3.4 Assessments of Members

Senior Health Partners builds a strong relationship with our members that starts before enrollment, a relationship that grows deeper over time. Providers partner with us in growing this relationship by supplying services to maximize care and satisfaction, and by communicating any changes in the member's status promptly to a Senior Health Partners care manager.

The Initial Assessment

An Intake Nurse goes to the prospective enrollee's home to conduct an assessment to evaluate the member's medical, cognitive and functional status, and also to evaluate the home environment. Based on the assessment, a Plan of Care/Service Plan is developed. The Plan of Care/Service Plan is communicated and agreed to by the enrollee, family and/or caregiver.

The new enrollee's Care Management Team (CMT) contacts providers based on the member's needs to arrange for required services. Thus begins the strong and unique relationship between the member/member's family/caregiver, the provider and Senior Health Partners.

It is the responsibility of Senior Health Partners CMT to assess or re-assess the need for a personal care aide, home health aide and housekeeper services, and to evaluate the member's resources. The Provider is responsible for servicing the member according to the services authorized by Senior Health Partners. The Provider must follow the Plan of Care. The Provider is responsible to open the case and supervise the Home Health Aides or Personal Care Aides according to contract or NYSDOH policies and procedures. The Provider should communicate any recommendations or revisions required to the service plan directly to the Senior Health Partners CMT.

Ongoing Assessments

Outgoing monthly telephone calls are made to each member by the CMT. The purpose of the calls is to ascertain if the member's needs are being met, distinguish changes in functionality, identify opportunities for improvement and maximize satisfaction. Results of these calls assist in determining changes in services or the Care Plan. Team nurses and/or social workers may also conduct home visits, as needed, to assist members in maximizing care and functionality and to deal with clinical and social issues.

Semiannual Assessments

Every 180 days, a formal assessment is conducted by a nurse during a visit to the member's home. As in the initial visit, the nurse conducts an assessment of the member's medical, cognitive and functional status, as well as the home environment. Based on the assessment, a Plan of Care/Service Plan is developed. The Plan of Care/Service Plan is communicated and agreed to by the enrollee his/her family/caregiver and to the designated CMT. CMT staff will then contact providers to meet the identified needs.