Comprehensive Medical Assessment Tool

NJ Family Care Community Based Palliative Care

Provider Guidance

This assessment form is intended to support eligibility determinations and health plan authorization of care for the Community-Based Palliative Care (CBPC) benefit. Please review the following instructions carefully before completing and submitting this form. In addition to submitting this form to the member's health plan, please retain a copy of this assessment and make it available to the Member's plan and other healthcare providers.

This form is used to:

- Evaluate whether a member meets clinical and disease severity criteria for CBPC
- Document the severity of a member's serious illness
- Identify physical, psychosocial, spiritual, and social needs
- Capture goals for care
- Facilitate development of a personalized care planning document

Any licensed, Medicaid enrolled healthcare provider may complete this assessment. The assessing provider **does not need to be the provider rendering ongoing CBPC services.**

General Guidance

- Complete all sections in collaboration with the member and, if appropriate, their caregiver/family.
- Use plain language and a culturally sensitive approach to gather responses.
- Document relevant findings objectively and accurately.
- If you identify urgent needs or safety concerns during the assessment, take immediate clinical action according to local policy.
- **The member qualifies for CBPC based on indications in sections E and F.** However, providers/MCOs have discretion to approve someone for palliative care who may not qualify based on the information collected in sections E and F alone. Sections G and H provide additional information that may be valuable when making this determination; any major findings from these four sections should be included in the Summary of Major Findings in section J.
- Submit this completed form to **the member's health plan** according to plan-specific protocols (e.g., fax, secure portal or email). **Do not submit directly to the state agency** unless directly instructed. Include any relevant attachments (e.g., clinical notes, signed advance directives). If you are unsure where to send this form, contact the health plan's provider services team.
- After MCO authorization (if applicable), ensure that a care plan reflecting the person's identified needs, priorities, and preferences is developed or updated.

Section-by-Section Guidance

SECTION A: MEMBER INFORMATION

- Complete member, caregiver, and primary care provider demographics

SECTION B: ASSESSMENT CADENCE

- Provide information related to whether the assessment completed is an initial assessment or a reassessment

SECTION C: ONGOING CARE INFORMATION

- If the form completed is a reassessment, provide information related to the member's current palliative care team, the reason for the reassessment, and the member's length of stay on service with the palliative care team.

SECTION D: MEDICAL ASSESSOR INFORMATION

- Provide information about the provider completing the assessment or reassessment.

SECTION E: QUALIFYING CLINICAL CONDITION

- Provide information related to the member's qualifying condition, including level of disease severity.

SECTION F: INDICATION OF DISEASE SEVERITY

- Provide information related to the member's level of disease severity for their qualifying condition, including the quality of life impacts qualifying the member for palliative care services. Please indicate whether this is a change from a previous assessment.

SECTION G: OTHER INDICATORS OF DISEASE SEVERITY

- Provide any documentation on clinical progression of the disease, including co-morbid conditions, clinical biomarkers, and durable medical equipment use.

SECTION H: COMPREHENSIVE ASSESSMENT

A1. Physical Assessment

- Use validated tools provided (e.g., ESAS, FAST, PPS, KPS) to document symptom severity and functional status.
- If performance status is ≤50%, consider hospice referral and document discussion with the member/family.

A2. Psychosocial Assessment

- Administer PHQ-2 initially. If positive, complete PHQ-9 to assess depression severity.
- Screen for caregiver burden with the Zarit Burden Interview (ZBI).
- If moderate to severe distress or burden is identified, include this in the care plan and consider referral to mental health or supportive counseling resources.

A3. Spiritual Assessment

- Use the FICA framework to explore spiritual needs.
- Document the person's faith/beliefs, importance of spirituality, participation in a spiritual

community, and preferences for spiritual support in their care.

SECTION I: GOALS OF CARE

- Indicate completion of a goals of care discussion, advance care planning document, POLST, or identification of a health care proxy.
- Ensure the person has opportunities to express their understanding of their illness, prognosis, and treatment options.
- Document preferences for treatment, including any advance directives or surrogate decision-makers.

SECTION J: CLINICAL SUMMARY & ELIGIBILITY DETERMINATION

- Summarize findings from the assessment.
- Indicate determination of member eligibility based on the existence of a qualifying clinical condition and evidence of severe disease.

SECTION K: SIGNATURES

- Ensure that the member or member's proxy and provider completing the assessment have signed and dated the document.

Next Steps After Completing the Tool

1. Summarize key findings for the palliative care team.
2. After MCO authorization (if applicable), develop or update a care planning document that addresses the identified needs, supports the person's goals, and outlines interventions and referrals.
3. If the person completing the assessment is not part of a contracted specialty palliative care team, send the completed assessment and care plan to the member's MCO care management team or specialty palliative care provider.
4. Ensure that a follow-up is scheduled to review progress and update the care plan as the person's needs change.

SECTION A: MEMBER INFORMATION			
Member Name: (last, first, mi)		Medicaid / Member ID #:	
Health Plan:	☐ Aetna Medicare FIDE (HMO D-SNP) ☐ Aetna Better Health of New Jersey ☐ Fidelis Care ☐ Horizon NJ Health ☐ UnitedHealthcare (UHC) ☐ Wellpoint	Age Cohort: ☐ Adult (over 19) ☐ Child DOB: (mm/dd/yyyy)	
Preferred Language:	☐ English ☐ Spanish ☐ Chinese-Mandarin ☐ Chinese-Cantonese ☐ Portuguese ☐ Tagalog ☐ Korean ☐ Other:_____		
English Fluency: (Verbal)	Member: ☐ High ☐ Medium ☐ Low ☐ No Fluency		
	Caregiver/Family Member: (if applicable) ☐ High ☐ Medium ☐ Low ☐ No Fluency		
English Fluency: (Written)	Member: ☐ High ☐ Medium ☐ Low ☐ No Fluency		
	Caregiver/Family Member: (if applicable) ☐ High ☐ Medium ☐ Low ☐ No Fluency		
Healthcare Power of Attorney (POA)?	☐ Yes ☐ No		

Caregiver/Alternate Contact Information If no Caregiver, enter 'None'; if Healthcare POA is Yes, enter Medical Decision Maker information			
Name:		Relationship:	
Email Address:		Cell Phone Number:	

Primary Care Physician Information					
Name:					
Address:					
	street address	city		state	zip code
Office Phone Number:		Fax Number:			

SECTION B: ASSESSMENT CADENCE			
Form completed as member's:	☐ First assessment of eligibility → Complete sections D-I ☐ Reassessment of eligibility → Complete sections C-I	Date: (mm/dd/yyyy)	

SECTION C: ONGOING CARE INFORMATION Only complete for reassessment of eligibility			
IDT Lead Clinician Name:		Clinician NPI #:	
Clinician Medicaid ID #:		Clinician Provider ID:	
Reassessment Justification:	☐ Scheduled 6-month reassessment ☐ Change in condition	Length of member's enrollment in palliative care with provider:	

Description of change in condition: (if checked above)	

SECTION D: MEDICAL ASSESSOR INFORMATION

Provider/Facility Name:			
NPI #:		Medicaid ID #:	

SECTION E: QUALIFYING CLINICAL CONDITION

Primary Disease Diagnosis(es)	Primary ICD 10 Code	Date of Onset

Eligible Serious Illnesses	Adult:	☐ Alzheimer's or dementias	☐ Cancer (Stage III or IV)	☐ COPD
		☐ Congestive Heart Failure	☐ Cirrhosis or liver disease	☐ Diabetes
		☐ ESRD or chronic kidney disease	☐ Stroke	☐ AIDS
		☐ Degenerative neural condition (i.e. Parkinson's, severe neurodegenerative disorders)		
		☐ Other *(explain below)*		
	Children:	☐ Pulmonary Disease	☐ Cardiac Disease	☐ Neonatal*
		☐ End-stage Liver Disease	☐ Genetic Disorders*	☐ Renal Disease
		☐ Metabolic/Inclusion Disease	☐ Infectious Disease	☐ Cancer
		☐ Orthopedic Disorders*	☐ Gastrointestinal Disease or Conditions*	
		☐ Neurological Disorder	☐ Other *(explain below)*	
		***For conditions marked with an *, children do not need evidence of disease severity to qualify for services.**		

Other Serious Illness Not Included Above & Description:	

Conclusions from Section E

Indication of assessment results: (select only 1)	☐ Yes – member meets one or more criteria ☐ Yes – member does not meet any criteria, but provider judgement deems enrollment clinically appropriate ☐ No – member does not meet any criteria
What (if anything) has changed since last assessment? (if reassessment)	

SECTION F: INDICATION OF DISEASE SEVERITY

Functional Status:	☐ MLTSS Enrollment	☐ PPS ≤ 70	☐ FAST ≥ 5
	☐ ECOG grade ≥ 3	☐ KPS ≤ 70	☐ MELD > 19
	☐ Other *(specify)*:		
	For provider: please attach any completed functional evaluation tools to this form and write the member's score in this section where appropriate.		

Utilization of Hospital and ER:	☐ 1 or more acute hospitalizations within the past 12 months ☐ 2 or more emergency department visits within the past 6 months
Other Functional Decline Not Included Above & Description:	
Conclusions from Section F	
Indication of assessment results: (select only 1)	☐ Yes – member meets one or more criteria (functional decline, hospitalization, or emergency department visits) ☐ Yes – member does not meet any criteria, but provider judgement deems enrollment clinically appropriate ☐ No – member does not meet any criteria
What (if anything) has changed since last assessment? (if reassessment)	
SECTION G: OTHER INDICATORS OF DISEASE SEVERITY	
Durable Medical Equipment Utilization or Dependency:	☐ 24-hour oxygen requirement ☐ Wheelchair dependence ☐ Tracheostomy dependence ☐ Feeding tube dependence ☐ Catheter dependence ☐ Ventilator dependence ☐ Hospital bed
Clinical Biomarker:	☐ Severe airflow obstruction: Forced Expiratory Volume (FEV)1 < 35% predicted ☐ International Normalized Ratio (INR) without medications > 1.3 ☐ Estimated Glomerular Filtration Rate (eGFR) of 25 or less ☐ Ejection Fraction < 30 for systolic heart failure ☐ Albumin < 3.0
Evidence of Comorbid Conditions:	☐ Subacute bacterial peritonitis ☐ Hepatic encephalopathy ☐ Chronic infections ☐ Evidence of pressure ulcers ☐ Coronary artery disease ☐ Ascites ☐ Progressive weight loss ☐ Bronchiolitis obliterans ☐ Frailty ☐ Extracorporeal membrane oxygenation (ECMO) or transplant candidate
SECTION H: COMPREHENSIVE ASSESSMENT	
H1. Physical Assessment Only one severity / functional assessment is required	
Edmonton Symptom Assessment (ESAS)	☐ Mild to Moderate Symptoms: 0-4 ☐ Moderate to Severe Symptoms: 4-6 ☐ Severe Symptoms: >7
Functional Assessment Staging Tool (FAST)	☐ Mild: Stage 3-4 ☐ Moderate: Stages 5-6 ☐ Severe: Stage 7
Palliative Performance Scale (PPS)	☐ >70% ☐ Greater than 50% but less than or equal to 70% ☐ <= 50% (if yes, consider referral to hospice care)
Karnofsky Performance Status (KPS)	☐ >70% ☐ Greater than 50% but less than or equal to 70% ☐ <= 50% (if yes, consider referral to hospice care)
What (if any) severity or functional change has occurred since last	

assessment? (if reassessment)	

H2: Psychosocial Assessment	
Patient Health Questionnaire-2 (PHQ-2)	☐ <3 ☐ 3 or greater (if yes, complete PHC-9) ☐ >= 4 (if yes, complete PHC-9)
Patient Health Questionnaire-9 (PHQ-9)	☐ Minimal: 0-4 ☐ Mild: 5-9 ☐ Moderate: 10-14 ☐ Moderately Severe: 15-19 ☐ Severe: 20-27
Zarit Burden Interview (ZBI)	☐ Mild to Moderate: 21-40 ☐ Moderate to Severe: 41- 60 ☐ Severe Burden: 61-88
What (if any) psychosocial change has occurred since last assessment? (if reassessment)	
H3: Spiritual Assessment (FICA)	
F: What is your faith or belief?	
I: Is it important in your life?	
C: Are you part of a spiritual or religious community?	
A: How would you like me, your healthcare provider, to address these issues in your healthcare?	
What (if any) change has occurred since last assessment? (if reassessment)	

SECTION I: GOALS FOR CARE			
Advance Directive on File?	☐ Yes ☐ No	POLST on File?	☐ Yes ☐ No
Health Proxy Identified?	☐ Yes ☐ No		

SECTION J: CLINICAL SUMMARY & ELIGIBILITY DETERMINATION Member is eligible if provider determines the existence of a qualifying clinical condition and evidence of severe disease (Yes for Section E and Section F) and member is not enrolled in hospice care	
Summary of Major Findings:	
No Hospice Attestation: *(if unchecked, mark ineligible)*	☐ Check to confirm the member is NOT currently enrolled in hospice care
Eligibility Determination:	☐ Eligible ☐ Ineligible

SECTION K: SIGNATURES Member signature indicates consent to proceed to Palliative Care enrollment if care authorized

Provider Signature:		Date: (mm/dd/yyyy)	
Member Signature:		Date: (mm/dd/yyyy)	
Caregiver Signature: (if applicable)		Date: (mm/dd/yyyy)	