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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 specifically 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

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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
			☐
			☐
			☐
			☐
			☐

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

Bathing	☐ Yes	☐ No	☐ N/A	Transferring	☐ Yes	☐ No	☐ N/A	
Dressing	☐ Yes	☐ No	☐ N/A	Using the toilet	☐ Yes	☐ No	☐ N/A	
Eating	☐ Yes	☐ No	☐ N/A	Walking	☐ Yes	☐ No	☐ N/A	

Treatment plan discussed with patient

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

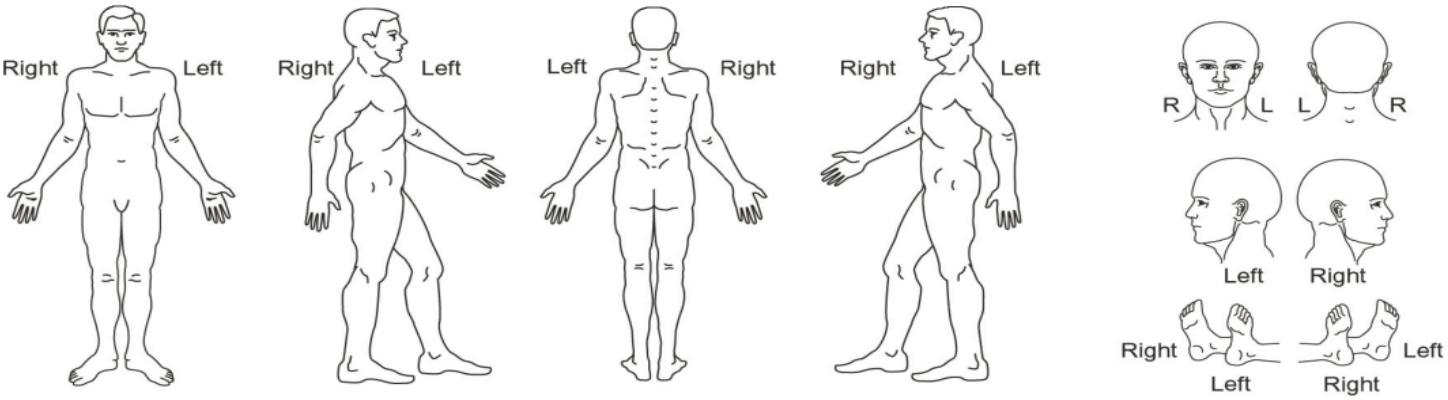
Physical activity assessment Date assessed: _____

Patient is physically active	☐Yes ☐No	Patient is active 30 minutes a day most days of the week	☐Yes ☐No
Patient plans to become active in the next few months	☐Yes ☐No	Patient expresses fear to become active or participate in physical activity	☐Yes ☐No
Patient participates in activity regularly	☐Yes ☐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? _____

Physician name and credentials:

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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, 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 electronically to the Humana secure upload site at www.submitrecords.com/humana. Enter the password: **hfstar83**.

- Under "Select the files to upload," click "Add files" and choose the medical records from your internet browser. You can upload single records in PDF or TIF formats or a zip file. Ensure any additional medication lists have a 2022 date.
- Add any information regarding the record(s) into the notes section. You can add records up to a maximum of 100 MB per upload.
- Click "Upload" and the selected records will be electronically routed to the Humana repository system.

For technical assistance, call **801-984-4540**.

Method 2

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

Method 3

Mail to: Humana
66 E. Wadsworth Park Drive, Suite 150S
Draper, UT 84020