BlueCross BlueShield Minnesota

Nursing Home /ICF Assessment and Support Plan

Member Information

Name:	**Bridgeview ID (8+ PMI):**	**Product Name** Choose One:	**Assessment Date:**
Facility Name:	**DOB:**	**Facility Admission Date:**	
Facility Address:	**Phone #:**		
	Primary Diagnosis:	**Assessment Type:** ☐ **Initial Health Risk Assessment** ☐ **Annual Reassessment** ☐ **Significant Change** ☐ **Other** ***See section V. for semi-annual contact*** ***See section VI. for Product Change***	
Is there an Advance Directive or Health Care Directive in place? ☐ **Yes** ☐ **No** **Was Advance Directive/Health Care Directive discussed:** ☐ **Yes** ☐ **No** **If no, reason:**	**Check all that apply:** ☐ **Do not resuscitate (DNR)** ☐ **Do not hospitalize (DNH)** ☐ **No tube feedings** ☐ **Comfort Care Only** ☐ **CPR** ☐ **Do not intubate (DNI)** ☐ **No IVs** ☐ **No antibiotics** ☐ **No hospice** ☐ **POLST/Physician Orders for Life Sustaining Treatment** **Comments:**		

I. Member's Care Team (Interdisciplinary Care Team-ICT)

Care Coordinator Name: **Phone #:**	**PCP:** **Phone #:** **Fax #:**	**Clinic:**
Legal Guardian/POA:	**Legal Guardian/POA Address/Phone:**	
Authorized Rep (if different):	**Authorized Rep Address/Phone:**	
DD Case Manager (for those residing in ICF): **Name:** **Phone:** If applicable, contact made with DD CM. **Date:**		

Ask member (if appropriate): Is there anyone else that you'd like to receive a copy of the 8.35 Nursing Home-ICF Visit Summary letter? ☐ Yes ☐ No If yes- name, address and relationship status?

Comments:

II. Facility Chart Review

Care Transitions (Hospital/ER Visits in the last 6 months)

Reminder- see Care Coordinator Guidelines for TOC responsibilities

Hospital/ER: Dates:

Comments:

☐ Reviewed list of medications

Comments:

Immunization Review *9.03 Immunization Guidelines available on the Care Coordination website*

Vaccination/Immunization	Is Member up to date?	If not up to date, must include a note.
Flu	☐ Yes	☐ No
Pneumococcal	☐ Yes	☐ No
TDAP	☐ Yes	☐ No
Zostavax (Shingles)	☐ Yes	☐ No
COVID-19	☐ Yes	☐ No
	☐ Yes	☐ No

Comments:

Nutritional Assessment:

Height Weight

☐ I have reviewed the current nutritional assessment

Comments/Recommendations:

Minimum Data Set (MDS)

Date of MDS: Cognitive Status: Mood Status:

Comments:

Annual Physician/Provider visit for primary and preventive care

Date:

Comments:

Facility's Plan of Care:

☐ I have reviewed the facility Plan of Care and Goals.

Comments:

Confirm that the Facility Care Plan addresses each of the following items below. If the Care Plan does not address any of the items below, describe in the Comments below:

☐ Multidisciplinary
☐ Depression screening
☐ Socialization needs
☐ Preventive in focus
☐ Member/Family Participation
☐ Nutrition
☐ Holistic
☐ Skin Integrity
☐ Tobacco/Alcohol Use (if applicable)
☐ Fall risk
☐ Mental Health status

☐ Other:

Comments:

Care Coordinator should retain a copy of the reviewed care plan. Blue Plus may request a copy at any time.

I have recommended the following modifications to the facility care plan (to include areas of need the member has expressed or potential gaps in care):

Date	Recommendation	Outcome
Ex: 1-2-1234	*Member expressed the need for more exercise.*	*CC discussed with nursing staff to consider adding facility walking program to care plan.*

Comments:

☐ **I have asked to be invited to the member's care conferences.**
☐ **I have attended OR reviewed the most recent care conference notes.** Care Conference Date:

Comments:

Additional Care Providers seen in the last year, as appropriate:

Provider	**Has member received the following services?**	**Check if Referral Needed**	**If no, must include a note.**
Podiatry	☐ Yes ☐ N/A	☐	☐ No
Psychiatry	☐ Yes ☐ N/A	☐	☐ No
Dental	☐ Yes ☐ N/A	☐	☐ No
Vision	☐ Yes ☐ N/A	☐	☐ No
Hearing	☐ Yes ☐ N/A	☐	☐ No
	☐ Yes	☐	☐ No
	☐ Yes	☐	☐ No

III. Member/Responsible Party Interview

1. What are the most important things to you? (For instance, being social, music, family, having choices, etc.)

2. What activities or things do you enjoy doing?

   2a. Is anything needed to support or help you do these activities?

3. Do you like where you live? ☐ Yes ☐ No **If no, what would you change?

4. Would you like to live elsewhere? ☐ Yes ☐ No
   Comments:

5. Are you worried that in the next 2 months, you may not have stable housing? ☐ Yes or ☐ No
   Comments:

6. Which of the following statements best describes the food eaten in your household in the past 12 months, that is since [current month] of last year?
   1. ☐ You (and other household members) always had enough of the kinds of foods you wanted to eat.
   2. ☐ You (and other household members) had enough to eat, but not always the kinds of food you wanted.
   3. ☐ Sometimes you (and other household members) did not have enough to eat.
   4. ☐ Often you (and other household members) didn't have enough to eat.

   Comments:

7. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living (check all that apply)
   ☐ Yes, it has kept me from medical appointments or getting medications.
   ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need.
   ☐ No

   Comments:

☐ I have assessed this member's desires and/or ability to relocate back to the community or another facility.
Date Assessed:

☐ If appropriate, Home and Community Based Services (HCBS) options were discussed.
Comments:

IV. Care Coordinator Tasks

☐ Met with member, explanation of Care Coordinator role, addressed member concerns (if any).
Comments:

☐ Contact made with member's guardian, POA, or responsible party (required if member is unable to fully participate).
Date:
Comments:

☐ Discussion of member's status with facility staff.
Comments:

☐ Discussed MSHO Supplemental Benefits with MSHO members. *Resources available on the Care Coordination portal*
Comments:

☐ Discussed SecureBlue MSHO enrollment (MSC+ members only)
Comments:

Additional Comments:

IV. Care Coordinator Signature (required)

Care Coordinator: **Organization:** **Date:**

V. Mid-Year Contact: Date

☐ Contact with member, addressed member concerns (if any).
Comments:

☐ Contact made with member's guardian, POA, or responsible party (required if member is unable to fully participate).
Date:
Comments:

☐ I have discussed any recent acute episodes or hospitalizations.
Comments:

☐ I have discussed any significant changes in condition or level of care.
Comments:

☐ I have assessed this member's desires and/or ability to relocate back to the community or another facility.
Date Assessed:

☐ If appropriate, Home and Community Based Services (HCBS) options were discussed.
Comments:

Are there any unmet needs/care concerns to follow up on? ☐ Yes ☐ No

Additional Comments:

V. Semi Annual Contact Care Coordinator Signature (required)

Care Coordinator: **Organization:** **Date:**

VI. 6.28.01 Nursing Home/Intermediate Care Facility Transitional Health Risk Assessment for Product Change

This section of the form is to be used only when a member changes Blue Plus Products (MSC+ to MSHO or MSHO to MSC+). Complete the section below and review the entire 6.15 Nursing Home/Intermediate Care Facility Member Health Risk Assessment/Care Plan Review form for any updates. This must be completed within the required assessment time frames for "new enrollees". The next annual assessment is due 365 days from the last full assessment date.
All member/authorized rep/physician letter requirements must be completed for product changes (see Nursing Home/Intermediate Care Facility Product Change section of the Nursing Home/Intermediate Care Facility Care Coordination Guidelines for complete details).

New Product: Choose One: New Product Enrollment Date:

☐ Reviewed current 6.15 Nursing Home/Intermediate Care Facility Member Health Risk Assessment/Care Plan Review including facility chart as needed. Date:

☐ Reviewed status changes with facility staff as needed.

☐ Met with member or guardian, POA, or responsible party (required if member is unable to fully participate). Date:

Comments:

☐ Reviewed MSHO Supplemental Benefits with member or responsible party (as applicable)

☐ Contact made with DD Case Manager (for those residing in ICF), if applicable.

Additional Comments:

VI. Product Change Transitional HRA Care Coordinator Signature (required)

Care Coordinator: **Organization:** **Date:**