STATE OF HAWAII
HEALTH AND FUNCTIONAL ASSESSMENT INSTRUCTIONS
CHILD AND ADULT

GENERAL INSTRUCTIONS

The Table of Contents may be formatted to go directly to the specific Sections.

Sections that do not apply to the member may be collapsed or hidden from view to provide a member-specific HFA.

All sections for the appropriate age cohort and program type must be answered.

When conducting the HFA for LTSS members, it is required to obtain and record current vital signs.

All sections for the At Risk and LTSS program types must be completed by a licensed clinical staff.

Health Coordinators (HC) and Community Health Workers (CHWs) are expected to:

1. **Prepare for all visits using additional available resources (e.g., claims data, medication history, utilization history) and telephonic responses to expedite the assessment process and make the most of the member's time.**
2. **Confirm and validate all pre-filled information with the member.**

The assessment should include a face-to-face interview. Assessments and reassessments may be conducted by telehealth, based on member's choice and preference. If using telehealth, it must meet privacy requirements.

When conducting reassessments, if there are no changes from the most previous assessment, check "No Change From Previous Assessment".

In accordance with the Home and Community-Based Setting Final Rule issued in January 2014, the following must be included in the planning process:

1. **Provide necessary information and support in order to enable the member to make informed choices, including providing choices regarding services and supports and who provides those services.**
2. **Ensure that the member directs the planning process to the maximum extent possible.**
3. **Ensure that the planning process reflects cultural considerations of the member.**
4. **Ensure that the planning process is conducted in plain language and in a manner that is accessible to members with disabilities and interpreted into the member's primary language for those with limited English proficiency.**
5. **Ensure that the member understands how to request updates to the plan as needed.**

CHAPTER 1. NON-CLINICAL INFORMATION (Identification, Financial, Social Supports and Caregivers, and Home Information)

Section A
Section B
Section C
Section D
Section E
Section J (Attachments for Sections A-C)

SECTION A. ADMINISTRATIVE INFORMATION
COMPLETE FOR ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS

A1. Member

a) Enter member's legal name (Last, First, Middle Initial).
b) Enter member's date of birth (MM/DD/YYYY).
c) Enter member's 10-digit Medicaid ID number.
d) Select whether member is a child or an adult (19 and over).
e) Select which program type member is currently in.

A2. Assessment

a) Check appropriate box to indicate the reason for assessment. See Appendix G Glossary for definitions.

If change in condition/status is checked, specify what type of change in condition/status occurred.

b) Fill-in Assessment Reference Information.

c) Fill-in Primary Assessor's legal name and title e.g., RN, SW, LSW, CHW etc.

d) Fill in Consult Assessor's legal name and title e.g., RN, SW, LSW etc.

e) Fill-in Additional Health Plan/Insurance, other than Medicare or Medicaid.

For questions i-iii, enter the Health Plan Name, Subscriber Name, and Subscriber Number, if applicable.

For question iv-v, answer question of whether they are a veteran and if they are receiving any veteran benefits.

f) Fill-in Medicare information:

For question i, select whether the member has Medicare coverage. If yes, indicate the Medicare ID number.

For question ii, select whether member has Medicare Advantage (delivered through a private health insurance company). If yes, indicate the plan name and ID.

g) Select whether the member has a legal guardian or authorized representative assisting in the assessment.

Indicate whether there were other individuals present. Enter all individuals that the member has chosen to assist in this assessment, with their legal name, their relationship to the member, their purpose in assisting member, and whether they were "Present", "Absent", or "Sent an Invite" (from drop down).

h) Provide comments, if appropriate.

A3. Legal Information

Check box if there is no change from previous assessment.

a) Check all appropriate boxes that identify individuals that have legal responsibilities regarding the member. For each box checked, identify whether a copy of the document legally delegating such responsibility was obtained for the Health Plan's record.

b) Answer questions for number i to ix for Advance Directives and Provider Orders for Life-Sustaining Treatment (POLST). For code status, include CPR order (Code or No Code), Medical Interventions (Comfort, Limited, Full, and additional orders if any), and Artificially Administered Nutrition status. Ensure that the POLST is signed and dated by the member or legally authorized representative and the provider in order for it to be valid.

c) Provide primary and secondary emergency contact information including their name, relationship to member, address, phone number, and email address.

d) If member is receiving HCBS, provide Emergency Plan by answering questions i - v. If answer to question iv is "No" (member did not complete their Individualized Emergency Back-up Plan), complete the Attachment for QI Individualized Emergency Back-Up Plan. Original should be attached to the HAP and a copy should go to the member. See Appendix G. Glossary for Definitions

e) Provide comments and identify any risk factors, if appropriate.

SECTION B. DEMOGRAPHIC INFORMATION
COMPLETE FOR ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS

B1. Demographics

Check box if there is no change from previous assessment.

a) Answer what sex was originally listed on member's birth certificate. If "Other" is selected, then describe.

b) Answer what gender(s) member identifies self as.

c) Answer what is member's preferred pronoun(s).

d) Click on drop down for member's current relationship status.

e) Select member's race/ethnicity. Check all that apply.

B2. Communication

Check box if there is no change from previous assessment.

a) Check member's primary means of communication. See Appendix G. Glossary for definitions.

b) Check member's primary spoken language. Click on drop-down list to select.

c) Answer yes or no if member needs interpretation services. If yes, provide name and contact of interpreter.

d) Check primary written language for written materials. Click on drop-down list to select.

Answer how often member needs help to read instructions, pamphlets, or other material from the doctor or pharmacy. If member selects "sometimes" or "always", provide an explanation.

e) Answer yes or no if member needs translation services. If yes, provide name and contact of translator.

f) Provide other assistive communication device(s) (e.g., TTY, TTD, etc). Check none if member does not use any other assistive communication device(s).
g) Provide comments, if appropriate.

B3. Residence and Living Arrangements

Check box if there is no change from previous assessment.
a) Answer what is the member's living arrangement. Click on drop-down list to select. See Appendix G. Glossary for definitions.
b) Ask member where they have lived in the past 30 days. Select all that apply. See Appendix G. Glossary for definitions.
(1) If houseless, at risk of houselessness, NF/Acute care hospital transition, other is checked in section above, complete **Section B4. Housing Transitions for Going Home Plus (GHP).**
(2) Answer question if member is receiving housing navigation services. If no, answer question 3.
(3) Answer question "Have you ever been screened for CIS". Complete table from the drop-down list. Include the date and comment, if appropriate.
(4) If "Not Identified, Screened, or Referred" is selected in question #3 above, refer to CIS and add housing tasks to HAP.
c) Check type of Subsidized Housing . Select all that apply.
d) Provide comments, if appropriate.

B4. Housing Transitions for Going Home Plus

a) For Going Home Plus (GHP)
i) Answer yes or no if member has been in the nursing facility and/or acute care hospital for more than 60 continuous days.
ii) Answer yes or no if member meet nursing facility level of care. This is based on the DHS Form 1147 – member needs to have been designated as meeting ICF or NF level of care by MQD or designee.
iii) If the answers to i and ii are both yes, refer member to GHP. Select "Yes" if member meets both criteria and would like to be referred to GHP, select "Not Eligible" if one or both criteria are not met, or select "Declined/Family Refused" if member meets both criteria, but does not want to be referred to GHP.

SECTION C. FINANCES/SOCIAL SUPPORTS/CAREGIVER(S)
COMPLETE FOR ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS

C1. Finances

Check box if there is no change from previous assessment.
a) Answer the finances questions numbers i to ix.
i) Answer yes or no if member has concerns about their financial situation. If yes, select all that apply.
ii) Indicate what income sources member has. Select all that apply.
iii) Indicate member's employment status. Select all that apply.
iv) Answer yes or no if member or family members that live with them have been unable to get any of the following items (numbered 1-7). Select all that apply. If yes, complete Attachment for SDOH/SRF and attach to this HFA and/or make appropriate referral (see question ix).
v) Answer yes or no if member is worried about losing their housing. If yes, complete Attachment for SDOH/SRF and attach to this HFA and/or make appropriate referral (see question ix).
vi) Answer yes or no if member thinks it would be helpful to review their monthly expenses. If yes, complete Attachment for Financial Worksheet, attach to this HFA, and/or make appropriate referral (see question ix).
vii) Answer yes or no if member previously applied for additional services.
viii) Answer yes or no if member is in process of applying for additional assistance.
ix) Indicate what referrals member will be referred to. Select all that apply.
b) Provide comments and identify any risk factors, if appropriate.

C2. Social Supports

Check box if there is no change from previous assessment.
a) Provide information for Social Supports.
i) Check yes or no if there are family and/or friends living in the same residence. If yes, identify the name, age, relationship to member, contact number, and type of support provided (if applicable) to the member. Place an asterisk (*) next to the name if they are primary caregiver.
ii) Check yes or no if there are family and/or friends NOT living in the same residence but are providing support to the member. If yes, identify the name, age, relationship to member, contact number, and type of support provided to the member.

iii) Select yes or no if member has strong and supportive relationships with family.
iv) Select yes or no if member has strong and supportive relationships with a friend or neighbor.
v) Ask member if they prefer having family or friends accompany them or help them when they go to medical appointments. Select yes, no, or no opinion.

b) Provide comments and identify any risk factors, if appropriate.

C3. Caregivers

Check box if there is no change from previous assessment.
Identify any caregivers. Include their name, age, relationship to member, phone number, type of help provided, whether they are through outside employment (i.e. agency), the employer's name if applicable, and the number of hours they work for the member per week.

a) Provide the Primary Caregiver's name.
i) This section will be an interview with the Primary Caregiver on their perspective. Assess member's primary caregiver status for possible caregiver burn out using suggested bullet points to start the conversation. HC or CHW and providers must be able to identify whether the primary caregiver is experiencing caregiver burnout to coordinate caregiver supports, e.g., respite care, education, and and/or counseling, etc.

b) Provide comments and identify any risk factors, if appropriate.

SECTION D. TRANSPORTATION
COMPLETE FOR ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS
Do not complete for NF/CCFFH/E-ARCH

a) Answer questions regarding transportation.
i) Identify whether the lack of transportation has kept member from medical appointments, meetings, work, or from getting things needed for family living. Check all that apply.
ii) Identify current mode of transportation. Select all that apply.
CCFFH and E-ARCH caregivers are responsible for transporting residents.
If member selects "Drives own vehicle" or "Family or Friends", you may skip to Section E.
If member selects neither, complete remaining questions of this section (iii-x).

b) Provide comments and identify any risk factors, if appropriate.

SECTION E. HCBS HOME ENVIRONMENT
COMPLETE FOR MEMBERS - - AT RISK, LTSS
** Complete only for HCBS and do not complete if member is in NF/CCFFH/E-ARCH***

a) Answer questions for current home
a1) Answer questions for safety. Select ALL that apply.
a2) Answer questions for accessibility. Select ALL that apply.
For question iii – Identify if THERE ARE accessibility issues to the specified areas (#1 – #7). If yes, select ALL that apply.
a3) Answer questions for electronic connectivity/communication.
a4) If there are any concerns noted above regarding safety, accessibility, and/or electronic communication, describe interventions to address those concerns in the Health Action Plan (HAP).

b) Answer questions regarding exterior of home. Provide comments as needed, to present a thorough assessment.

c) Answer question regarding interior of home. In the "Other" space, provide information if there are pets in the home and if the home is smoker-free. Provide comments as needed, to present a thorough assessment.

d) Provide comments and identify any risk factors, if appropriate.

Chapter 2. CLINICAL INFORMATION (Health Status, Medical Care Conditions, Needs, and Services, Functional Abilities, Psychosocial Well-Being, and Long-Term Services and Supports Information)

SHCN/EHCN

Section F
Section G
Section H
Section I
Section J (Attachments for Sections F-H)
Section K

SECTION F. MEDICAL INFORMATION
COMPLETE FOR ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS

F1. Disease Diagnosis(es)

Check box if there is no change from previous assessment.

a) In the first column, list all member's disease diagnosis(es). In the second column, list the corresponding ICD-10 code for each the diagnosis. In the third column, include the date the diagnosis was made. If unsure, select box for unknown. Refer to Appendix E for list of disease diagnoses that require the completion of disease specific attachments, if applicable to member, and attach to this HFA.

b) Provide comments and identify any risk factors, if appropriate.

F2. Transplant

Check box if there is no change from previous assessment.

a) Answer questions i-iii regarding transplant, if applicable.

b) Provide comments and identify any risk factors, if appropriate.

F3. Medications (Prescribed and OTC)

Check box if there is no change from previous assessment.

Answer questions i-viii regarding medications. Attach current Medication list with start date, dose, frequency, and instructions to the HAP and/or complete Attachment for Medications, if appropriate, and attach to the HAP.

F4. Treatment and Therapy(ies)

Check box if there is no change from previous assessment.

Provide information for each column. Refer to Appendix A for list. If therapy is not listed in Appendix A, select "Other", and note the treatment or therapy in the table.

Note: Complete Skilled Nursing Tool for any treatment or therapy, if applicable. Refer to Appendix A for treatment and therapies that require assessment with Skilled Nursing Tool (identified with an asterisk).

F5. Medical Equipment and Supplies

Check box if there is no change from previous assessment.

Provide information for each column. Refer to Appendix B for list. If therapy is not listed in Appendix B, select "Other" and note the equipment or supply on the table.

Note: Complete Skilled Nursing Tool for any treatment or therapy, if applicable. Refer to Appendix B for medical equipment and supplies that require assessment with Skilled Nursing Tool (identified with an asterisk).

F6. Physician(s) and Provider(s)

Check box if there is no change from previous assessment.

Provide information for each column. List the primary physician/provider(s) first.

F7. Utilization of Hospital, Emergency Room, and Physician Services

Check box if there is no change from previous assessment.

a) Answer whether member needed medical attention within the past three (3) months. If yes, ask if they were able to get help by phone and/or by telehealth. Select yes or no for each follow-up item.

b) Answer question of how many times member was hospitalized within the past three (3) months for physical health, mental health, and/or SUD. For each category, select one checkbox for the number of times. In the proceeding column for each category, indicate the cumulative number of days the member was hospitalized.

c) Answer question of how many times member was in the emergency room within the past three (3) months for physical health, mental health, and/or SUD. Select only one for each column.

d) Answer question on how many times member stayed at a crisis home or unit in the past three (3) months. In the first column, select one box for the number of times the member stayed in a crisis home or unit within the past three months. In the second column, indicate the cumulative number of days the member stayed in a crisis home or unit within the past three months.

e) Answer questions regarding physician services last visit and next schedule visit. If unknown, indicate the reason.

f) Provide comments and identify any risk factors, if appropriate.

F8. Prevention & Immunizations

Check box if there is no change from previous assessment.

a) Answer screening questions. Answer questions i and ii for children only. Answer questions iii to v for all members.

b) Answer questions i-vi for members in HCBS residential or institutional settings.

c) Provide comments and identify any risk factors, if appropriate.

SECTION G. GENERAL HEALTH
COMPLETE IF APPROPRIATE FOR MEMBERS IN SHCN, EHCN, AT RISK, LTSS

G1. Cognition

Check box if there is no change from previous assessment.

a) Answer questions regarding cognition.
   i) Answer yes or no if member is comatose? If yes, skip to Section G4.
   ii) Mental Status. Choose one (1) answer from (a), (b), or (c):
      (a) Check box to indicate if member is oriented to person, place, time, and situation.
      Use guide below to help determine mental status – orientation:
      Here are suggestions to help determine orientation:
         (1) What is your name? (Person)
         (2) Do you know where you are? (Place)
         (3) What is today's date or year? (Time)
         (4) What is happening right now (or) What are we doing? (Situation)
      If member is unable to answer any of the questions correctly, they don't meet the criteria for oriented and should be considered disoriented (options b or c below).

      (b) Check box to indicate if member is partially or intermittently disoriented and/or requires supervision. Provide an explanation.
      (c) Check box to indicate if member is disoriented and/or disruptive. Provide and explanation.

      If member is disoriented or is 65+, complete the Attachment for Cognition and attach to this HFA.

b) Answer questions i-iv regarding wandering.
c) Provide comments and identify any risk factors, if appropriate.

G2. Vision/Hearing/Speech & Communication

Check box if there is no change from previous assessment.

a) Answer questions for vision.
   Answer yes or no if member is visually impaired or struggles with vision loss.
   Answer questions about vision impairment and corrective lenses. Select all that apply from i-iii.
   Indicate the date of the member's last eye exam. If unknown or member declines to answer, check appropriate box.
b) Answer questions for hearing.
   Answer yes or no if member is hard of hearing or hearing impaired.
   Answer questions about hearing impairment and assistive device(s) for hearing. Select all that apply from i-iii.
   Describe if member uses a hearing aid for one or both ears or if member uses another type of device (e.g. amplifier).
   Indicate the date of the member's last hearing exam. If unknown or member declines to answer, check appropriate box.
c) Answer questions for speech.
   i) Select best option for member's speech pattern from options 1-3.
   ii) Indicate the date of the member's last speech evaluation. If unsure or if member has not had a speech evaluation, select box for unknown.
d) Answer questions for communication.
   i) Select best option for member's ability to verbally express ideas from options 1-3.
e) Answer questions for comprehension.
   i) Select best option for member's ability to understand others from options 1-4.
f) Provide comments and identify any risk factors, if appropriate.

G3. Mood, Behavior, and Psychological Well-Being – PHQ9 for Adults / PSC 17 for Children

Check box if there is no change from previous assessment. Check if member is enrolled in CCS.

a) Answer questions i-ii for PHQ-2. If there is a score of three (3) or greater on the PHQ-2, complete Attachment PHQ-9 for Adults or complete the Pediatric Symptom Checklist for Children in part b. Otherwise, skip to question c.
   Note that questions b-e are for children only
b) Complete Depression (Pediatric Symptom Checklist) only if they scored 3 or greater on the PHQ-2 in part a. If they score 15 or higher on the Pediatric Symptom Checklist, refer member to their PCP or refer for a behavioral health evaluation.

c) Ask parent/guardian question c for the child member. If they select yes, refer member to their PCP or refer for a behavioral health evaluation.
d) Ask parent/guardian question d for the child member. If they select yes, refer member to their PCP or refer for a behavioral health evaluation.
e) Check box if making a referral and specify. This should be done if score on the Pediatric Symptom Checklist is 15 or higher.

Note that questions f-m are for adults only.

f) Answer yes or no if adult member has had any recent major life stressor(s). If yes, provide an explanation.
g) Answer question for coping skills. Select all that apply from options i-iii.
h) Answer question for anger. Select all that apply from options i-ii. If option ii is checked, provide an explanation.
i) Answer question for anxiety. Select all that apply from options i-iii.
j) Answer question for behavior. Indicate if this information is gathered from observing the behavior or member/guardian answering. Select all that apply from options i-vi. If option vi is checked, provide an explanation.
k) Answer question for social relationships. Select all that apply from options i-iii. If any of the options is/are checked, provide an explanation.
l) Answer yes, no, or does not apply to question regarding whether member has an order from physician for use of physical restraints.
If yes, answer parts ii and iii by selecting the type of restraint(s) used. Indicate the appropriate code for limitation coding for each type of restraint.
m) Provide comments and identify any risk factors, if appropriate. Identify provider referrals, if any.

G4. Health Status

Check box if there is no change from previous assessment.

a) Take and enter vital signs (required for LTSS). Mode refers to the method by which the vital sign was taken. For example, pulse can be taken with a pulse oximeter, feeling for a radial pulse, or taking an apical pulse with a stethoscope.
b) Answer questions for fall history.
   i) Answer yes or no if member has problems with balance or gait or is a risk of falls.
   ii) Answer yes or no if member has a history of falls.
   iii) Select all that apply from options 1-3.
   iv) Indicate the number of falls member has had within the past year. This can be a witnessed fall, a self-reported fall, or if member was found on the ground.
   v) Indicate the number of fall-related injuries member has had within the past year.
   vi) Indicate the date of the member's last fall.

   If member is 18 years or older and has had at least one fall with injury or at least two falls with/without injury within the past year, complete the Attachment for Fall Risk Assessment and attach to this HFA.
c) Answer questions for pain. If member is verbal and able to answer, use the Numeric Rating Scale. If member is non-verbal or is verbal but unable to answer appropriately, use the Faces Pain Rating Scale.
d) Answer questions for substance and/or drug use. If response is "yes" for smoking use, complete Tobacco Screener. If response is yes for alcohol use or substance/drug use, complete CAGE-AID Screener.
e) Provide comments and identify any risk factors, if appropriate. If any referral was made, specify.
f) Answer questions for cardiac/respiratory**. If any of the boxes i-x are checked, complete Attachment for Heart Disease and attach to this HFA. If box x is checked, complete Attachment for Asthma/COPD/Respiratory/Tracheostomy/Ventilator and attach to this HFA.**
g) Provide comments and identify any risk factors for section f, if appropriate.

G5. Nutrition

Check box if there is no change from previous assessment.

a) Answer questions for height, weight, and Body Mass Index (BMI). To calculate BMI, you may use an online BMI calculator or calculate using this formula: Calculate the member's weight (pounds) x 703. Take this answer and divide by the member's height (inches). Take this answer and divide again by the member's height (inches). Ensure that you are using a recent height and weight to calculate an accurate BMI.
b) Answer questions for dental:
   i) whether member has any natural teeth that are broken, fragmented, loose, or non-intact.
   ii) whether member has dentures. If yes, indicate if they are full or partial dentures.
   iii) whether member uses their dentures. If no, indicate the reason they do not.

iv) whether member is experiencing any toothache or pain (either chewing or at rest). If yes, make appropriate dental referral.
v) note the date of member's last dental exam.

c) Answer questions for weight loss or gain.
i) When answering this question, include typical foods/drinks that member consumes. Also include the time-of-day member eats these items.
ii) A special diet can be the types of food/drink recommended – for example, cardiac diet, no concentrated sweets (NCS), no added salt (NAS), etc.
iii) Answer yes or no if the member show any signs and symptoms of possible chewing and/or swallowing disorder or difficulty. Check all the options that apply.
iv) Answer question for planned/unplanned weight loss.
v) Answer question for planned/unplanned weight gain.
vi) Answer question of whether physician or provider counseled member on weight loss or weight gain.
vii) Answer yes or no of whether there is a plan for managing member's weight. If yes, describe the plan.

d) Answer questions for Nutritional Intake**. If member requires tube or parenteral feedings, refer to Skilled Nursing Tool to determine allotted hours.**
i) Answer yes or no if member is able to eat by mouth.
ii) Answer yes or no if member is able to feed themselves independently, without the assistance from others or with or without assistive devices (i.e. weighted utensils, plate guard, etc.)
iii) Indicate if member has any dietary modifications.
a) Food may be regular, chopped, minced, or pureed. Select appropriate box(es). Note that while most dietary modification orders apply to all foods, there may be exceptions with approval from provider or consent from member or guardian.
b) Liquids may be thickened to either nectar, honey, or pudding consistency. Select appropriate box(es). Note that while most thickened liquid orders apply to all liquids member consumes, there may be exceptions with approval from provider or consent from member or guardian.
iv) Answer yes or no if member requires enteral feedings. If yes, indicate if it is via NG tube, GT, or G/J tube.
v) Answer yes or no if member requires parenteral feedings. If yes, indicate if it is via TPN or other (describe).

e) Provide comments and identify any risk factors, if appropriate.

G6. Continence

Check box if there is no change from previous assessment.

a) Answer questions for bladder and bowel continence. If option #2 is selected, describe the type of catheter or ostomy and size (if applicable).
b) Answer yes or no if member uses incontinence products. If yes, describe (e.g., incontinent briefs, underwear liner, etc.).
c) Provide comments and identify any risk factors, if appropriate. If member uses a catheter or has an ostomy, provide information about the care provided. This includes how often the device is changed, instructions if the tube becomes dislodged, how often the bag is emptied, and the care instructions/frequency.

G7. Skin

Check box if there is no change from previous assessment.

a) Answer questions for skin. Select all that apply. For those selected, provide a description. HC and provider(s) must be able to identify any skin problems to coordinate and provide appropriate services as needed.
b) Provide comments and identify any risk factors, if appropriate.

G8. Musculoskeletal

Check box if there is no change from previous assessment.

a) Answer questions for Bones, Muscles, or Joints. Select all that apply. For those selected, provide description. HC, CHWs, and provider(s) must be able to identify any bone, muscle, or joint problems that affect functional activities to coordinate and provide appropriate services as needed.
b) Provide comments and identify any risk factors, if appropriate.

G9. Family Planning

Check first box if there is no change from previous assessment or not applicable.
Answer questions for reproductive health.

i) Ask member if they are sexually active. If member is an adolescent or younger, approach this question delicately and use best judgement. The purpose of asking this question is to lead up to the following questions in this section. For example, question iv below asks about birth control.
ii) Answer yes, no, or N/A for whether member is pregnant. **If yes, complete the ATTACHMENT for Pregnancy and attach to this HFA.**
iii) Answer if member would like to become pregnant in the next year. Select one option.
iv) Answer yes or no if member is currently using birth control. If yes, indicate the type being used. Answer yes or no if they are satisfied with their birth control. If they are not satisfied, provide reason.

Answer questions 1-3.

b) Provide comments and identify any risk factors, if appropriate.

G10. Functional Status **COMPLETE FOR AT-RISK, LTSS**

Check box if there is no change from previous assessment.

a) Answer questions for Long-Term Services and Supports (LTSS) to assess function and document the level of assistance needed to complete ADLs and IADLs.

i) Answer yes or no if member has concerns about taking care of themselves. Include member's response in the ATTACHMENT for iADLs and ADLs.
ii) Answer yes or no if member has a caregiver (family member/friend or agency) that assists them with their daily activities.
iii) Answer yes or no if member identifies any assistance and/or services that they need to remain in their home.
iv) Complete the ATTACHMENT for iADLs and ADLs and attach to this HFA and to the HAP.

G11. Self-Reported Health

Check box if there is no change from previous assessment.

a) Ask member how they would describe their health in general. Select one box. If they select "Fair" or "Poor", ask member questions b-d. If not, skip to section H.
b) Ask member how many days their physical health was not good in the past 30 days.
c) Ask member how many days their mental health was not good in the past 30 days.
d) Ask member how many days their poor physical or mental health keep them from doing their usual activities, such as self-care, work, or recreations.

SECTION H. PSYCHOSOCIAL HISTORY
COMPLETE FOR ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS

H1. Member's Perspective

Check box if there is no change from previous assessment.

Answer questions a-h for personal history/lifestyle/goals. The strategy should be to "talk story" with the member and use the provided questions as a guide. Ask appropriate questions that are currently relevant to the member. If member shows no interest in answering interview questions, skip this section and document in comments section. If unable to obtain information from member, you may obtain from parents, others, etc.

i) Complete Attachment for One Page Description and attach to the HAP.

SECTION I. CURRENT SERVICES AND SUPPORTS
COMPLETE IF APPROPRIATE FOR MEMBERS IN SHCN, EHCN, AT RISK, LTSS

I1. Home and Community Based Services (HCBS) **COMPLETE FOR AT RISK, LTSS**

Check box if there is no change from previous assessment or not applicable.

Complete only for LTSS/At Risk.

a) List the HCBS Services, provider(s)/agency(ies) that provide those services, the frequency/amount of those services, and any comments or additional needs. Refer to Appendix C for list.

Document frequency/amount of services provided per week, e.g., 10 hours per week, 2 sessions per week, 10 times per week.

b) Provide comments, if appropriate.

I2. Institutional Services **COMPLETE LTSS**

Check box if there is no change from previous assessment or not applicable.

a) List the institutional services, the provider of those services, and any comments or additional needs. Provide the start date of the service, if applicable. Refer to Appendix D for list.

b) Provide comments, if appropriate.

I3. Additional Support Services **COMPLETE FOR SHCN, EHCN, AT RISK, LTSS**

Check box if there is no change from previous assessment or not applicable.

a) Answer questions i-ii for State Program(s).

i. Answer yes or no if member is currently receiving any services from any State Programs.

ii. Indicate which school the member is attending. If not applicable to member, select N/A.
Select the State Program(s) that member is participating in and enter the referral date and/or enrollment start date. Provide the contact name for the State Program, phone number and email address, agency name (if applicable), and any other additional information. If member is enrolled in a State Program that is not listed here, provide this information on the row for "Other".
If unknown, check box for unknown.

b) Provide comments, if appropriate.

c) Provide information for Non-State Program(s). Provide Non-State Program, contact name, phone number, services/hours. If unknown, check box for unknown.

d) Provide information for referrals. Select the applicable type of referrals, note the contact name, phone number, and services/hours.

e) Provide comments, if appropriate.

SECTION J. ATTACHMENTS SECTION
COMPLETE IF APPROPRIATE FOR MEMBERS IN SHCN, EHCN, AT RISK, LTSS

The following attachment document questionnaire are triggered by certain items or questions in the HFA. Check ALL that apply, complete the attachment, and attach to this HFA.

☐ A3.d ATTACHMENT FOR QI Individualized Back Up Plan
☐ B3.b ATTACHMENT FOR Housing Screener
☐ C1.a ATTACHMENT FOR SDOH/SRF
☐ C1.a ATTACHMENT FOR Financial Worksheet
☐ F3.3 ATTACHMENT FOR Medications
☐ G1.a ATTACHMENT FOR Cognition
☐ G3.a ATTACHMENT FOR PHQ-9
☐ G4.b ATTACHMENT FOR FALL RISK ASSESSMENT
☐ G4.d ATTACHMENT FOR Tobacco and/or CAGE-AID
☐ G4.f ATTACHMENT FOR Heart Disease
☐ G4.f-F1.10 ATTACHMENT FOR Respiratory/Tracheostomy/Ventilator
☐ G9.a ATTACHMENT FOR Pregnant Female
☐ G10.a ATTACHMENT FOR IADLs and ADLs
☐ H1.j ATTACHMENT FOR One Page Description – MY PROFILE

Complete disease specific questions for those that have been identified in Section F1a. Disease Diagnosis(es). HC and CHW will ask relevant questions appropriate to the member to gather information for HAP.
Check ALL that apply, complete the attachment, and attach to this HFA.

☐ F1.1. ATTACHMENT FOR Asthma, Chronic Obstructive Pulmonary Disease (COPD)
☐ F1.2. ATTACHMENT FOR Cancer
☐ F1.3. ATTACHMENT FOR Diabetes
☐ F1.4. ATTACHMENT FOR End Stage Renal Disease (ESRD)
☐ F1.5. ATTACHMENT FOR Hepatitis B/C
☐ F1.6. ATTACHMENT FOR High Blood Pressure
☐ F1.7 ATTACHMENT for Heart Disease
☐ F1.8. ATTACHMENT FOR HIV/AIDS
☐ F1.9. ATTACHMENT FOR Seizures

SECTION K. SUMMARY/NARRATIVE OF VISIT
COMPLETE FOR ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS

a) Describe and provide summary of visit and include answers for questions i-iv.

SECTION L. VERIFICATION OF HFA COMPLETION
COMPLETE FOR ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS

L1. Provide the Name, Signature, and Title of individuals completing the HFA. In the Sections column, note what sections that individual completed. In the Date Section Completed column, indicate the date the sections were completed. If an individual completed more sections on different days, list these separately.
L2. Provide the Name, Signature, and Date of when the Health Coordination Licensed Clinical Staff reviewed and approved the completion of the HFA. Please note that this may be the same person indicated in section L1.

APPENDICES

Appendix A. Treatments and Therapies

1. BiPAP/CPAP
2. Catheter care
3. Chemotherapy
4. Chest physiotherapy
5. Cough Insufflator/Exsufflator*
6. Dialysis
7. Enteral Feeding*
8. Home Health
9. Hospice care
10. IV therapy*
11. Occupational therapy
12. Oxygen therapy
13. Palliative care
14. Personal Emergency Response System (PERS)
15. Physical therapy
16. Psychological therapy
17. Radiation
18. Respiratory therapy
19. Speech language therapy
20. Suctioning*
21. Tracheostomy care*
22. Transfusion
23. Ventilator care*
24. Wound care*
99. Other

Appendix B. Medical Equipment and Supplies

1. Bath chair/shower bench
2. BiPAP/CPAP
3. Cane
4. Catheter Supplies
5. Chest Vest
6. Commode
7. Cough Insufflator/Exsufflator*
8. Enteral Feeding Supplies*
9. Feeding Pump*
10. Grab bars
11. Hand held shower head
12. Hospital Bed
13. Incontinence supplies
14. Nebulizer*
15. Ostomy Supplies
16. Oxygen concentrator*
17. Oxygen tank*
18. Patient lift
19. Personal Emergency Response System (PERS)
20. Pulse oximeter*
21. Scooter
22. Specialty mattress
23. Stander
24. Suction machine*
25. Toilet Chair
26. Tracheostomy Supplies*
27. Transfer board
28. Walker
29. Wheelchair
99. Other

Appendix C. HCBS Services

1. Adult Day Care (ADC)
2. Adult Day Health (ADH)
3. Assisted Living Facility (ALF)
4. Community Care Management Agency (CCMA) Services
11. Moving Assistance
12. Non-Medical Transportation
13. Personal Assistance Services – Level I (PA I)
14. Personal Assistance Services – Level II (PA II)

5. Counseling and Training
6. Community Care Foster Family Home (CCFFH)
7. Environmental Accessibility Adaptations (EAA)
8. Expanded-Adult Residential Care Home (E-ARCH)
9. Home Delivered Meals
10. Home Maintenance
15. Personal Assistance Services – Level II (Delegated) (PA II- Delegated)
16. Personal Emergency Response Systems (PERS)
17. Respite Care
18. Skilled (or private duty) Nursing (SN)
19. Specialized Medical Equipment and Supplies
99. Other

Appendix D. Institutional Services

1. Acute Waitlisted ICF/SNF
2. Nursing Facility (NF), Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF)
3. Sub-Acute Facility
4. Rehabilitation Center

Appendix E. Diseases

1. Asthma
2. Cancer
3. Chronic Obstructive Pulmonary Disorder (COPD)
4. Diabetes
5. End Stage Renal Disease (ESRD)
6. Heart Disease
7. Hepatitis B/C
8. High Blood Pressure
9. HIV/AIDS
10. Respiratory/Tracheostomy/Ventilator Use
11. Seizures
12. Transplant
99. Other

Appendix F. Additional Acronyms

1. **ABA** Applied Behavioral Analysis
2. **ADAD** Alcohol and Drug Abuse Division
3. **ADC** Adult Day Care
4. **ADH** Adult Day Health
5. **ADLs** Activities of Daily Living
6. **AIDS** Acquired Immunodeficiency Syndrome
7. **ALF** Assisted Living Facility
8. **AMHD** Adult Mental Health Division
9. **APS** Adult Protective Services
10. **AR** Authorized Representative
11. **ARCH** Adult Residential Care Home
12. **ASL** American Sign Language
13. **BH** Behavioral Health
14. **BMI** Body Mass Index
15. **BPM** Beats Per Minute
16. **CAGE-AID** Cut, Annoyed, Guilty, Eye-opener - Adapted to Include Drugs
17. **CAMHD** Child and Adolescent Mental Health Division
18. **CBCM** Community Based Case Management
19. **CCFFH** Community Care Foster Family Home
20. **CCMA** Community Care Management Agency
21. **CCS** Community Care Services
22. **CDPA** Consumer-Directed Personal Assistance
23. **CIS** Community Integration Services
24. **CHW** Community Healthcare Worker
25. **CM** Case Manager
26. **CMO** Comfort Measures Only
27. **CNA** Certified Nurse Assistant
28. **COVID** Coronavirus Disease
29. **CPR** Cardiopulmonary Resuscitation
30. **CSAC** Certified Substance Abuse Counselor
31. **CWS** Child Welfare Services
52. **GT** Gastrostomy tube
53. **IADLs** Instrumental Activities of Daily Living
54. **ICF** Intermediate Care Facility
55. **ID** Intellectual Disabilities
56. **ID #** Identification number
57. **IDT** Interdisciplinary Team
58. **IEP** Individual Educational Plan
59. **ISP** Individual Service Plan
60. **ITP** Individual Treatment Plan
61. **LIHEAP** Low Income Home Energy Assistance Program
62. **LOC** Level of Care
63. **LPN** Licensed Practical Nurse
64. **LSW** Licensed Social Worker
65. **LTSS** Long-Term Services and Supports
66. **L/min** Liter per minute (Oxygen concentrator setting)
67. **MCSA** Member Care Service Associate
68. **MH** Mental Health
69. **MQD** Med-QUEST Division
70. **NA** Not Available, Not Applicable, Not Appropriate
71. **NF** Nursing Facility
72. **NG** Nasogastric (tube)
73. **OB-GYN** Obstetrics-Gynecologist
74. **OT** Occupational Therapy
75. **PA** Personal Assistance
76. **PCP** Primary Care Provider
77. **PERS** Personal Emergency Response Systems
78. **PHN** Public Health Nurses
79. **PHQ** Patient Health Questionnaire
80. **POA** Power of Attorney
81. **POLST** Provider Orders for Life-Sustaining Treatment

32. **DD** Developmental Disabilities
33. **DDD** Developmental Disabilities Division
34. **DHS** Department of Human Services
35. **DOE** Department of Education
36. **DOH** Department of Health
37. **EAA** Environmental Accessibility Adaptations
38. **E-ARCH** Expanded Adult Residential Care Home
39. **EHCN** Expanded Health Care Needs
40. **EPSDT** Early and Periodic Screening, Diagnostic, Treatment
41. **ER** Emergency Room
42. **FIO2** Fraction of Inspired Oxygen
43. **HFA** Health and Functional Assessment
44. **HAP** Health Action Plan
45. **HC** Health Coordinator(s)
46. **HCBS** Home and Community-Based Services
47. **HH** Home Health
48. **HIV** Human Immunodeficiency Syndrome
49. **HP** Health Plan
50. **GHP** Going Home Plus
51. **G/J** Gastrojejunostomy (tube)
82. **PPD** Purified Protein Derivative
83. **PS** Pressure support (ventilator setting)
84. **PSD** Department of Public Safety
85. **PT** Physical Therapy
86. **QI** QUEST Integration
87. **RN** Registered Nurse
88. **SDOH** Social Determinants of Health
89. **SHCN** Special Health Care Needs
90. **SHOTT** State of Hawaii Organ and Tissue Transplant
91. **SMES** Specialized Medical Equipment/Supplies
92. **SN** Skilled Nursing (Private Duty)
93. **SNAP** Supplemental Nutrition Assistance Program
94. **SNF** Skilled Nursing Facility
95. **SRF** Social Risk Factors
96. **SSI** Supplemental Security Income
97. **ST** Speech Therapy
98. **SW** Social Worker
99. **SUD** Substance Abuse Disorder
100. **TB** Tuberculin
101. **TPN** Total Parenteral Nutrition
102. **VOC Rehab** Vocational Rehabilitation Division
103. **Vt** Tidal Volume (ventilator setting)

Appendix G. Glossary

For A2.a: Reason for Assessment

1. **Initial** – An assessment that is conducted for the first time.
2. **6-month assessment –** An assessment that is conducted every six (6) months for a member in CCFFH, E-ARCH, and ALF.
3. **Annual –** An assessment that is conducted every 12 months.
4. **Member Request** – An assessment that is conducted at member's request.
5. **Change of Condition/Status –** An assessment conducted other than what is listed above. Enter other type of assessment e.g., a reassessment that is conducted within ten (10) days when significant events occur in the life of a member, including but not limited to, the death of a caregiver, significant change in health status, change in living arrangement, institutionalization and change in provider(s) (if the provider(s) change affects the service plan) follow up reassessment, request by Member or authorized representative when Member is experiencing any changes in situation or condition

For A3.d: Emergency Plan

Emergency Back-up plan – this is to ensure member has emergency caregivers, transportation, and DME/life support.
Emergency Plan – this is to ensure there is a plan for natural disasters.

For B2.a: Primary Means of Communication

i) **Verbal –** Member is able to communicate verbally.
ii) **Non-Verbal –** Member is unable to communicate verbally but is able to communicate by using hand gestures, facial expressions, eye contact, body language, etc.
iii) **Written –** Member is unable to communicate verbally but prefers to and able to communicate in writing.
iv) **American Sign Language –** Member is able to communicate through Sign Language primarily used in the United States.
v) **Other –** Enter type of communication, e.g., speech communicating device, etc.

For B3.a: Living Arrangement

i) **Alone –** Lives by self.
ii) **With spouse/partner only –** Lives with spouse or partner, boyfriend or girlfriend.
iii) **With spouse/partner and other(s) –** Lives with spouse or partner and other individual(s), whether family or unrelated.
iv) **With child (not spouse/partner) –** Lives with child(ren) only, or child(ren) and other individual(s) but not spouse or partner.

v) **With parent(s)/guardian(s) –** Lives with parent(s) or guardian(s) only, or with parent(s) or guardian(s) and other individual(s) but not spouse or partner or child(ren).
vi) **With sibling(s) –** Lives with sibling(s) only, or sibling(s) and other individual(s) but not spouse or partner, parent(s) or guardian(s) or child(ren).
vii) **With other relative(s) –** Lives with relative(s) (i.e., aunt or uncle) only, or relative(s) and other individual(s) but not spouse or partner, parent(s) or guardian(s), sibling(s) or child(ren).
viii) **With non-relative(s) –** Lives in a group setting (e.g., NF, CCFFH, etc).
ix) **Other**

For B3.b: Residence

i) **Own private house/apartment –** Any house, apartment, or condominium owned by the member.
ii) **Rent private house/apartment/room –** Any house, apartment, condominium, or room rented by the member.
iii) **Houseless (with or without shelter) –** Member has no permanent residence (a house, apartment, condominium, room, or a place to stay on a regular basis). Member may reside on the streets, in a car, in open areas, or at a homeless shelter, e.g., Institute for Human Services (IHS), etc.
iv) **At risk of houselessness** – Member who will lose their primary nighttime residence.
v) **Assisted Living Facility (ALF) –** A licensed facility that consists of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.
vi) **Adult Residential Care Home (ARCH) –** A licensed facility that provides twenty-four (24) hour living accommodations, for a fee, for five unrelated people who require minimal assistance in the activities of daily living and do not need assistance from skilled, professional personnel on a regular long-term basis.
vii) **Expanded-Adult Residential Care Home (E-ARCH) –** A licensed facility that provides twenty-four (24) hour living accommodations, for a fee, for five unrelated people who require at least minimal assistance in the activities of daily living and who may need the professional health services provided in an intermediate care facility or skilled nursing facility. There are two types of E-ARCHs:
Type I – allowing five (5) or fewer residents and up to six (6) residents may be allowed at the discretion of the department with no more than (3) nursing facility level residents; and
Type II – allowing six (6) or more residents with no more than twenty (20%) nursing facility level residents of the home's licensed capacity.
viii) **Foster Home (Children) –** A home that a minor has been placed into as a ward of the State.
ix) **DD Adult Foster Home/DD Dom – DD Adult Foster Home –** A private home in which care, training, and supervision are provided on a twenty-four (24) hour basis for not more than two (2) adults with developmental or intellectual disabilities (DD/ID) who are unrelated to the foster family at any point in time. **DD Domiciliary Homes** – Individuals in a DD Dom setting need supervision or care, but do not need the professional health services of a registered nurse. A DD Dom serves adults with intellectual or developmental disabilities (DD/ID) unrelated to the caregiver. A DD Dom is allowed to serve up to five (5) DD/ID individuals.
x) **Community Care Foster Family Home (CCFFH) –** A certified home that provides twenty-four (24) hour living accommodations, including personal care and homemaker services.
xi) **Nursing Facility (NF) –** A licensed facility that provides appropriate care to persons referred by a physician. Such persons are those who: need twenty-four (24) hour a day assistance with the normal activities of daily living; need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis; and, may have a primary need for twenty-four (24) hours of skilled nursing care on an extended basis and regular rehabilitation services.
xii) **NF transition –** Member is currently residing in a NF and with ongoing discharge planning.
xiii) **Rehabilitation hospital/unit –** Any licensed acute care facility, e.g., Rehabilitation Hospital of the Pacific, in the service area to which a member is admitted to rehabilitation services pursuant to arrangements made by a physician.
xiv) **Psychiatric hospital/unit –** Any licensed acute care facility, e.g., Kahi Mohala Behavioral Health, Kekela at Queens Medical Center, in the service area to which a member is admitted to receive psychiatric services pursuant to arrangements made by a physician.
xv) **Acute care hospital –** Any licensed acute care facility in the service area to which a member is admitted to receive. inpatient services pursuant to arrangements made by a physician.
xvi) **Acute care hospital transition –** Member is currently in an acute care hospital and with ongoing discharge planning.

xvii) **Other –** If "Other," enter current residence e.g., ICF-ID

xviii) **Other/Transition** – Member is currently in a setting not listed above **(**e.g., prison or state hospital)

For G3: Mood, Behavior, and Psychological Well-Being

a) PHQ-2 – Code items i and ii following the guideline below:

Not at all – No problems.

Several days – Has been bothered at least 1-6 days.

More than half the days – Has been bothered at least 7-11 days.

Nearly every day – Has been bothered at least 12-14 days.

STATE OF HAWAII
Health Action Plan Instructions

General Instructions:
In accordance with the HCBS Setting Final Rule issued in January 2014, the health action plan must be person-centered 42 CFR 441.301 (C) (1)-(2). eCFR: 42 CFR 441.301 -- Contents of request for a waiver.

For the header:

1. Provide the Initial Health Action Plan (HAP) Date. The Initial HAP Date at the top of the page represents the date of the first HAP for the member.
2. Provide the Member Name, Member Medicaid ID#, and HAP Date.
   For the initial assessment, the HAP Date is the same as the initial HAP date. For each reassessment, the HAP Date is the same as the date of the reassessment.

Indicate the member's age cohort by checking the appropriate box.
Indicate the member's program type by checking the appropriate box.

SECTION A. AUTHORIZATION OF MY SUPPORT SERVICES

A1. Member/Authorized Representative (AR).

This section is member or AR's attestation indicating that they directed the HAP meeting to the maximum extent possible; the member and/or AR was enabled to make informed choices and decisions in the meeting; and, the member and/or AR reviewed and agreed to the support services written in the plan.

1. Provide the member's name, signature, and date.
2. Provider the AR's name, signature, and date.
3. Indicate who directed the meeting. If someone other than the member directed the meeting, explain why.

A2. Health Coordinator(s) (HC)

1. Provide the lead health coordinator's name, signature, title, and date.
2. Provide the consulting health coordinator's name, signature, title, and date.

A3. Copy of HAP given to

1. Provide the names of the PCP and support provider(s).
2. Give/Send a copy of the HAP to the Primary Care Provider's (PCP) and the support provider(s).

MY CAREGIVERS (INTERDISCIPLINARY TEAM (IDT))

1. Provide the designated point of contact for all IDT members.
2. List all natural supports, caregivers, and other providers who are involved in the member's care. Indicate whether these individuals are invited and/or attend any of the IDT meetings by checking the box under yes, no, or not applicable (n/a).
   Provide business or agency name in the spaces provided, if applicable.

SPECIAL INSTRUCTIONS

1. Check the appropriate box(es) to indicate whether the listed information is available and up to date.

Information	Additional instructions	Location in the HFA
Advance Directives	Attach copy to the HAP	A3.b.iv
POLST	Specify the location of POLST copy in the home. Check boxes to indicate code status and treatment based on the POLST.	A3.b vi-viii A3.d Attachment QI Individualized Emergency Back-Up Plan
Emergency Contact List		A3.c A3.d Attachment QI Individualized Emergency Back-Up Plan
Infection Control Guidelines	Refer to "Resources/Handouts for Infection Control in the Home" section of this instructions	
List of Allergies		F3.viii
Recent (within 90 days) Hospitalization	Recent means since the last HAP update or within the last 90 days	F7.b
Recent (within 90 days) ER visit	Recent means since the last HAP update or within the last 90 days	F7.c
Fall Risk		G4.b (including Attachment for Fall Risk Assessment)

2. Provide "Other" information, if appropriate.

SECTION B to J. MY GOALS AND MY ACTIONS

Complete this section using member's own words as much as possible. Document the findings identified in the HFA sections B-J using the template provided in this section.

Important TO me (My Goals)	Enter the member's (person-centered) desired outcome. Check the box to indicate that the goal has been met.
Start Date	Enter the start date of the goal.
Modified Date:	Enter the date that a revision was made to the member's HAP for each need identified, if applicable. If no revision was made or member declined, enter "N/A".
Next Review Date	Enter the next review date of the goal with the member.
My strengths and great things about me	Enter the member's strengths related to the member's identified goal. Enter things that other people like and admire or other great things about the member.
My Preferences/Choices	Enter member's preferences and choices related to the member's identified goal.
Barriers	Identify and enter any barriers to the member completing the action(s).
Past Efforts to Meet Goal	Enter prior efforts the member has made to meet this goal previously. Both successful and unsuccessful efforts should be documented, as well as the approximate time frame these efforts were made.
Important FOR me (My Actions)	Enter the actions or interventions that move the member towards the identified goal. These are the steps that will be taken to assist the member in reaching the desired outcome.
Who Will Help Me	Identify and enter who will assist the member in performing the action, in applicable. The member may specify that they will complete this action alone.
Action Progress	Track progress of the specific action. The HC will mark whether the action has 'Not Started', is 'In Progress', has been 'Completed', or 'Member declined'. This will help the member track their progress towards meeting their goal.
Progress Note	The HC and member can use this section to update notes specific to the action. It can be used to demonstrate why an action has not yet been started, or why an action has remained in progress.

Example:

Important TO me (My Goal) # 1: *I will remain in my home.* **Start Date:** *12 / 12 / 2023* **Modified Date:** _____/ _____/ _____ **Next Review Date:** *01 / 12 / 2024*
☐ **Please check this box when member has attained this goal.**

My strengths and great things about me	**My Preferences/Choices**	**Barriers**	**Past Efforts to Meet Goal (Include successful & unsuccessful efforts**
I can feed myself after my meal has been set up in front of me. *People tell me that they love my determination no matter the hardships I have faced.*	*I prefer to remain in my home with assistance from my family and/or other paid caregivers.*	*I need assistance in my ADLs due to left-sided weakness from stroke 2 years ago.*	*Successful - My family assisted when any of the paid caregivers were not available in the past 2 years.*
What is important FOR me (My Actions)	**Who Will Help Me**	**Action Progress**	**Progress Note**
I will have assistance in shopping for food and preparing meals for the next 3 months.	*Home Health Agency or my mother*	☐ **Not Started** ☒ **In Progress** ☐ **Completed** ☐ **Member declined**	*I continue to need assistance in shopping for my food and preparing my meals.*
I will continue to feed myself after my meal has been set up in front of me for the next 3 months	*No help*	☐ **Not Started** ☒ **In Progress** ☐ **Completed** ☐ **Member declined**	*I continue to be independent.*
		☒ **Not Started** ☐ **In Progress** ☐ **Completed** ☐ **Member declined**	

SECTION F. DISEASE MANAGEMENT/EDUCATION

This section is for members that need referrals for disease management/education.
In the first column, identify and enter learning needs related to the different diagnoses listed in Section F1. Disease Diagnosis (es) in the HFA. For each learning need, enter the provider's name and contact information, frequency/amount and duration of service, and any relevant information in the subsequent columns.
Document frequency/amount of services provided per week, e.g., 10 hours per week, 2 sessions per week, 10 times per week.

SECTION F-G. MY SUPPORT PLAN DETAILS

Complete this section to indicate the tasks that need to be completed by the health plan, paid caregiver, or self-directed PA services based on member's needs, risks, and issues as identified in sections F-G in the HFA.

1. Check all applicable tasks to the member.
2. Document frequency/amount of services provided per week, e.g., 10 hours per week, 2 sessions per week, 10 times per week.
   Enter specific instructions which may include member's personal preferences, member's abilities, instructions for agencies, and doctor's orders, if applicable. Examples include:
   - Special lotion
   - Time of bath
   - Member has right-sided weakness.
   - Member to comb own hair or brush own teeth.
   - Document observation of wound size, odor, drainage, etc. when performing wound care.
   - Toileting hygiene: The ability to maintain perineal/feminine hygiene, adjust clothes before and after toileting. If managing an ostomy, include wiping the opening but not managing equipment.
3. Note that tasks with an asterisk (*) are to be completed by skilled nursing RN/LPN only.

SECTION I. MY SUPPORT PLAN

Complete this section using information from section I in the HFA.

1. Check all services and supports applicable to the member.
2. Identify and enter the start date, the provider(s) (including natural supports), the frequency/amount, and duration of each of the services and supports.
   Document frequency/amount of services provided per week, e.g., 10 hours per week, 2 sessions per week, 10 times per week.
3. Complete I3.d. Referrals for members that require referrals for service(s)/specialty(ies). Identify and enter the type of referral, the provider's name and contact information, the frequency/amount and duration of the service and support, and any additional relevant comments.
   Document frequency/amount of services provided per week, e.g., 10 hours per week, 2 sessions per week, 10 times per week.

Items that do not apply to the member:

1. *should be marked N/A*
2. *may be collapsed or hidden from view to provide a member-specific HAP print out.*

SECTION K. SUPPORT PROVIDER RESPONSIBILITIES

1. All LTSS HAP must identify the Consulting Health Coordinator. The HC will check all team member responsibilities that apply to the member. Check "Other" for responsibilities that are not listed and describe.
2. Fill in the text boxes, if appropriate.

SECTION L. ADDITIONAL COMMENTS

1. This section is for text entry for any additional relevant comments that should be communicated to the member or the caregiver that is not otherwise captured in the HAP. Examples include safety concerns, pet information, gaps in care. If not applicable to the member, it is not required to be filled out.
   This section may also be used to enter any risk modification plan(s) based on the results of the following surveys (Refer to the Health Plan Manual - Appendices):
   a. Appendix AC: HCBS Provider Attestation and Evidence Tool
   b. Appendix AE: Health Plan HCBS Member Satisfaction Survey
2. Identify and enter other areas of concern identified in the HFA and prioritize.

Resources/Handouts for Infection Control in the Home

Hand Hygiene

New_HandWash_Poster (who.int)

When and How to Wash Your Hands | Handwashing | CDC

Standard Precautions

Standard Precautions (cdc.gov)

WHO-UHL-IHS-IPC-2022.1-eng.pdf

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1. BiPAP/CPAP 2. Catheter care 3. Chemotherapy 4. Chest physiotherapy 5. Cough Insufflator/Exsufflator* 6. Dialysis 7. Enteral Feeding* 8. Home Health 9. Hospice care 10. IV therapy* 11. Occupational therapy 12. Oxygen therapy	13. Palliative care 14. Personal Emergency Response System (PERS) 15. Physical therapy 16. Psychological therapy 17. Radiation 18. Respiratory therapy 19. Speech language therapy 20. Suctioning* 21. Tracheostomy care* 22. Transfusion 23. Ventilator care* 24. Wound care* 99. Other
Appendix B. Medical Equipment and Supplies	
1. Bath chair/shower bench 2. BiPAP/CPAP 3. Cane 4. Catheter Supplies 5. Chest Vest 6. Commode 7. Cough Insufflator/Exsufflator* 8. Enteral Feeding Supplies* 9. Feeding Pump* 10. Grab bars 11. Handheld shower head 12. Hospital Bed 13. Incontinence supplies 14. Nebulizer* 15. Ostomy Supplies	16. Oxygen concentrator* 17. Oxygen tank* 18. Patient lift 19. Personal Emergency Response System (PERS) 20. Pulse oximeter* 21. Scooter 22. Specialty mattress 23. Stander 24. Suction machine* 25. Toilet Chair 26. Tracheostomy Supplies* 27. Transfer board 28. Walker 29. Wheelchair 99. Other
Appendix C. HCBS Services	
1. Adult Day Care (ADC) 2. Adult Day Health (ADH)	10. Home Maintenance 11. Moving Assistance

3. Assisted Living Facility (ALF) 4. Community Care Management Agency (CCMA) Services 5. Counseling and Training 6. Community Care Foster Family Home (CCFFH) 7. Environmental Accessibility Adaptations (EAA) 8. Expanded Adult Residential Care Home (E-ARCH) 9. Home Delivered Meals	12. Non-Medical Transportation 13. Personal Assistance Services – Level I (PA I) 14. Personal Assistance Services – Level II (PA II) 15. Personal Assistance Services – Level II (Delegated) (PA II-Delegated) 16. Personal Emergency Response Systems (PERS) 17. Respite Care 18. Skilled (or private duty) Nursing (SN) 19. Specialized Medical Equipment and Supplies 99. Other
Appendix D. Institutional Services	
1. Acute Waitlisted ICF/SNF 2. Nursing Facility (NF), Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF)	3. Sub-Acute Facility 4. Rehabilitation Center
Appendix E. Diseases	
1. Asthma 2. Cancer 3. Chronic Obstructive Pulmonary Disorder (COPD) 4. Diabetes 5. End Stage Renal Disease (ESRD) 6. Heart Disease 7. Hepatitis B/C	8. High Blood Pressure 9. HIV/AIDS 10. Respiratory/Tracheostomy/Ventilator use 11. Seizures 12. Transplant 99. Other
Appendix F. Acronyms	
1. **ADAD** Alcohol and Drug Abuse Division 2. **ADC** Adult Day Care 3. **ADH** Adult Day Health 4. **ADLs** Activities of Daily Living 5. **AIDS** Acquired Immunodeficiency Syndrome 6. **ALF** Assisted Living Facility 7. **AMHD** Adult Mental Health Division 8. **APS** Adult Protective Services 9. **AR** Authorized Representative 10. **ARCH** Adult Residential Care Home 11. **ASL** American Sign Language 12. **BH** Behavioral Health 13. **BMI** Body Mass Index 14. **CAMHD** Child and Adolescent Mental Health	41. **HCBS** Home and Community-Based Services 42. **HH** Home Health 43. **HIV** Human Immunodeficiency Syndrome 44. **G-tube** Gastrostomy tube 45. **IADLs** Instrumental Activities of Daily Living 46. **ICF** Intermediate Care Facility 47. **ID** Intellectual Disabilities 48. **ID #** Identification Number 49. **IDT** Interdisciplinary Team 50. **LIHEAP** Low Income Home Energy Assistance Program 51. **LOC** Level of Care 52. **LPN** Licensed Practical Nurse 53. **LSW** Licensed Social Worker 54. **LTSS** Long-Term Services and Supports

Division
15. **CBCM** Community Based Case Management
16. **CCFFH** Community Care Foster Family Home
17. **CCMA** Community Care Management Agency
18. **CCS** Community Care Services
19. **CDPA** Consumer-Directed Personal Assistance
20. **CIS** Community Integration Services
21. **CHW** Community Healthcare Worker
22. **CM** Case Manager
23. **CMO** Comfort Measures Only
24. **CNA** Certified Nurse Assistant
25. **CPR** Cardiopulmonary Resuscitation
26. **CSAC** Certified Substance Abuse Counselor
27. **CWS** Child Welfare Services
28. **DD** Developmental Disabilities
29. **DDD** Developmental Disabilities Division
30. **DHS** Department of Human Services
31. **DOE** Department of Education
32. **DOH** Department of Health
33. **EAA** Environmental Accessibility Adaptations
34. **E-ARCH** Expanded Adult Residential Care Home
35. **EHCN** Expanded Health Care Needs
36. **EPSDT** Early and Periodic Screening, Diagnostic, Treatment
37. **ER** Emergency Room
38. **FIO2** Fraction of Inspired Oxygen
39. **HAP** Health Action Plan
40. **HC** Health Coordinator(s)
55. **L/min** Liter per minute (Oxygen concentrator setting)
56. **MCSA** Member Care Service Associate
57. **MH** Mental Health
58. **MQD** Med-QUEST Division
59. **NF** Nursing Facility
60. **OB-GYN** Obstetrics-Gynecologist
61. **OT** Occupational Therapy
62. **PA** Personal Assistance
63. **PCP** Primary Care Provider
64. **PERS** Personal Emergency Response Systems
65. **PHN** Public Health Nurses
66. **POA** Power of Attorney
67. **POLST** Provider Orders for Life-Sustaining Treatment
68. **PS** Pressure support (ventilator setting)
69. **PSD** Department of Public Safety
70. **PT** Physical Therapy
71. **RN** Registered Nurse
72. **SHCN** Special Health Care Needs
73. **SMES** Specialized Medical Equipment/Supplies
74. **SN** Skilled Nursing (Private Duty)
75. **SNAP** Supplemental Nutrition Assistance Program
76. **SNF** Skilled Nursing Facility
77. **ST** Speech Therapy
78. **SW** Social Worker
79. **SUD** Substance Abuse Disorder
80. **VOC Rehab** Vocational Rehabilitation Division
81. **Vt** Tidal Volume (ventilator setting)