

Nursing Home - ICF Member Assessment and Support Plan

**Member Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** | **Bridgeview ID (8+ PMI):** | **Product Name:** | | **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 intubate (DNI)** | | **Do not hospitalize (DNH)** | **No IVs** | | **No tube feedings** | **No antibiotics** | | **Comfort Care Only** | **No hospice** | | **CPR** | **POLST/Physician Orders for Life Sustaining Treatment** | | **Comments:** | | | | | |

1. **Member’s Care Team (Interdisciplinary Care Team-ICT)**

|  |  |  |
| --- | --- | --- |
| **Care Coordinator Name:**    **Phone #:** | **Primary Physician/Provider:**  **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:

1. **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 |
| <other> | 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 | Preventive in focus | Holistic | Fall risk |
| Depression screening | Member/Family Participation | Skin Integrity | Mental Health status |
| Socialization needs | Nutrition | Tobacco/Alcohol Use (if applicable) |  |
| 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 |
| <other> | Yes |  | No |
| <other> | Yes |  | No |

1. **Member/Responsible Party Interview**
2. What are the most important things to you? (For instance, being social, music, family, having choices, etc.)

<member/responsible party response>

1. What activities or things do you enjoy doing?

<member/responsible party response>

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

<member/responsible party response>

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

<member/responsible party response>

1. Would you like to live elsewhere?  Yes  No

Comments:

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

Comments:

1. 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?
2. You (and other household members) always had enough of the kinds of foods you wanted to eat.
3. You (and other household members) had enough to eat, but not always the kinds of food you wanted.
4. Sometimes you (and other household members) did not have enough to eat.
5. Often you (and other household members) didn't have enough to eat.

Comments:

1. 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:

1. **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:***

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Care Coordinator Signature (required)**  |  |  |  | | --- | --- | --- | | **Care Coordinator:** | **Organization:** | **Date:** | |

1. **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***:

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Semi Annual Contact Care Coordinator Signature (required)**  |  |  |  | | --- | --- | --- | | **Care Coordinator:** | **Organization:** | **Date:** | |

**Section VI. Nursing Home-ICF Transitional HRA 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 Nursing Home-ICF Member Assessment and Support Plan above 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.

|  |  |
| --- | --- |
| New Product: | New Product Enrollment Date: |

Reviewed current Nursing Home-ICF Member Assessment and Support Plan 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:***

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Product Change Transitional HRA Care Coordinator Signature (required)**  |  |  |  | | --- | --- | --- | | **Care Coordinator:** | **Organization:** | **Date:** | |