BlueCross BlueShield Minnesota

Nursing Home Member Assessment/Care Plan Review

☐ Initial ☐ Annual ☐ Other_ ___ **Product:** ☐SecureBlue (MSHO) ☐Blue Advantage (MSC+)

Member Name:		Assessment Date:	
Member ID #		DOB:	
Facility:		Facility Phone:	
Facility Address:		Primary Care Clinic:	
		Clinic Address:	
County:			
SNF Admission Date:		Doctor:	
Product Enrollment Date:		Doctor Phone #:	

Member Chart Review Section

☐ **Representative Contact Information:** Name:

Address: Phone:

Relationship status (ie. son, daughter, POA, guardian, etc):

☐ **Health Care Directive or Living Will on file?** ☐ Yes ☐ No If no, discussed or provided info? ☐
If not discussed, why?

Health Care Agent name:

Check all that apply:
☐Do not resuscitate (DNR) ☐Do not intubate (DNI) ☐Do not hospitalize (DNH)
☐No tube feedings ☐No IVs ☐No antibiotics
☐No hospice ☐Comfort Care only ☐ CPR
☐POLST/Physician Orders for Life Sustaining Treatment

Comments:

Primary Diagnosis:

Medications:

☐ **Hospital/ER Visits:** Dates:

Comments:

Immunizations: ☐ Flu ☐ Pneumonia ☐ Other Type:
Comments:

☐ **Reviewed Nutritional Assessment** Date of nutritional assessment:
Height Weight BMI
Comments:

☐ **Reviewed Minimum Data Set (MDS) or other current comprehensive health assessment** Date of MDS assessment:

Comments:

☐ **Cognitive status**

Comments:

☐ **Mood status**

Comments:

Falls Risk
Are you afraid of falling? ☐Yes ☐No
Have you fallen in the past year? ☐Yes ☐No
If the answer above is yes, how many times have you fallen in the past year?
Comments:

☐ **Rehab Therapies/Skilled Services (OT, PT, ST)**

Comments:

☐ **Annual physician/provider visit for primary and preventative care**

Comments:

☐ **Review of most recent MD or NP nursing home visit:**

Comments:

Confirm that the Nursing Home's 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 ☐ Holistic ☐ Preventive in Focus ☐ Member/Family Participation
☐ Psychosocial ☐ Behavioral ☐ Environmental ☐ Nutritional Concerns/Wt loss or gain
☐ Pain Management ☐ Skin Integrity ☐ Utilizes Facility Services
☐ Reviewed Care Plan Goals ☐ Reviewed barriers to goals (if any)
Comments:

☐ Reviewed notes from or attended most recent care conference.
Date of most recent care conference:

Comments:

Ancillary care Providers seen in the last year as appropriate:
Podiatry ☐ Psychiatry ☐ Dental ☐ Vision ☐ Other:

Comments:

☐ **Level of Care Appropriate?** ☐ Yes ☐No
☐ If no, alternative services Home and Community Based Services (HCBS) addressed.
Comments:

Member and/or Collaborative Contacts Section

☐Met with member, reviewed Care Coordinator role, addressed member concerns (if any).

☐Met family or representative

Comments:

Discussion with Facility Staff

Name: _____ Discipline: _____ Date:

Name: _____ Discipline: _____ Date:
Comments:

Case Comments:

Care Coordinator: _____Organization: _____ _____Date:_____