostic criteria for major depression, and up to 15% have clinically significant depressive symptoms that impact their functioning (otherwise known as sub-syndromal depression or minor depression).[2] However, the prevalence of depression is substantially higher in older adults with medical illnesses, and in those who receive services from aging service providers. For instance, a recent study found that more than one-quarter (27%) of older adults assessed by aging service providers met criteria for having current major depression and nearly one-third (31%) had clinically significant depressive symptoms.[3] Depression is often under-recognized and under-treated in older adults.

Depression can impair an older adult's ability to function and enjoy life and can contribute to poor health outcomes and high health care costs. Compared to older adults without depression, those with depression often need greater assistance with self care and daily living activities and often recover more slowly from physical disorders. Without appropriate treatment, symptoms of depression can limit an older adult's ability to achieve successful aging.[4]

Depression in older adults may be linked to several important risk factors. These include, among others[4,5]:

- Medical illness (particularly chronic health conditions associated with disability/decline),
- Perceived (self-reported) poor health, disability, or chronic pain,
- Progressive/disabling sensory loss (e.g., macular degeneration),
- History of recurrent falls,
- Sleep disturbances,
- Cognitive impairment or dementia,
- Medication side effects (e.g., benzodiazepines, narcotics, beta blockers, corticosteroids, and hormones),
- Alcohol or prescription medication misuse or abuse,
- Prior depressive episode, or family history of depression,
- Extended or long-standing bereavement,
- Stressful life events (e.g., financial difficulties, new illness/disability, change in living situation, retirement or job loss, and interpersonal conflict), and
- Dissatisfaction with one's social network.

Anxiety in Older Adults

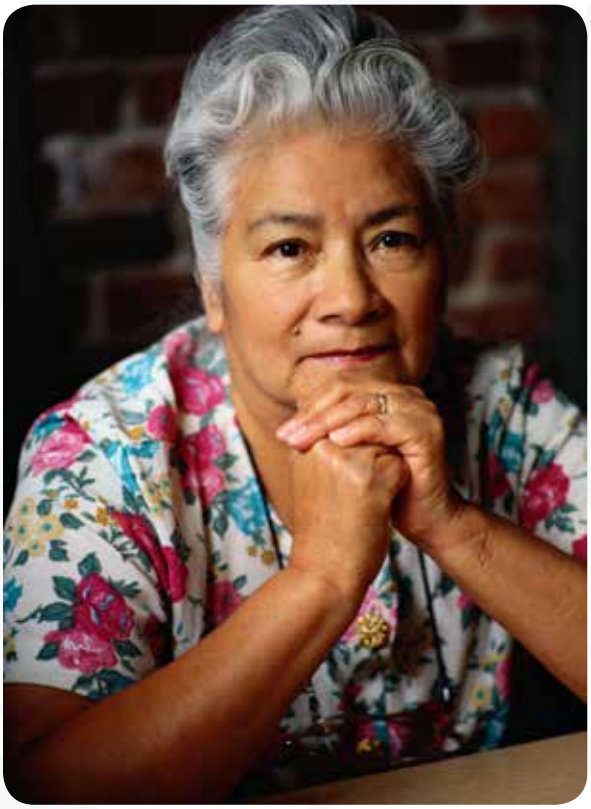
Like depression, excessive anxiety that causes distress or that interferes with daily activities is not a normal part of aging. Anxiety disorders cause nervousness, fear, apprehension, and worrying. They can worsen an older adult's physical health, decrease their ability to perform daily activities, and decrease feelings of well-being.[6]

Three to 14% of older adults meet the diagnostic criteria for an anxiety disorder,[6] however a greater percent of older adults have clinically significant symptoms of anxiety that impact their functioning. For instance, a recent study found that more than one-quarter (27%) of aging service network care management clients have clinically significant anxiety.[7] The most common anxiety disorders include specific phobias and generalized anxiety disorder. Social phobia, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder (PTSD) are less common.[6] Like depression, anxiety disorders are often unrecognized and undertreated in older adults. The detection and diagnosis of anxiety disorders in late life is complicated by medical comorbidity, cognitive decline, changes in life circumstances, and changes in the way that older adults report anxiety symptoms.[6]

Anxiety in older adults may be linked to several important risk factors. These include, among others: [6]

- Chronic medical conditions (especially chronic obstructive pulmonary disease (COPD), cardiovascular disease including arrhythmias and angina, thyroid disease, and diabetes),
- Perceived (self-reported) poor health,
- Sleep disturbance,
- Side effects of medications (e.g., steroids, antidepressants, stimulants, bronchodilators/inhalers),
- Alcohol or prescription medication misuse or abuse,
- Physical limitations in daily activities,
- Stressful life events,
- Adverse events in childhood, and
- Neuroticism or preoccupation with somatic (physical) symptoms.

Older adults with mixed anxiety and depression often have more severe symptoms of depression and anxiety, poorer social functioning, greater use of health care services, more physical health symptoms (e.g., chest pain, headaches, sweating, gastrointestinal problems), more thoughts of completing suicide, and a slower response to treatment. Older adults with depression and anxiety are more likely to stay in treatment if they are seen frequently and are told that they should call with any concerns related to treatment.[4]



Assessing Symptoms of Depression and Anxiety

Several tools can help aging service, behavioral health, and primary care providers identify older adults who have symptoms of depression and anxiety. These tools can be used to screen for symptoms, assess the severity of symptoms, and monitor treatment progress. The following depression and anxiety scales are available without charge, and have been translated into several languages.

- Geriatric Depression Scale (GDS): A 15-item screening measure for depression in older adults. (**http://www.stanford.edu/~yesavage/GDS.html**).
- Patient Health Questionnaire (PHQ-9): A 9-item scale that assesses DSM-IV depression criteria. (**http://www.phqscreeners.com**). The first two questions of the PHQ-9 are often referred to as the PHQ-2 and can be used to identify the need for a more complete assessment of depressive symptoms using the PHQ-9 or GDS.
- The Generalized Anxiety Disorder 7-item Scale (GAD-7): A 7-item scale that assesses common anxiety symptoms.

Treating Symptoms of Depression and Anxiety

EVIDENCE-BASED TREATMENT	DEPRESSION[4,5]	ANXIETY[6]
Antidepressant medications	→ Effective	→ Effective
Cognitive behavioral therapy	→ Effective	→ Effective
Problem solving therapy	→ Effective	
Interpersonal therapy	→ Effective	

Several treatments can reduce the symptoms of depression and anxiety for most older people. These treatments can be delivered by care providers from different disciplines and in different settings. The most common and effective treatments for depression and anxiety, based on scientific evidence, include medications and psychotherapy.

Many communities have embedded effective depression treatments into service models delivered within primary care or social service settings, or within the older adult's home. These programs often include meaningful collaboration across different types of service providers (e.g., aging service, behavioral health, and primary care providers).

The PEARLS and Healthy IDEAS models of community-based depression care management have been implemented in over 25 states. Estimates from 2012, suggested that over 114 sites and 30,000 older adults have participated in these programs. Similarly, the IMPACT model of integrated physical and behavioral health has been implemented in over 30 states. Estimates from 2007, suggested that over 500 sites and 50,000 older adults have participated in IMPACT. To identify if these programs are available in your community, visit the websites identified in the table below or contact the program developers.

If these evidence-based treatments or service delivery models are not available in your community, consider whether you can implement them in your organization. Training manuals and implementation support are available (see Resources: *Treatment of Depression in Older Adults EBP KIT*).

PROGRAM	SETTING	PRIMARY COLLABORATIONS	KEY COMPONENTS	ADDITIONAL RESOURCES
IMPACT: Improving Mood, Promoting Access to Collaborative Treatment	Primary care	Primary care, Behavioral health	Collaborative care, care from a depression care manager, consultation with a designated psychiatrist, outcome measurement, and stepped care (with antidepressant medications and problem solving treatment).	**http://impact-uw.org** **http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=105**
PROSPECT: Prevention of Suicide in Primary Care Elderly	Primary care	Primary care, Behavioral health	Recognition of depression and suicidal thoughts by primary care practitioners, use of a treatment algorithm with antidepressant medication and interpersonal therapy, and treatment management by depression care managers.	**http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=257**
PEARLS: Program to Encourage Active, Rewarding Lives for Seniors	Home	Primary care, Home health, Social services, and Aging services	Targets older adults with minor depression or dysthymia through 6-8 in-home sessions using problem-solving therapy and behavioral activation.	**http://www.pearlsprogram.org**
Healthy IDEAS: Identifying Depression, Empowering Activities for Seniors	Home	Behavioral health, Social services, and Aging services	Screening and assessment, education for clients and family caregivers, referral and linkages to appropriate health professionals, and behavioral activation.	**http://careforelders.org/default.aspx?menugroup=healthyideas**

Lessons Learned from the Field

Aging service, behavioral health, and primary care providers and administrators can take important steps to identify older adults with depression and anxiety, and reduce symptoms of these disorders. General recommendations across all settings include:

- Identify gaps in services available for older adults with depression and anxiety, and identify the type of program that can be most useful in meeting your needs.
- Seek implementation support from technical experts or program developers.
- Actively involve older adults and their families or caregivers when implementing and sustaining a new program to address depression or anxiety (e.g., marketing, advisory councils, etc.).
- Use standardized depression and anxiety scales as outcome measures to evaluate the effectiveness of program implementation and treatment.
- Learn how demographic characteristics and cultural beliefs influence perceptions of depression and anxiety, treatment access, treatment preferences, and desired outcomes.
- Incorporate cultural awareness into the assessment and treatment of older adults.

Key Actions for Aging Services Providers

- Train aging service providers (and laypersons) to identify warning signs and provide treatment or refer to services those older adults who are at-risk for depression, anxiety, or suicide.
- Introduce routine depression, anxiety, and suicide screening in the course of non-clinical activity (e.g., senior day care, senior transportation, senior companions).
- Provide systematic outreach to assess and support high-risk older adults in improving life conditions, and addressing issues and needs that can reduce stress.
- Focus services on reducing disability and enhancing independent functioning.
- Increase provider awareness of substance abuse and mental health problems in older adults.

Key Actions for Behavioral Healthcare Providers

- Assess for co-occurring behavioral health conditions (e.g., depression, anxiety, substance misuse or abuse, cognitive impairment) and structure the older adult's care to address these areas.
- Assess the degree to which anxiety symptoms cause distress or interfere with daily activities, even if the older adult does not meet diagnostic criteria for an anxiety disorder.
- Increase the effectiveness of behavioral health services by implementing evidence-based practices, tracking outcomes systematically, and taking steps to improve treatment compliance.
- Tailor psychotherapy interventions to address the cognitive, physical, and sensory needs of older adults (e.g., providing between-session reminder telephone calls, repetition, weekly review of concepts, at-home assignments, and breaking tasks into smaller components).

Key Actions for Primary Healthcare Providers

- Implement routine, standard screening and follow-up assessments for depression, anxiety, and suicidal ideation (e.g., PHQ-9, GDS, GAD-7).
- Optimize treatment of chronic medical conditions, pain, sleep problems, or other physical symptoms that can decrease quality of life and increase risk for depression and anxiety.
- Optimize diagnosis and treatment of late-life depression by using collaborative depression care management interventions.
- Adapt existing collaborative care models to include management of late-life anxiety, and to include linkages between aging service, behavioral health and primary care networks.

Actions for Coordination, Integration, and Financing of Services

Partnerships, coordination of care, and integration across service settings can help provide effective care for older adults with depression or anxiety.

- Build collaborative relationships with community, state, and federal partners.
- Build collaborative relationships across aging, behavioral health, and primary care partners. Many public and private funding sources support behavioral health services for older adults. The National Council on Aging (NCOA), in partnership with SAMHSA, developed *Lessons Learned on Sustainability of Older Adult Community Behavioral Health Services*, available on **http://www.ncoa.org**. The report features a Financial Resource Guide that reviews funding sources and financing strategies that organizations used to sustain behavioral health programs after grant funding ended. Although financing case identification and appropriate treatment can be a challenge, there are several options for funding services:
- Many treatments for depression and anxiety can be reimbursed through Medicare, Medicaid, and private insurance.
- Some non-billable services may be funded through private foundation support.
- Outreach and case identification can be performed by well-trained volunteers (e.g., Gatekeepers[8]).
- Braided funding options incorporate funding from multiple funding streams.

Resources

- National Registry of Evidence-based Programs and Practices: **http://www.nrepp.samhsa.gov**
- Center for Mental Health Services. (2011). *Treatment of depression in older adults evidence-based practices (EBP) KIT*. HHS Publication No. SMA-11-4631. Rockville, MD: Substance Abuse and Mental Health Services Administration. **http://store.samhsa.gov/product/Treatment-of-Depression-in-Older-Adults-Evidence-Based-Practices-EBP-KIT/SMA11-4631CD-DVD**
- National Council on Aging. (2012). *Lessons Learned on Sustainability of Older Adult Community Behavioral Health Services*. **http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/lessons-learned-on.html**

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Washington State Department of Social & Health Services
Transforming lives

HEALTH HOME

Goal Setting and Action Planning Worksheet

Washington State Health Care Authority

NAME	DATE

Long Term Goal

Short Term Goal

Describe something you will do now to improve your health.

Describe what you will do

1. What you'll do:
2. Where you'll do it:
3. The number of times each day / week:
4. How long will you commit to doing this:

Possible barriers to your success:

Plan to overcome the barriers:

Conviction

How **important** is it for you to work on the goal you identified above? Check the box which best shows your response.

Not at all convinced ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Totally convinced

Confidence

How **confident** are you that you will be successful in reaching the goal you identified above?
Check the box which best shows your response.

Not at all confident ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Totally confident

Readiness

How **ready** are you to work on the goal you identified above? Check the box which best shows your response.

Not at all ready: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Totally ready

Plan for follow-up:

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE ☐ FEMALE ☐ UNKNOWN ☐ OTHER ☐	DATE OF BIRTH	PROVIDER ONE CLIENT ID
HEALTH HOME LEAD ORGANIZATION			HH LEAD ORGANIZATION PHONE	

DATE OF HAP: BEGIN END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE

REASON FOR CLOSURE OF THE HAP

☐ Beneficiary Opted Out ☐ Move to a county that does not have Health Home services
☐ Death ☐ No longer eligible

REASON FOR TRANSFER OF THE HAP

☐ Client choice to change CCO or Lead Organization
☐ Eligibility changed (change to/from FFS or MCO)

CLIENT INTRODUCTION

CLIENT'S LONG TERM GOAL	DIAGNOSIS (PERTINENT TO HAP)

Initial / Annual HAP Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM		/	
CAM		/	
PPAM		/	
Katz ADL			
PHQ-9			
PSC-17			
BMI			

OPTIONAL SCREENING SCORES

SCREEN	DATE	SCORE	
DAST			
GAD-7			
AUDIT			
FALLS RISK			
PAIN			☐ FLACC ☐ FACES ☐ NUMERIC

ADDITIONAL COMMENTS

Four Month Update Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM		/	
CAM		/	
PPAM		/	
Katz ADL			
PHQ-9			
PSC-17			
BMI			

OPTIONAL SCREENING SCORES

SCREEN	DATE	SCORE	
DAST			
GAD-7			
AUDIT			
FALLS RISK			
PAIN			☐ FLACC ☐ FACES ☐ NUMERIC

ADDITIONAL COMMENTS

Eight Month Update Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM		/	
CAM		/	
PPAM		/	
Katz ADL			
PHQ-9			
PSC-17			
BMI			

OPTIONAL SCREENING SCORES

SCREEN	DATE	SCORE	
DAST			
GAD-7			
AUDIT			
FALLS RISK			
PAIN			☐ FLACC ☐ FACES ☐ NUMERIC

ADDITIONAL COMMENTS

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE ☐ FEMALE ☐ UNKNOWN ☐ OTHER ☐	DATE OF BIRTH	PROVIDER ONE CLIENT ID
HEALTH HOME LEAD ORGANIZATION			HH LEAD ORGANIZATION PHONE	
DATE OF HAP: BEGIN END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE

Initial / Annual HAP	Four Month Update	Eight Month Update
Short Term Goal:	Short Term Goal:	Short Term Goal:
Goal Start Date: Goal End Date:	Goal Start Date: Goal End Date:	Goal Start Date: Goal End Date:
Outcome:	Outcome:	Outcome:
☐ Completed ☐ No longer pertinent – life or health change	☐ Completed ☐ No longer pertinent – life or health change	☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue	☐ Revised ☐ Client request to discontinue	☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE ☐ FEMALE ☐ UNKNOWN ☐ OTHER ☐	DATE OF BIRTH	PROVIDER ONE CLIENT ID
HEALTH HOME LEAD ORGANIZATION			HH LEAD ORGANIZATION PHONE	
DATE OF HAP: BEGIN END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE

Initial / Annual HAP			Four Month Update			Eight Month Update		
Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue			Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue			Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue		
START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS

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Health Action Plan (HAP)

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DATE OF HAP: BEGIN END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE

Initial / Annual HAP

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS

Four Month Update

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS

Eight Month Update

Short Term Goal:

Goal Start Date: Goal End Date:

Outcome:

☐ Completed ☐ No longer pertinent – life or health change
☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE ☐ FEMALE ☐ UNKNOWN ☐ OTHER ☐	DATE OF BIRTH	PROVIDER ONE CLIENT ID
HEALTH HOME LEAD ORGANIZATION			HH LEAD ORGANIZATION PHONE	
DATE OF HAP: BEGIN END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE

Initial / Annual HAP	Four Month Update	Eight Month Update
Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue	Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue	Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

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HEALTH HOME LEAD ORGANIZATION			HH LEAD ORGANIZATION PHONE	
DATE OF HAP: BEGIN END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE

Initial / Annual HAP	Four Month Update	Eight Month Update
Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue	Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue	Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue

START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS

Washington State Department of Social & Health Services

Health Action Plan (HAP)

Washington State Health Care Authority

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE ☐ FEMALE ☐ UNKNOWN ☐ OTHER ☐	DATE OF BIRTH	PROVIDER ONE CLIENT ID
HEALTH HOME LEAD ORGANIZATION			HH LEAD ORGANIZATION PHONE	
DATE OF HAP: BEGIN END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE

Initial / Annual HAP	Four Month Update	Eight Month Update
Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue	Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue	Short Term Goal: Goal Start Date: Goal End Date: Outcome: ☐ Completed ☐ No longer pertinent – life or health change ☐ Revised ☐ Client request to discontinue

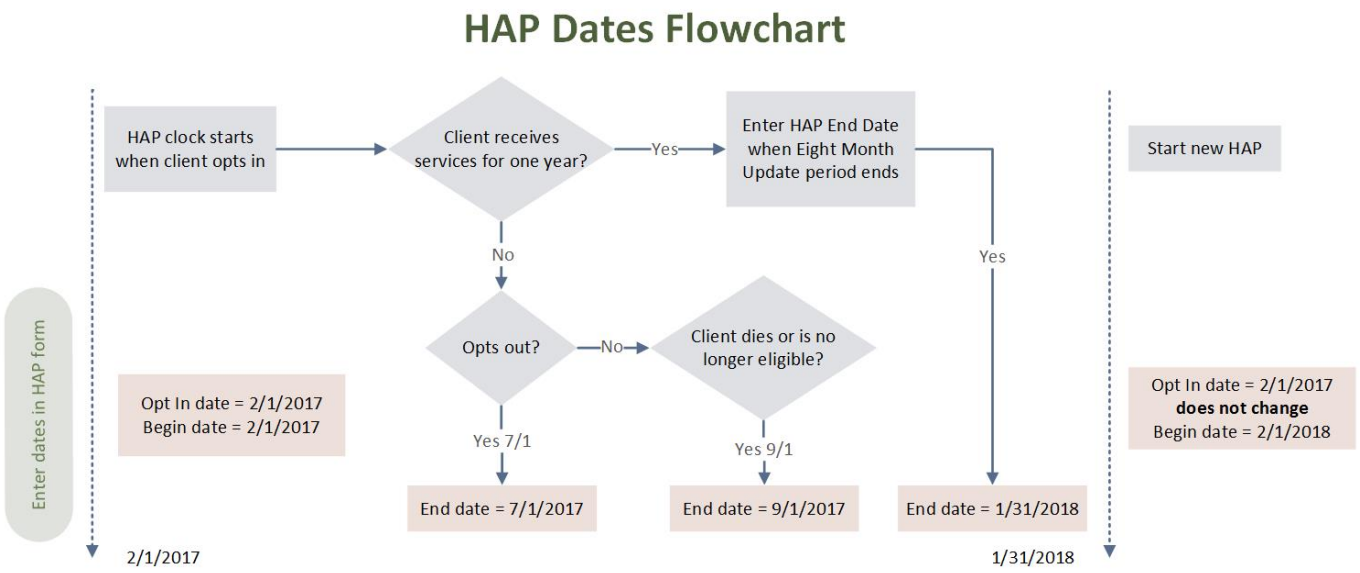
START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS

HEALTH HOME

Health Action Plan
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 four month time period. Each time period ranges from 120 to 123 days depending on the number of days within the four months.

The HAP must be updated a minimum of once during each four month activity period. 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.



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.

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.

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" 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.

Begin Date of HAP: Enter the date the Care Coordinator initiates the HAP. The HAP Begin Date and Opt-in Date are the same. This date establishes the first date of the 12-month cycle for the first and subsequent 12-month cycles.

End Date of HAP: Enter the End Date when the Eight Month Update activity period ends. If the client leaves the program before the end of the 12 month cycle (e.g., 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 by signing the Information Sharing Consent HCA 22-852 form. This date becomes the client's anniversary date. It triggers the start of a new HAP for the next HAP reporting year.

2/1/2017 – 5/31/2017	6/1/2017 – 9/30/2017	10/1/2017 – 1/31/2018
Initial/Annual	Four Month Update	Eight Month Update
Activity Period 1	***Activity Period 2***	***Activity Period 3***

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 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 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.

HAP Required Screenings: Administer and report these mandatory screenings within each of the three HAP activity 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. 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 zero for the score. If a screening was completed enter the date, the score and activation level if indicated.

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).

Optional Screenings: Optional 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 stated within the HAP. Enter the date the screening was completed and the score. Optional screenings may include:

a. DAST = Drug Abuse Screening Test: Enter the score. The value range is 0 to 10.
b. GAD-7 = Generalized Anxiety Disorder 7 item scale: 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: 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 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" 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 Coordinators 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.

Health Home Program
Washington

Please contact your Lead Organization for access to the Patient Activation Measure

Health Home Program
Washington

Please contact your Lead Organization for access to the Caregiver Activation Measure

Health Home Program
Washington

Please contact your Lead Organization for access to the Parent Patient Activation Measure

Washington State Department of Social & Health Services

Pediatric Symptom Checklist (PSC–17)

Name of Person Completing this Form First Name Last Name	Child's Name First Name Last Name	Date Child's Date of Birth

	Please check the box under the heading that best describes your child or you.			For Office Use Only
	(0) Never	(1) Sometimes	(2) Often	
1. Feels sad, unhappy	☐	☐	☐	
2. Feels hopeless	☐	☐	☐	
3. Is down on self	☐	☐	☐	
4. Worries a lot	☐	☐	☐	Internalizing Total
5. Seems to be having less fun	☐	☐	☐	
6. Fidgety, unable to sit still	☐	☐	☐	
7. Daydreams too much	☐	☐	☐	
8. Distracted easily	☐	☐	☐	
9. Has trouble concentrating	☐	☐	☐	Attention Total
10. Acts as if driven by a motor	☐	☐	☐	
11. Fights with other children	☐	☐	☐	
12. Does not listen to rules	☐	☐	☐	
13. Does not understand other people's feelings	☐	☐	☐	
14. Teases others	☐	☐	☐	
15. Blames others for his/her troubles	☐	☐	☐	
16. Refuses to share	☐	☐	☐	Externalizing Total
17. Takes things that do not belong to him/her	☐	☐	☐	
			Total Score	

A score of 15 or higher may indicate the need for an assessment by a qualified medical or mental health professional.

Instructions for Scoring the Pediatric Symptom Checklist - 17 (PSC-17)

What is the PSC–17?

The Pediatric Symptom Checklist (PSC) is brief screening questionnaire that is used to improve the recognition and treatment of psychosocial problems in children ages 4 to 17 years. It is used in place of the PHQ-9 for Health Home beneficiaries within this age group. Health Home beneficiaries ages 18 years and older are screened for psychosocial issues using the Patient Health Questionnaire - 9 (PHQ-9).

What is the purpose for administering the PSC-17?

The PSC-17 should not be considered a diagnostic tool. Its purpose is to alert parents and guardians of potential behavioral issues and encourage them to pursue further evaluation by a qualified medical or mental health professional. Review of the scoring of the PSC-17 can provide an opportunity for Care Coordinators, family members or guardians, caregivers, and the child to discuss development of the Health Action Plan (HAP) with goals and actions steps developed to address some of the moods and behaviors the child may be exhibiting.

Is consent needed to administer or release the PSC-17?

Consent is not required by the biological, adoptive, or foster parent for children ages 13 years and older to self-administer the PSC-17. Written consent is required by the parent or representative to release the questionnaire results for children under the age of 13 years. Children ages 13 years and older must provide written consent to release the results of the questionnaire.

Who completes the PSC-17?

The checklist is completed by the biological, adoptive, or foster parent, or guardian on behalf of the child. Children ages 13 or older may complete the questionnaire. The person who completes the questionnaire should check the box that best describes the frequency of current moods or behaviors listed on the form.

What is the scoring for the PSC-17?

The values for scoring the 17 responses are: Never = 0 (zero) points Sometimes = 1 point Often = 2 points

The Care Coordinator tallies the score and enters the date and total score on the HAP. If a question is unanswered or left blank, it is scored as a 0 (zero). Four or more responses left blank invalidate the questionnaire and the total score is not entered on the HAP. If the family member or guardian is unable or declines to complete the questionnaire or the questionnaire is invalidated, leave the score blank (do not enter a zero for the score) and note the reason that the questionnaire was not completed or invalidated on Page 1 of the HAP.

How is the PSC-17 interpreted?

A total score of 15 or more points may indicate the need for a referral to a qualified medical or mental health professional. The responses and score should be reviewed and discussed with the person who completes the questionnaire. With proper written consent the results of the questionnaire may be released to other mental and/or medical healthcare providers. The PSC-17 contains subscales for internalizing behavior, externalizing behavior, and attention. These subscale scores are not recorded on the HAP but may be reviewed with the person completing the questionnaire.

Where can I find further information about the PSC-17?

For further information about the PSC, visit the Massachusetts General Hospital website at:
http://www.massgeneral.org/psychiatry/services/psc_home.aspx

Washington State Health Care Authority

Health Home Participation Authorization and Information Sharing Consent

1 Participation Authorization

I, _____ , agree to participate in the Health Home program with _____
Print name of beneficiary — Print name of Health Home Lead

_____ _____
Signature of beneficiary or beneficiary's legal representative — Date

2 Information Sharing Consent

Your health information is private and cannot be given to other people unless you agree or applicable Washington State or federal laws allow the information to be shared. The providers/partners that can get and see your health information must obey all these laws. This is true if your health information is on a computer system or on paper. In addition to laws that apply to all types of health information, specific laws provide greater protection of information related to sexually transmitted diseases, mental health treatment, and substance use disorder.

I agree that my Health Home can obtain all of my health information from the providers/partners listed on this form to coordinate my care. I also agree that the Health Home and the providers/partners listed on this form may share my health information with each other, and other providers/partners involved in managing my care. I understand this form takes the place of any other Health Home Participation Authorization and Information Sharing Consent forms I may have signed before. I can change my mind and take back my consent at any time by signing a **Health Home Participation-Opt-Out/Decline Services** form and giving it to my Health Home.

PLEASE NOTE: If your health records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose information about (please put initials next to all that apply):

_____Mental health_____HIV/AIDS and STD test results, diagnosis, or treatment

Note: To give consent for the release of confidential alcohol or drug treatment information you must complete a separate Release of **Information (ROI) for Substance Use Disorder (SUD) Services** form.

Please initial the appropriate choice below.

This consent is valid: _____ as long as my Health Home needs my records for this program; or

_____ until _____
date or event

I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared. A copy of this form provides my permission to share records.

_____ _____
Print name of beneficiary — Beneficiary's date of birth

_____ _____
Signature of beneficiary or beneficiary's legal representative — Date

_____ _____
Print name of legal represenative (if applicable) — Relationship of legal representative to beneficiary

List your providers/partners on page two.

Print name of Health Home beneficiary

List the name of participating providers/partners	Beneficiary gives consent		Beneficiary withdraws consent	
	Date (MM/DD/YYYY)	Initials	Date (MM/DD/YYYY)	Initials
Past Care Coordination Org. (CCO)/Lead				
Past CCO/Lead				

Annual consent review date (MM/DD/YYYY)	Care coordinator name	Care coordinator signature

This release of information should include page 1 of the *Health Home Participation Authorization and Information Sharing Consent* form in order to provide the legal authority to release information for the beneficiary listed above.

Details about the beneficiary information sharing and consent process:

1. **How will providers/partners use my information?**
   Providers/partners will use your health information to coordinate and help you manage your health care.

2. **Where does my health information come from?**
   Your health information comes from places and people that gave you health care or health insurance in the past. These may include hospitals, doctors, pharmacies, laboratories, health plans, the Washington Apple Health (Medicaid) program, and other groups that share health information. You can get a list of all the places and people by calling your care coordinator.

3. **What laws and rules cover how my health information can be shared?**
   The laws and regulations that protect your health information include Chapter 70.02 RCW in Washington statute, the federal Health Insurance Portability and Accountability Act ("HIPAA"), and federal regulation 42 CFR Part 2.

4. **If I agree, who can obtain and see my information?**
   Your information may be obtained or seen by the providers/partners you agree can obtain and see it. Information can also be obtained or seen when allowed by applicable laws. For example, when you get care from a person who is not your usual doctor or provider, such as a new pharmacy, hospital, or other provider, some information, such as what your health plan pays for or the name of your Health Home provider, may be given to them or seen by them. For more information on who can get information, see our Notice of Privacy Practices.

5. **What if a person uses my information and I did not agree to let them use it?**
   If you think a person inappropriately used your information, call your case coordinator or call the HCA Medical Assistance Customer Service Center (MACSC) toll-free line at 1-800-562-3022 (TRS: 711).

6. **How do I make changes to the list of providers/partners on the form?**
   You can add new names to the list at any time by adding the provider/partner information and filling out the "Beneficiary Gives Consent" columns next to the addition. You can delete someone you no longer wish to include by filling out the "Beneficiary Withdraws Consent" columns next to the previously added provider/partner.

7. **What if I change my mind later and want to take back my consent?**
   You can cancel your consent at any time by signing a Health Home Participation - Opt-Out/Decline Services form and giving it to your Care Coordinator. You get this form online or by calling the HCA Medical Assistance Customer Service Center (MACSC) toll-free line at 1-800-562-3022 (TRS: 711). Your care coordinator will help you fill out this form if you want.

Note: If you decide to cancel your consent, providers who already have your information do not have to give your information back to you or take it out of their records.

8. **When do I get a copy of this Health Home Participation Authorization and Information Sharing Consent form?**
   You can have a copy of the form after you sign it.

Washington State Health Care Authority

Washington State Department of Social & Health Services
Transforming lives

Health Home — Adolescent Information-Sharing Consent

You have been enrolled into Health Homes. Your health care providers and others involved in your care need to be able to talk to each other about your health needs and care. At times, your health records may include information about:

- Family planning services, such as birth control and abortion
- HIV/AIDS
- Sexually transmitted diseases (diseases you can get from having sex)
- Mental health medications and services
- Chemical dependency services

Since this type of health information is private, the health care providers and others who have your health information cannot give it to anyone unless you agree or the law allows it. This is true whether your health information is on a computer system or on paper.

By signing this consent, you are agreeing that the people you have identified on this form have permission to view your private confidential medical information and may consult with one another to help you manage your health care. This health information may be from before or after the date you sign this form. Your health records may have information about illnesses or injuries you have or may have had before; test results, such as x-rays or blood tests; and the medicines you are taking now or have taken before.

If you are age 13 years and older and have been referred to Health Homes, you will be asked to sign this form, whether or not this type of health information applies to you. If you do not sign this form, you will still be able to get Health Home services.

The laws that apply to these health records include:

- Sexually transmitted diseases: Revised Code of Washington (RCW) 70.24.105
- Mental health records: Revised Code of Washington (RCW) 71.05.620
- Chemical dependency: 42 Code of Federal Regulations (CFR) Part 2

I agree to allow Health Homes to receive and share my health information with the health care providers and others listed on this form as it applies to:

☐ All my client records, including reproductive health (i.e., birth control, pregnancy, abortion); HIV/AIDS and sexually transmitted disease (STD) test results, diagnosis, or treatment; mental health; and chemical dependency.

OR

Only the following records (check all that apply):

☐ HIV/AIDS and STD test results, diagnosis, or treatment
☐ Reproductive health
☐ Mental health
☐ Chemical dependency
☐ Other (list): _____

I also agree that the health care providers and others listed on this form may share my health information with each other, and cannot share it with anyone who is not listed on this form. I can change my mind and take back my consent at any time by updating page 2 of this form and giving it to my Health Home care coordinator. This will not affect any information already shared. Initials: _____

Unless previously revoked by me, the specific information above is valid until:

☐ I am no longer participating in Health Homes.

☐ Or until _____ (enter expiration date).

Print name of client	Client's date of birth
Client or legal representative's signature	Date
Print name of legal representative	Relationship of legal representative to client

If you think someone used your information and you did not agree to give the person your information, call your care coordinator or the Medical Assistance Customer Services Center (MACSC) toll-free line at 1-800-562-3022 (TTY: 1-800-848-5429).

Print name of client

List the names of participating health care providers and others	Client gives consent		Client withdraws consent	
	Date	Client's initials	Date	Client's initials
Children's Administration social worker				
Natural parent, adoptive parent, foster parent				
Primary care provider				
Managed care organization				
Past managed care organization				
Health Home care coordinator/lead				
Past Health Home care coordinator/lead				
Tribal social worker/director				
Family planning provider				
Chemical dependency provider				
Mental health provider				
Additional care providers				

NOTICE: PROHIBITING REDISCLOSURE OF CONFIDENTIAL ALCOHOL- OR DRUG-TREATMENT INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol- or drug-abuse patient.

Release of Information (ROI) for Substance Use Disorder (SUD) Services

Washington State Health Care Authority

I, _____ (Client name), _____ (Date of birth) hereby authorize _____ (Provider/Organization) to release to:

Name of agency/health care provider	**Contact info**

To communicate with and disclose to one another the following information: (nature of the information, as limited as possible)

Initial each category that applies:

- ☐ Demographics
- ☐ Blood alcohol level
- ☐ Labs & other diagnostic test results
- ☐ Assessment/screening results
- ☐ Medications
- ☐ Discharge summary
- ☐ Urinalysis results
- ☐ Tx status/compliance
- ☐ Tx recommendations
- ☐ Attendance
- ☐ Employment-related information
- ☐ Education and training-related information
- ☐ Other: _____

Purpose of this release: (enter reason, i.e., client request, coordination of services, payment of services, etc.)

_____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Specify the date, event, or condition upon which this consent expires. Initial each category that applies:

- ☐ The date my public assistance/medical assistance benefits are discontinued, or
- ☐ Other: (Specify earlier date if required by law) _____

_____ _____

Signature of patient — Date

_____ _____

Signature of parent, guardian or authorized representative (when required) — Date

Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information

Prohibition on Redisclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Health Home Participation (Opt-Out/Decline Services)

1 Applicant information

Client name

Date of birth

ProviderOne ID number

Qualified Health Home Lead

Care Coordination Organization

Managed Care Organization (MCO) (if applicable)

☐ I have completed a Health Action Plan (HAP)

☐ I have **not** completed a Health Action Plan (HAP)

- The Health Home program has been explained to me and I have decided not to participate.
- I understand that I will continue to get my other Apple Health (Medicaid) services.
- If I want Health Home services in the future, I can call: 1-800-562-3022 (TRS: 711)

I am declining services because:

☐ My benefits and services work for me.

☐ I do not need any help with my medical and health care needs.

☐ I am not comfortable with using this benefit or program.

☐ Other
Explain _____

2 Protecting your health information

When you opt out of Health Home services the following information is important for you to understand:

- Any previously signed Health Home Information Sharing Consent Forms are no longer valid.
- Your health information will be kept by providers/partners who already have your information. They do not have to give it back to you or take it out of their records.
- Your personal health information will still be protected under Washington State and Federal laws and rules. These laws and regulations include Washington State and federal confidentiality rules, RCW 71.05.630, RCW 70.24.105, RCW 70.02, the Uniform Health Care Information Act, 42 CFR 2.31(a)(5), and include 45 CFR Parts 160 and 164, which are the rules referred to as "HIPAA," and 42 CFR Part 2. No one can obtain any new health information about you. Information already shared with others will not be given back.
- If you think a person used your information, and you did not agree to give the person permission to use your information, call your Care Coordinator or Apple Health customer service at 1-800-562-3022 (TRS: 711)

3 Client signature

Client signature or authorized representative (if applicable)

Date signed

Print authorized representative's name (if applicable)

4 Health Home Care Coordinator

☐ I discussed the Health Home program with the client or authorized representative. The benefits were explained and they decided not to participate or to end their participation in Health Home.

Signature of the Care Coordinator or Allied Staff

Date signed

Name of Care Coordinator or Allied Staff

5 Care Coordinator or Allied Staff instructions

The Care Coordinator or Allied Staff is responsible for:

- Documenting the client's request to opt-out or decline services, on this form and in the client's case file.
- Signing on the *Signature of the Care Coordinator* or *Allied Staff* line after the form has been completed. If the client's request to opt-out or declines services is made over the phone, the client does not need to sign this form and the Care Coordinator or Allied Staff must document the request on their behalf.
- Providing the client a copy of the form, in person or by mail.
- Ensuring that the Qualified Health Home Lead or MCO is provided with a copy of the form.

6 Qualified Health Home Lead or MCO instructions

The Qualified Health Home Lead or MCO must maintain this form and document on the Health Home Opt-Out Form Registry, for monthly submission to the Health Care Authority.

Washington State Health Care Authority

Health Home Incident Report

Washington State Department of Social & Health Services

Care Coordination Organization

Care coordinator	Care coordination organization	Qualified Health Home lead entity/MCO
Date of incident	Time of incident ☐ AM ☐ PM	Location of Incident
Beneficiary involved in the incident (name and ProviderOne ID if available)		Date of birth
Briefly describe the incident Continue on the back if additional space is needed.		
Did the incident lead to injury		Was first aid or medical attention required? ☐ Yes ☐ No
If first aid or medical attention was required, who provided the treatment?		Office/hospital
Names of witnesses and/or other individuals involved		
Care coordinator* signature		Date

Supervising Organization (Qualified Lead or MCO)

Name of supervisor to whom this incident was reported	Care coordinator organization	Date	Time ☐ AM ☐ PM
List any planned actions including, but not limited to, training and policy initiatives.			
Supervisor's signature		Date	

What is an incident?

In the context of this form, an "Incident" is a negative event or occurrence which was not desired and/or anticipated, for which the care coordinator* was present or came into contact, or was otherwise made aware of.

Instructions

After an incident, the care coordinator* must report the incident to their supervisor and complete the first portion of the *Health Home Incident Report* form. Send a copy of the partially completed and signed form through secure email to healthhomes@hca.wa.gov within one working day, with "Health Home Incident Report Final" on the email subject line.

After the supervising organization portion of the form has been completed and signed, send the form through secure email to healthhomes@hca.wa.gov, with Health Home Incident Report Final on the email subject line.

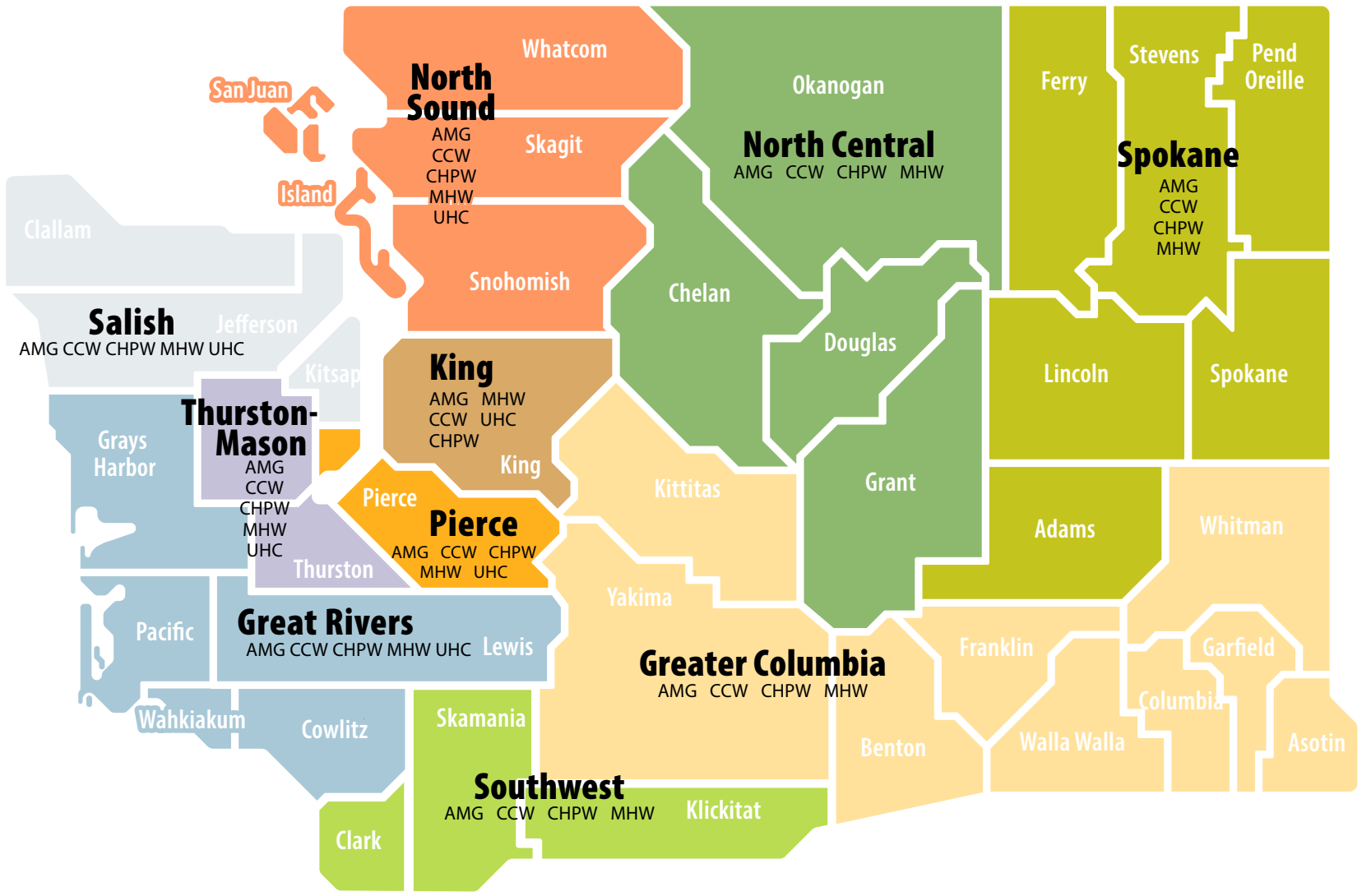
Copies of the final completed form should be supplied to the Health Home care coordinator and maintained on file with care coordination organization and the qualified Health Home lead entity.

The completion of this form does not replace any required reporting to Adult Protective Services, Child Protective Services, Residential Care Services Complaint Resolution Unit, Department of Health, law enforcement, and/or other mandatory reporting agencies. Report abuse and neglect at: **www.dshs.wa.gov/endharm.shtml**

***Care coordinator, or other staff or volunteer, representing the care coordination organization or qualified Health Home lead entity.

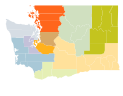
Apple Health managed care

Service area map - January 2023



Integrated managed care regions

- Greater Columbia
- King
- North Sound
- Pierce
- Spokane
- Thurston-Mason
- Salish
- Great Rivers
- Southwest Washington
- North Central



Apple Health Foster Care (statewide)†

Health plans offered

AMG	–	Amerigroup Washington
CCW	–	Coordinated Care of Washington
CHPW	–	Community Health Plan of Washington
MHW	–	Molina Healthcare of Washington
UHC	–	UnitedHealthcare Community Plan

† Apple Health Foster Care is a statewide program. Integrated managed care is provided through Apple Health Core Connections (Coordinated Care of Washington - CCW).

Washington Apple Health

HCA 19-0036 (10/22)

Behavioral Health-Administrative Services Organizations (BH-ASO)

Counties in each BH-ASO

Greater Columbia
Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima

King
King

North Sound
Island, San Juan, Snohomish, Skagit, Whatcom

Carelon Behavioral Health - Pierce
Pierce

Spokane
Adams, Ferry, Lincoln, Pend Orielle, Spokane, Stevens

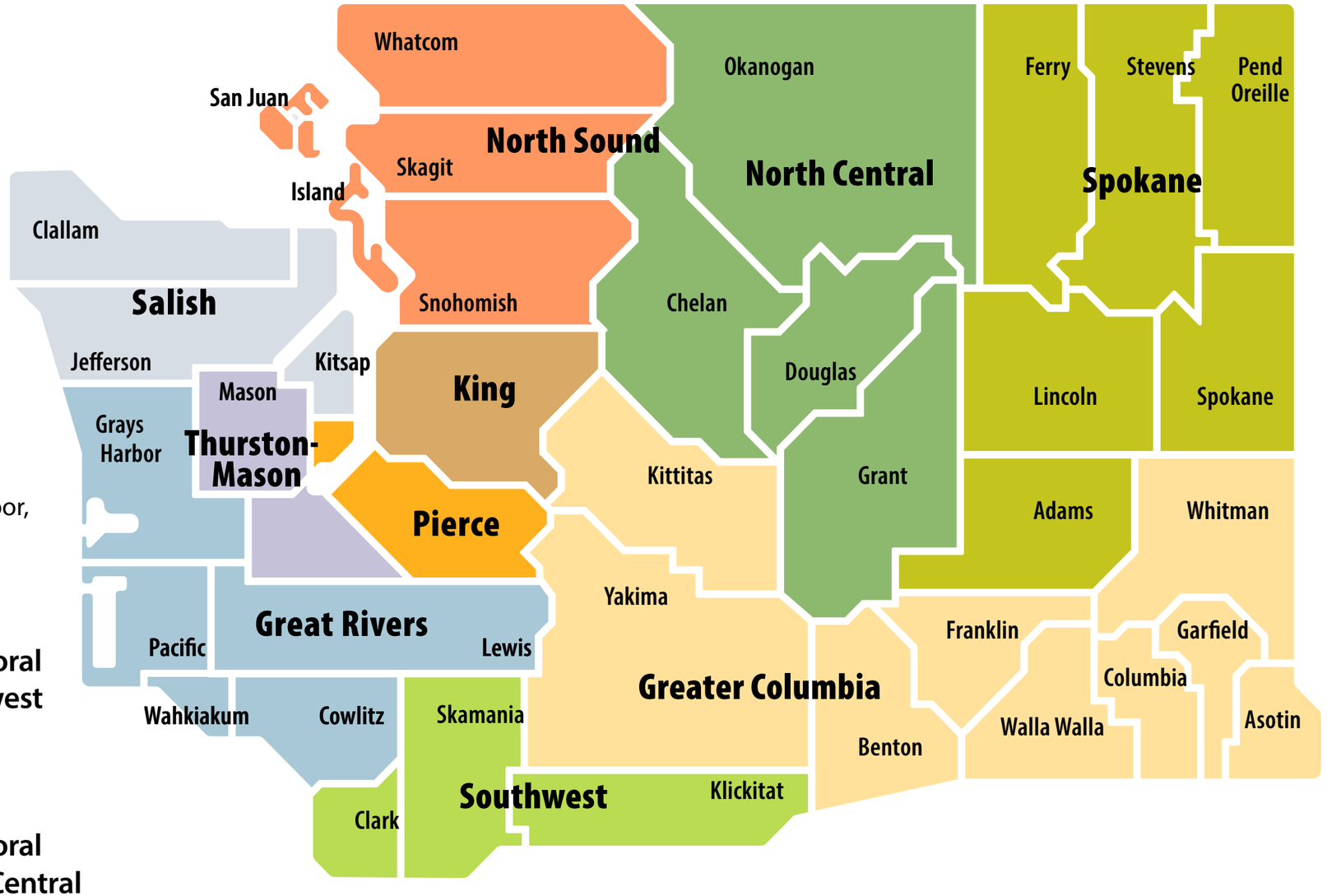
Thurston-Mason
Mason, Thurston

Salish
Clallam, Jefferson, Kitsap

Great Rivers
Cowlitz, Grays Harbor, Lewis, Pacific, Wahkiakum

Carelon Behavioral Health - Southwest
Clark, Klickitat, Skamania

Carelon Behavioral Health - North Central
Chelan, Douglas, Grant, Okanogan



Regional crisis assistance (24/7/365) for mental health and substance use disorder crises available to all individuals, regardless of their insurance status or income level.

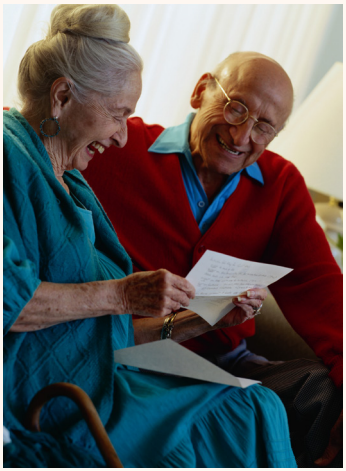
Washington Apple Health

HCA 19-0040 (11/23)

FOR CLIENTS

Health Home Program
Washington

Care Coordination for a Healthier You



The Health Home Program provides care coordination of medical, behavioral health and long-term services and supports for individuals of all ages.

This program is an extra Medicaid benefit available at no cost to you. Your Health Home connects a network of your current providers along with local organizations and agencies that work together to provide support to you.

Medicaid clients of all ages and Medicaid clients who also receive Medicare may be eligible for Health Home services.

Health Home Care Coordinators:

- Supports you in improving your quality of life
- Helps with post-hospital care
- Helps you manage multiple providers
- Assists you in getting appointments
- Identifies helpful community resources
- Helps connect you to available benefits

Visit the web site:

www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes

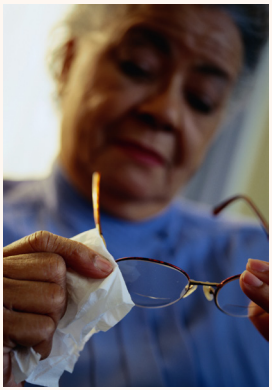
healthhomes@hca.wa.gov
1-800-562-3022

DSHS 22-1588 (Rev. 8/22)

FOR PROVIDERS

Washington Health Home Program

Care Coordination for Healthier Clients



The Health Home Program provides care coordination of medical, behavioral health and long-term services and supports for eligible individuals of all ages, at no cost to you or your client. The program uses a network of local agencies that work together to help clients understand and manage their health concerns. This helps reduce dependence on emergency departments and prevents avoidable hospitalizations.

Health Home Care Coordinators:

- Help coordinate services for eligible Medicaid clients with chronic and complex medical and social needs
- Provide appointment assistance
- Identify gaps in care and remove barriers
- Connect clients to a broad range of benefits such as, medical and behavioral health services, long-term services and supports, and other social services
- Support successful transition from hospital to other levels of care
- Link clients to community services
- Support improved quality of life
- Helps establish primary care relationships

For More Information:

www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes

Washington State Department of Social & Health Services

Transforming lives

Washington State Health Care Authority

healthhomes@hca.wa.gov
1-800-562-3022