



## Care for Older Adults assessment

### What is the Care for Older Adults assessment form?

The National Committee for Quality Assurance (NCQA) has developed a set of metrics called the Healthcare Effectiveness Data and Information Set (HEDIS®). Under the HEDIS umbrella is a set of measurements specific to the care for older adults. The measurements look for evidence of:

- Advance care planning
- Medication review
- Functional status assessment
- Pain assessment

### Who is considered for the Care for Older Adults assessment?

- Patients 66 years old and older enrolled in a Special Needs Plan (SNP)
- Patients enrolled in a SNP and are either dual-eligible for Medicare and Medicaid and/or have a chronic condition

To determine if a Humana-covered patient is enrolled in a SNP, please check his or her eligibility and benefits.

### Why should I complete this form?

- This form serves as a tool to assess and address issues identified as common among older adults who are dual-eligible for Medicare and Medicaid and/or are chronically ill.
- This form allows Humana to improve care coordination for its members.

### Who can complete this form?

Any practitioner with prescribing rights can complete this form. Depending on your state, this may include:

- Licensed medical physicians
- Licensed nurse practitioners
- Licensed physician assistants

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).



Care for Older Adults assessment

Patient name: \_\_\_\_\_ Date of service: \_\_\_\_/\_\_\_\_/\_\_\_\_(mm/dd/yyyy)

Member ID: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_(mm/dd/yyyy)

Physician name: \_\_\_\_\_

This document is intended to capture requested clinical quality information only. Other write-in information will not be considered.

Prescription (Rx)	Dosage	Disease being treated/reason for medication	Side effects discussed
			<input type="checkbox"/>

Functional assessment: Does patient have difficulties performing the following activities? Date assessed: \_\_\_\_\_

Bathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Transferring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Dressing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Using the toilet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Eating	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Treatment plan discussed with patient

- Occupational therapy referral
- Review of Rx
- Physical therapy referral
- Assistive device evaluation

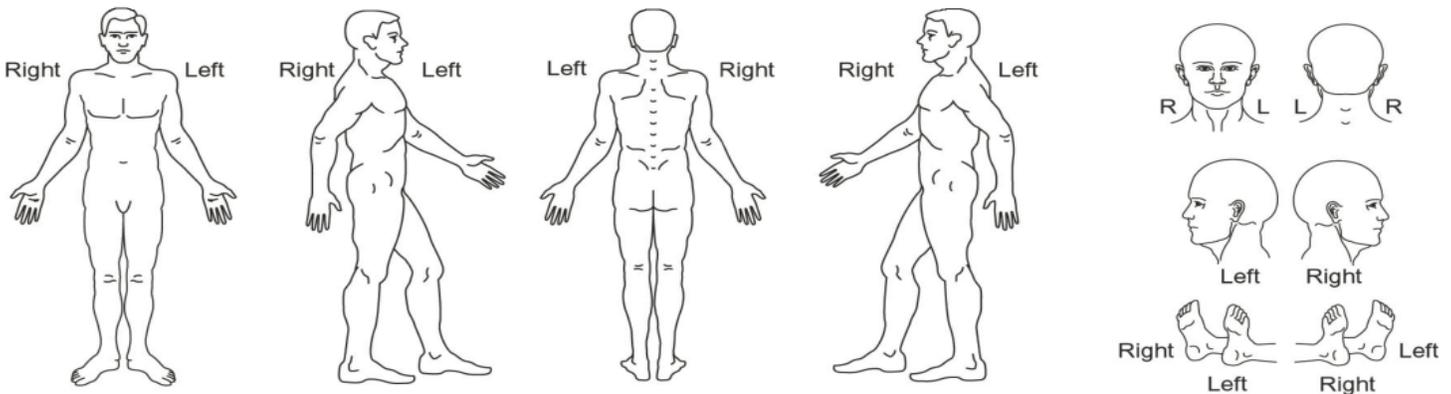
Physical activity assessment Date assessed: \_\_\_\_\_

Patient is physically active	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient is active 30 minutes a day most days of the week	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient plans to become active in the next few months	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient expresses fear to become active or participate in physical activity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient participates in activity regularly	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, what type?	_____	

Patient advised:  Daily walks  Stretching  Start taking the stairs  Increase walking as tolerated

Advance care planning:  Advance directive in medical record Discussion on \_\_\_\_/\_\_\_\_/\_\_\_\_

Pain assessment Date assessed: \_\_\_\_\_



Pain intensity (0 lowest to 10 highest) \_\_\_\_\_ Present pain \_\_\_\_\_ Worst pain \_\_\_\_\_ Best pain \_\_\_\_\_

Quality of pain: \_\_\_\_\_ Onset, duration, variation and rhythms? \_\_\_\_\_

What causes the pain? \_\_\_\_\_ What relieves the pain? \_\_\_\_\_



Patient name: _____	Date of service: ____/____/____(mm/dd/yyyy)
Member ID: _____	Date of birth: ____/____/____(mm/dd/yyyy)

**Affirmation statement:**

The physician acknowledges and agrees that Humana may update and adjust this template form as necessary. Updated forms are available at [Humana.com/provider/medical-resources/clinical/quality-resources](http://Humana.com/provider/medical-resources/clinical/quality-resources), under the Preventive Care tab.

Medicare payment to Medicare Advantage organizations is based, in part, on each patient’s diagnosis, as attested to by the patient’s attending physician by virtue of his or her signature on this medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to a fine, imprisonment or civil penalty under applicable federal laws.

By signing this document, you attest to reviewing the medical documents to complete the form, using the best of your medical knowledge, placing the completed original of this form in the patient’s medical record and ensuring fully documented proof of service of all completed fields is contained in the patient’s medical record. (Note: If the practice has an electronic medical record system, scan the assessment and attach the image to the electronic record.)

To the best of my knowledge, information and belief, the information provided regarding diagnoses is truthful and accurate.

Physician name and credentials (printed)	Physician signature and credentials (signed)	Date
Provider office number: ( ) - _____	Provider: _____	Type: _____
Billing provider ID: _____	National Provider ID: _____	Tax ID number: _____
Provider address: _____		
Street address		
_____	_____	_____
City	State	ZIP code

**Submitting a completed form**

**Method 1**

Upload electronic health records directly to Humana using the fast and secure provider portal by following these steps:

1. Go to the secure upload site at [www.submitrecords.com/humana](http://www.submitrecords.com/humana) and enter the password **hfstar83**.
2. Click the “Add files” button and choose the medical record(s) from your browser, then choose “Open.” You can upload single records as PDFs or tag image file formats (TIFFs). In addition, you can batch upload a zip file of all records as PDFs or TIFFs.
3. Add any information regarding the record(s) into the notes section. You can add records up to a maximum of 100MB of data per upload.
4. Click “Upload,” and the selected medical record(s) will be electronically routed to the Humana repository system.

For technical assistance with the provider upload portal, call **801-984-4540**, Monday – Friday, 6 a.m. – 5 p.m., Mountain time.

**Method 2**

Fax to Humana medical record retrieval at **800-391-2361**.