Humana

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 pain and functional assessment?

- Patients 66 years of age 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

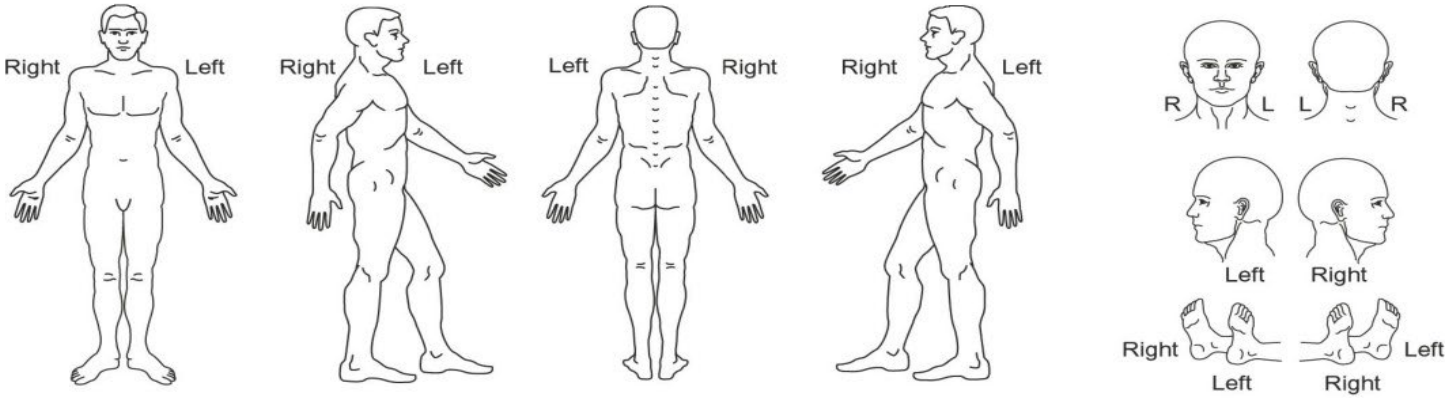
Physical activity assessment Date assessed: ____

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 Discussed on ____/____/_____

Pain assessment Date assessed: ____



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

Quality of pain _____ Onset, duration, variation, rhythms? _____

What causes the pain? _____ What relieves the pain? _____

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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

How do I submit this form?

Method 1

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

1. Go to the secure upload site at www.submitrecords.com/humana and enter the password hfstar83.
2. Select the "Add files" button and choose the medical record(s) from your internet browser, then select "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. Select "Upload" and the selected medical record(s) will be electronically routed to the secure 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**.