Health Home Care Coordination Documentation Guide

Health Home Activities	Activities	Documentation
General guidelines	• Documents all activities related to the provision of Health Home services	• Document in the client's record periodic contacts: ○ The type of contact: telephone call, secure email message, written correspondence, face-to-face visits, multidisciplinary care team meetings, and attendance at appointments or other meetings ○ Attempted or completed contacts ○ Names and relationships of those contacted if not the client ○ Highlights from the conversation ○ Objective observations ○ Outcome of the contact ○ Other important information ○ Location of the visit and names and relationship of collaterals (e.g. family members, guardians, agency staff, caregivers, or others) present ○ Name of staff person completing the activity (include the writer's title for the first entry)
Outreach and Engagement	• Completes required activities for due diligence: ○ Telephone contacts ○ Letters	• Document in the client's record: ○ Date and type of letters or program information mailed ○ Alternate addresses used for clients that are homeless ○ Date letter mailed to the client if a new address is known or to a collateral 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.)

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		○ 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 collaterals who will be present and their relationship to the client ○ Due diligence requires three attempts to contact the client by telephone, document the dates and times of the calls. Three attempts must be completed during three different months (do not have to be consecutive months) • When telephone contacts and letters 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 collaterals such as secure email and include the date
Initial contact: client opts out of the program	• Offers to send the Opt-out Form • Completes the Opt-out form if client declines to complete the form	• Document 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 • Document the date the Opt-out Form (HCA 22-853) was mailed to the client and returned. Or, complete the Opt-out form on behalf of the client. Note the date the completed form was submitted to the Lead.
Loss of Contact	• Attempts to contact the client by mail, secure email, and telephone	• Document in the client's record: ○ Dates and types of contact attempted with client

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	• Accesses available databases to locate updated contact information for client • Contacts collaterals and other providers to identify client's current location and contact information	○ Dates and types of contact attempted with collaterals, 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	• Initiates contact with client and/or collaterals • Completes initial and follow up visits with the client and/or collaterals • Completes telephone contacts and follow up • Reviews PRISM data prior to initial client contact or face-to-face visit • Completes the required and optional screenings • Assesses the client's self-management skills and readiness • Completes the initial Health Action Plan (HAP) OR • Completes a review and updates the HAP • Provides monthly contacts to: ○ Ensure continuity of care between providers	• Document in the client's record: ○ Outreach attempts to locate and contact the client ○ Date outreach was completed, who completed the outreach, and names of collaterals if client was not contacted ○ Verbal approval by the client or client's representative to contact collaterals 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 and relationship of the person if another completes the screening. ▪ When the client or representative declines to complete a required screening note the date, reason if given, and the name and relationship of the person who declined

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	○ Support the client to achieve their self-directed health goals ○ Assist as needed to improve functional or health status or prevent or slow declines in functioning • Provides cross-system care coordination to identify gaps in 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 steps and progress toward meeting short and long term goals	○ Discussion with the client about their activation and readiness to initiate behavioral changes should be noted ○ A summary of conversations with the client and collaterals to establish or review the HAP and their reported progress on the goals and action steps ○ 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	• 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 steps and any revision to action steps and short term and long term goals in the HAP ▪ Enter end date and reason if applicable

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	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 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 that are tailored to the client's medical, social, economic, behavioral health, cultural, and environmental factors impacting the client's health and health care choices
		○ If client or collateral 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
		○ Names 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
		○ 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 goals

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	• Fosters cross-systems communication between providers of care including:
	  ○ Primary and behavioral health care providers
	  ○ Entities authorizing Long Term Services and Supports (LTSS)
	• Reviews progress on action steps, short and long term goals, and updates or revises the HAP	

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
	• 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
		• 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®
		  ○ 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, collaterals, and providers, including the date and type of contact. Documentation may include next steps for the client, Care Coordinator, and allied staff.

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The Six Core Services: Comprehensive Transitional Care	• Coordinates with client and/or collaterals to prevent avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment, or residential habilitation setting) • Ensures that the client and/or collaterals received and understand the discharge plan and orders • 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 collaterals that require contacting their medical and behavioral health providers • Follows up with LTSS case manager when there has been a significant	• Document in the client's record: ○ Follow up calls and visits before and after discharge ○ Timely follow-up and discussions with inpatient facility staff, the client, parents, family members, paid and unpaid caregivers, providers, collaterals, 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/s 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 ○ Arrangements for transportation and escort to medical and other medical or behavioral health appointments ○ Name 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

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	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	
The Six Core Services: Individual and Family Support	• Identifies the role of family members, informal supports, and paid and unpaid caregivers • 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 collaterals in the development and implementation of the HAP	• Document in the client's record: ○ Names of family members, caregivers, legal representatives and other providers and contact information. The Participation Authorization and 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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	• 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 • 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	• 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 collaterals in completing and submitting applications ○ Support or completion of eligibility reviews for Medicaid, housing, and other services ○ Resource and referral information including name of resource, contact name and phone number, and type of services/supports requested and provided ○ Contacts with other service providers

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	• Helps acquire and maintain eligibility for services such as Medicaid and housing	
Health Action Plan (HAP)	• Works with the client, family members, parents, guardians, caregivers, and other collaterals to establish a person-centered long term goal, short term goal/s, and action steps • Offers and completes required and optional screenings and Body Mass Index (BMI) • In collaboration with the client and collaterals completes required fields for the HAP • Enters the HAP into the Lead's data platform	• Document in the client's record: ○ The client's person-centered long term goal ○ The client's short term goal or goals ○ Actions steps specifying who will complete the action step 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 ▪ Note subsequent offers to complete the screenings and the outcome ▪ Note client's consent to have the caregiver complete the CAM® ○ When optional screenings (My Falls-free Plan, Pain Scales [FLAAC, 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, short term goal/s, and action steps

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		▪ Obstacles to completing long term goal, short term goal/s, and/or action steps ○ Face-to-face visits for initial and subsequent HAPs and telephonic support of the client and collaterals in meeting goals and action steps
Transition Planning	• Facilitates discussion with the client and/or parents, caregivers, guardians, or representatives when client: ○ opts out of the program ○ is no longer eligible • 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 collaterals about the process of health action planning if the client wishes to pursue future goals • Identifies community resources and completes referrals • Provides contact information to client or collaterals for follow-up for referrals	• Document in the client's record: ○ Discussion of the HAP goals and successes ○ Efforts to encourage client to continue to work with allied staff or other collaterals when Health Home services are terminated. Document the client's decision to continue or discontinue their pursuit of goals. ○ Contact with collaterals ○ Referrals to other providers ○ Client or collateral's acceptance of an offered service, such as a referral to a provider. Note if client or collateral decline to accept assistance. ○ Discussion about the transfer process with the client and collaterals and date of discussion ○ Closure of the HAP including the date and reason. ○ Actions taken to transfer the case back to the Lead

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	• Closes the HAP	
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 • May collaborate with client and IP to develop a role for the IP to support the HAP	• Document in the client's record: ○ Discussions with the client and collaterals about the pilot and client's interest in participating ○ Discussion with the IP about the completion of required training and interest in participating with the client ○ Contact with the Area Agency on Aging or DSHS Developmental Disabilities Administration case manager ○ Revision of the HAP, with the client's agreement, to include a role and possible action steps for the IP to support the client and their goals.
Special Programs: Community Integration (CI) in Adult Family Homes (AFH)	• Educates the client, collaterals, and AFH about the program • Identifies resources and opportunities for the client to better integrate into their community	• Document in the client's record: ○ Efforts to collaborate with the client, collaterals, 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 goals and action steps

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	• When appropriate, incorporates CI activities into the HAP as goals and action steps	○ Contacts with the Developmental Disability Administration Case Resource Manager or DSHS Home and Community Services Social Service Specialist or Nurse

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