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 age 66 and older who have special needs plans
- Patients who have special needs plans 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 special needs plan, 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
Patient advised:

Care for older adults

Patient name: ___________________________ DOB ____/____/_____ (mm/dd/yyyy)

Member ID: ___________________________ DOS ____/____/_____ (mm/dd/yyyy)

Physician name: _______________________

Prescription (Rx)  Dosage  Disease being treated/reason for medication  Side effects discussed

<table>
<thead>
<tr>
<th>Prescription (Rx)</th>
<th>Dosage</th>
<th>Disease being treated/reason for medication</th>
<th>Side effects discussed</th>
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Functional assessment: Does patient have difficulties performing the following activities?

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

Date assessed: ____________

Treatment plan discussed with patient

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

Physical activity assessment

Patient is physically active  Yes  No

Patient plans to become active in next few months  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

- 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:

6373ALL1218-B GHHKNU3EN
Patient name: _______________________________ DOS__/__/____ (mm/dd/yyyy)
Member ID: _______________________________ DOB__/__/____ (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/quality resources, under the Additional Practitioner Resources heading.

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.

<table>
<thead>
<tr>
<th>Physician name and credentials (printed)</th>
<th>Physician signature and credentials (signed)</th>
<th>Date</th>
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<tbody>
<tr>
<td>Provider office number: (____) – ____________</td>
<td>Provider □ NPI</td>
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<tr>
<td>Billing provider ID: ______________________</td>
<td>Type □ TIN</td>
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<td>Provider address: _______________________</td>
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Submitting a completed form

Method 1
Upload electronically to the Humana secure upload site at www.submitrecords.com/humana. Enter the secure 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 2018 date.
- Add any information regarding the record(s) into the notes section. You can add records to a maximum of 100MB per upload.
- Click “Upload,” and the selected records will be electronically routed to the Humana repository system.

For technical assistance, call 1-801-984-4540.

Method 2
Fax to Humana medical record retrieval at 1-800-391-2361.

Method 3
Mail to: Humana
66 E. Wadsworth Park Drive, Suite 150 S
Draper, UT 84020

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