



# MSC+/MSHO Institutional Health Risk Assessment

Assessment Date:	<input type="checkbox"/> MSC+ <input type="checkbox"/> MSHO
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**MEMBER INFORMATION**

Member Name	DOB	Member ID	UCare Enrollment Date
Facility Name	Facility Phone Number	Facility Address	
Facility Admission Date	Primary Contact at Facility (Name, Title, Phone)		

**FACILITY CHART REVIEW**

The following IHRA/Support Plan information was gathered by the care coordinator through interaction with the member/representative, facility staff, and facility chart review:  Yes  No  
 If no, provide reason:

Discussion with nursing home staff?  Yes  No  
 Name, Discipline, Date:

Is there an Advanced Directive, Health Care Directive, and/or POLST on file?  Yes  No  
 Was the Advanced Directive, Health Care Directive, and/or POLST discussed with member/representative?  Yes  No  
 If not discussed, provide reason:

Hospital/ER Visits in the past year?  Yes  No  
 If yes, provide dates and reasons:

Discussed Transitions of Care?  Yes  No  
 If not discussed, provide reason:

Date of most recent MDS:  
 Care Coordinator reviewed MDS?  Yes  No  
 Copy of MDS received and attached to IHRA?  Yes  No

Date of most recent nursing home care plan:  
 Care Coordinator reviewed facility care plan?  Yes  No  
 Copy of facility care plan received and attached to IHRA?  Yes  No

Current diagnosis/problem list attached?  Yes  No  
 If not attached, list diagnoses/problem:

Current medication list attached?  Yes  No  Not applicable, no medications  
 If not attached, list medications:

**Preventative Care Review**

Preventative Screening and Immunization Record	Is Member up to Date?	Recommendation made to nursing home staff or PCP?	Notes (dates, education provided)
Annual Primary Care Visit	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Flu	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Pneumococcal	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
TDAP	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
COVID-19	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colon Screening	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Cancer Screening	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs)**

<b>ADL/IADL</b>	<b>Independent</b>	<b>Some Assistance Needed</b>	<b>Dependent</b>	<b>Notes</b>
Dressing				
Grooming				
Bathing				
Toileting				
Bed Mobility				
Transferring				
Ambulation				
Eating				
Phone Calling				
Shopping				
Meal Preparation				
Light Housekeeping				
Managing Medications				
Money Management				
Transportation				

**Member Interview**

**Emotional Health Screening**

PHQ-9 or PHQ-9-OV Score:

If score not available, or the score is 10 or above, complete the Emotional Health Screening.

How would you rate your health?	Excellent	Good	Fair	Poor	Unable to answer	Chose not to answer	N/A
			Yes	No	Unable to answer	Chose not to answer	N/A
In the past three months, have you been stressed or anxious?							
In the past three months, have you had little interest or pleasure in doing things that you normally like?							
In the past three months, have you been feeling down, depressed, or "blue" more than usual?							
In the past three months, have you been limited in your social activities with family, friends, neighbors, or groups (not related to transportation)?							

**Cognitive Status/Communication Screening**

C0100 Brief Interview for Mental Status (BIMS) Score:

If score not available, complete the Cognitive Status/Communication Screening.

	Excellent	Good	Fair	Poor	Unable to answer	Chose not to answer	N/A
How well would you say your memory is?							

How well would you say you are able to communicate your needs or concerns with providers?							
<b>Pain Screening</b>		Yes		No		Unable to answer	Chose not to answer
Are you experiencing any pain now or in the last two weeks?							
Has your pain affected your function or quality of life?							
Have you talked to your doctor or someone else about the cause of your pain?							
<b>Substance Use</b>		Yes	No	N/A		Unable to answer	Chose not to answer
Do you use any substances such as, but not limited to, alcohol, marijuana, cocaine, or amphetamines?							
If yes, do you or anyone close to you have any concerns about your use?							
If yes, would you like any assistance to address your concerns?							
<b>Tobacco Use</b>		Yes	No	N/A		Unable to answer	Chose not to answer
Do you use tobacco products (including cigarettes, cigars, smokeless tobacco)?							
If yes, do you or anyone close to you have any concerns about your use?							
If yes, would you like any assistance to address your concerns?							
<b>Safety</b>		Yes		No		Unable to answer	Chose not to answer
Is anyone currently mismanaging your money or stealing from you?							
Is anyone currently hurting you physically (hitting, slapping, pushing, kicking)?							
Is anyone currently touching you in a way that makes you feel uncomfortable?							
Is anyone currently emotionally abusive to you?							
<b>Living Situation</b>						Check one:	
What is your living situation today?	I have a steady place to live.						
	I have a steady place to live, but I am worried about losing it in the future.						
	I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)						
	Unable to answer						
	Chose not to answer						
Not applicable							
Do you like where you live?		Yes	No	Unable to answer		Chose not to answer	
If no, what would you change?							
Think about the place you live. Do you have problems with any of the following:		Yes	No	Unable to answer		Chose not to answer	
Pests, such as bugs, ants, or mice?							
Mold							
Lead paint or pipes							
Lack of heat							
Oven or stove not working							

Smoke detectors missing or not working						
Water leaks.						
<b>Care Coordinator has assessed the member's desire and/or ability to relocate back to the community or another facility.</b>						
<input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>If the member is interested in transition to another setting, the Care Coordinator provided resources and benefits available regarding transition planning and relocation.</b>						
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable						
If no, explain:						
<b>Was a referral for services made?</b>						
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable						
If no, explain:						
<b>Food</b>	Often true	Sometimes true	Never true	Unable to answer	Chose not to answer	N/A
Within the past 12 months, you worried that your food would run out before you got money to buy more?						
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more?						
Outside of mealtimes, can you get something to eat or grab a snack when you get hungry?	Yes	No	Unable to answer	Chose not to answer		
<b>Transportation</b>	Often true	Sometimes true	Never true	Unable to answer	Chose not to answer	
In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?						
Do you put off or neglect going to the doctor because of distance or transportation?						
<b>If the member indicated they need support access to food and/or transportation, the Care Coordinator will complete these follow up actions:</b>						
<input type="checkbox"/> N/A, no needs identified.						

Comments: