

<p>Standard 27</p> <p><u>Family Caregiver Health Promotion Activity Plans or HPAPs:</u> HCBS Waiver providers who offer High Acuity In-Home Supports shall develop HPAPs for people receiving this waiver service. Providers shall train the person, family and caregivers - including day program staff - on HPAPs and how to operationalize them.</p> <p>Required for: Anyone enrolled in the HCBS Waiver receiving High Acuity In-Home Supports.</p> <p>Recommended for: N/A</p>	<p>Family Caregiver Health Care Management Plans or Health Promotion Activity Plans (HPAPs)</p> <p>Family Caregiver Health Care Management Plans, also referred to as Health Promotion Activity Plans (HPAPs) are diagnosis-specific documents developed by a provider RN for a person receiving High Acuity in Home Supports through the Developmental Disabilities Administration (DDA). HPAPs are designed to plan supports for a person based upon his or her health care diagnoses and prescribed treatment. They are individualized to the person and include a definition of the person’s conditions, signs and symptoms, and a plan of action to address each condition.</p> <p>HPAPs summarize the person’s diagnosis, care and treatment information, for use by the person and their caregivers, including family, other natural supports, and day program staff. A person may have multiple HPAPs, depending on their medical conditions. For example, a person may have one HPAP for seizure disorder, and another for hypertension. Protocols should also be included, for example seizure, fall or aspiration protocols. By following the treatment and care outlined in a person’s HPAPs, and receiving training on them, a person, his or her Qualified Intellectual Disabilities Professionals (QIDPs), Direct Support Professionals (DSPs) whether at the person’s home or during daily activities, and family should be able to maintain the person’s optimal health within their scope of practice.</p> <p>More than 100 diagnostic examples are available online: https://www.pchc.org/resources/hpaps. Please note that while the diagnostic examples may be used as the template when a person has the corresponding condition, the HPAP must be individualized to the person. The High Acuity In-Home Support provider is responsible for uploading completed HPAPs into MCIS under the Clinical Services tab.</p>	<p><u>Documentation:</u> For people who receive DDA High Acuity In-Home Supports, the provider’s RN in cooperation with the person, family caregivers, QIDPs and DSPs, shall create HPAPs, aimed at improving the person’s health care and health. The RN shall use the established template to individualize HPAPs for the person’s diagnoses. The RN is responsible for documenting all required training on the HPAPs. HPAPs must be uploaded to MCIS.</p>
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HPAP Components

HPAPs are an effective way to plan health care activities for various diagnoses. They are developed by the provider's Registered Nurse (RN). HPAPs shall include useful general information on diagnoses and be individualized to a person's needs and address specific diagnoses in terms of:

- Relevant body system
- General definition
- General signs and symptoms
- Signs and symptoms specific to the individual
- Details of the strategy needed to promote or support the person
 - Information on how to support the health condition
 - Who should be called for changes or problems in the person's health condition
- What kind of documentation is tracked and who is responsible for follow-up?
- What type of ongoing training is needed for caregivers to support this person's health condition? And for how long?
- Frequency of support
- Desired outcome
- Person (family member, caregiver, etc.) or agency responsible

HPAPs are living documents appropriate for both chronic and acute conditions involving diagnosis, care and/or treatment. For those new to these supports, HPAPs must be initiated by the RN within 30 days of admission. The RN's signature and the date of any updates including annual reviews must be documented on the last page of the HPAPs. HPAPs shall be revised at least annually by the RN and presented at the person's ISP meeting by the nurse or his/her designee. Subsequent revisions shall be made as-needed, based on changes in the person's health status. The HPAPs should be revised if the person receives new diagnoses and/or exhibits a change in health status, or the HPAP is deemed

ineffective. These updates must be done within 7 days of identifying the new health concern.

Desired Outcomes

The HPAP includes the identification of “Desired Outcomes.” It is important to identify desired outcomes in collaboration with the person to the fullest extent possible in keeping with their preferences and goals identified through the person centered thinking process.

Health care that is focused on outcomes:

- Person-Centered HPAP
- Promotes the participation of the person in their own health care
- Clearly communicates the expectations for the plan of care
- Promotes accountability
- Desired outcomes:
 - Focus on the person and are a part of person-centered thinking
 - Consist of clear and concise statements
 - Are measurable
 - Are time-limited
 - Present realistic goals
 - Represent a mutual decision between the nurse, the person and any health care decision-maker

Role of Registered Nurses

RNs charged with creating HPAPs do not treat or care for a person as part of their HPAP responsibilities; the role is the distinct one: RNs train Licensed Practical Nurses (LPNs), QIDPs, DSPs, family members and other natural supports on their responsibilities outlined in the person’s HPAPs to meet those responsibilities to improve health outcomes. RNs also train the trainers, meaning that RNs train LPNs and QIDPs on how to train others on the person’s HPAPs. The RN may also train the family member to train other natural supports. Here are some examples. For migraines, while a physician may recommend one or more specific medications, the RN may include

on the HPAP that the family ensure that the person rests in quiet, calm, dark environment with their head slightly elevated (see the HPAP for migraines). For diabetes, the nurse creating the HPAP might recommend that those involved in daily care of the person check the feet and skin are checked daily for red or open areas (see the HPAP for diabetes).

Below are the top three responsibilities for the RN in the development and implementation of HPAPs.

1. Cooperating with the person, LPNs, QIDPs, DSPs and family, the nurse will develop HPAPs in accordance with the DDS Health and Wellness Standards.
2. Presenting and explaining the HPAPs to the person, family, QIDPs and LPN, if available.
3. Providing training on diagnoses, treatment and care listed in HPAPs to the QIDPs and/ or LPNs, training the trainers, and coordinating such training with the QIDPs for the person, family and any other residents of the person's home who provide natural (unpaid) supports, and residential and day program staff. This training may be completed by the RN, or a QIDP or LPN who received train-the-trainer session on the HPAP by the RN.
4. Ensuring all paid support staff have requisite knowledge to carry out delegated functions

Role of the Qualified Intellectual Disabilities Professional

The QIDP serves as an integral part of a health services team and supports professionals working collaboratively with a person, nurses and other health personnel, day services, DSPs and the person's family and other natural supports. In settings where RNs are part of the support team, the QIDP and the RN must work collaboratively. While the RN is responsible for the development of the HPAPs, the QIDP must be knowledgeable of all aspects of the plan and would be expected to reference the HPAP when discussing the health

support needs of a particular person as part of a support team meeting or monitoring session, with the exception of the critical parameters outlined below. The QIDP must be knowledgeable about: (1) signs and symptoms to report to the RN or a supervisor that may indicate a change in health status (2) specific diet, behavioral and positioning protocols and (3) their responsibilities as outlined in each person's HPAPs.

QIDPs And DSPs Must Know And Follow Protocols

In addition to knowing these critical reporting parameters, QIDPs are expected to know the following specific information about the people they support:

1. Diet restrictions related to diabetic, low sodium, fluid restricted or calorie restricted diets.
2. Recognition of high or low glucose and emergency procedures for people with insulin-dependent diabetes.
3. Food, environmental, seasonal or drug allergies.
4. Seizure recognition and first aid.
5. Existence of mealtime, positioning and behavioral support plans and protocols.
6. Use of adaptive equipment including internal devices such as pacemakers, baclofen pumps and shunts.
7. When to activate the Emergency Response System (911) and when to initiate Cardio-Pulmonary Resuscitation (CPR) or the Heimlich maneuver.

The skills of the QIDP are essential to attaining the desired outcomes articulated within the HPAPs.

Role of Direct Support Professionals (DSPs)

The HPAPs delineate the interventions that are the responsibility of the DSP. The DSP needs to be

	<p>able to demonstrate competency to complete interventions that relate to their assigned duties. The DSP is expected to reference the HPAP when discussing the health support needs of the person with the QIDP and the person’s family or other caregivers.</p> <p>The National Association of Direct Support Professionals (DSP) Code of Ethics (https://www.nadsp.org/code-of-ethics-text/) notes that one of the responsibilities for a DSP is to support “...the emotional, physical, and personal well-being of the individuals receiving support.” The code goes on to define how this is implemented to include vigilance “in identifying, discussing with others, and reporting any situation in which the individuals I support are at risk of abuse, neglect, exploitation or harm.”</p> <p>INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program to improve the identification, evaluation, and communication about changes in a vulnerable person’s status. It was first designed in a project supported by the Centers for Medicare and Medicaid Services and evaluated in 30 nursing homes in New York and Massachusetts. Due to the effectiveness of the program, today it is used in many nursing homes across the country. One of the tools developed by INTERACT is a communication tool that uses the mnemonic <i>Stop and Watch</i> to train staff on important observations to make and report. DSPs are trained to report changes they note immediately to their supervisor who follows the protocol identified by their agency for reporting health changes. Depending on the setting and the independence of the person, the person themselves may call their primary care provider, or an agency RN is notified who then triages the information for relay to the PCP or the activation of emergency medical services.</p> <p>DSPs need to be able to report observable changes in the person that may indicate a change in health states and address specific diet or activities of daily living needs outlined in the HPAP.</p>	
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Observable Changes

DSPs need to be trained on the elements of *Stop and Watch* and reporting protocols for the individual and their agency.

The essential observations include:

- ✓ **S**eems different than usual
- ✓ **T**alks or communicates less
- ✓ **O**verall needs more help
- ✓ **P**ain, new or worsening. Participates less in activities.

- ✓ **a**te less
- ✓ **n**o bowel movement in three days – or diarrhea
- ✓ **d**runk less

- ✓ **W**eight change
- ✓ **A**gitated or nervous more than usual
- ✓ **T**ired, weak, confused or drowsy
- ✓ **C**hange in skin color or condition
- ✓ **H**elp with walking, transferring or toileting more than usual

Agency policies need to outline DSP training and reporting protocols.