

**MSC+/MSHO Institutional Health Risk Assessment**

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| **MEMBER INFORMATION** | | | |
| Assessment Date: | | Care Coordinator Name: | |
| Member Name | DOB | | Member ID |

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| **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: |
| Advanced Directive, Health Care Directive, and/or POLST on file? Yes No  Discussed Advanced Directive, Health Care Directive, and/or POLST with member/representative? Yes No  If no, provide reason: |
| Hospital/ER visits in the past year? Yes No  If yes, provide reason and dates: |
| Discussed Transitions of Care with member/representative and provided handout? Yes No  If no, provide reason: |
| Date of most recent MDS:  Care coordinator reviewed MDS? Yes No |
| Date of most recent nursing home care plan:  Care coordinator reviewed facility care plan? Yes No  If modifications are needed to the facility’s care plan, discussed with nursing home staff? Yes No N/A  If no, provide reason: |
| Current diagnosis/problem list attached? Yes No  If no, list diagnoses/problem: |
| Current medication list attached? Yes No N/A (no medications)  If no, list medications: |

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| **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 | Yes No Unknown | | | Yes No N/A | |  |
| Flu | Yes No Unknown | | | Yes No N/A | |  |
| Pneumococcal | Yes No Unknown | | | Yes No N/A | |  |
| TDAP | Yes No Unknown | | | Yes No N/A | |  |
| Shingles | Yes No Unknown | | | Yes No N/A | |  |
| COVID-19 | Yes No Unknown | | | Yes No N/A | |  |
| Hearing Exam | Yes No Unknown | | | Yes No N/A | |  |
| Vision Exam | Yes No Unknown | | | Yes No N/A | |  |
| Dental Exam | Yes No Unknown | | | Yes No N/A | |  |
| Colon Screening | Yes No Unknown | | | Yes No N/A | |  |
| Breast Cancer Screening | Yes No Unknown | | | Yes No N/A | |  |
| Other: | Yes No Unknown | | | Yes No N/A | |  |
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| **ACTIVITES OF DAILY LIVING (ADLs)/INSTRUMENTAL ACTIVITES OF DAILY LIVING (IADLs)** | | | | | | |
| **ADL/IADL** | | **Independent** | **Some Assistance Needed** | | **Dependent** | **Notes** |
| Dressing | |  |  | |  |  |
| Grooming | |  |  | |  |  |
| Bathing | |  |  | |  |  |
| Toileting | |  |  | |  |  |
| Bed Mobility | |  |  | |  |  |
| Transferring | |  |  | |  |  |
| Ambulation | |  |  | |  |  |
| Eating | |  |  | |  |  |
| Phone Calling | |  |  | |  |  |
| Shopping | |  |  | |  |  |
| Meal Preparation | |  |  | |  |  |
| Light Housekeeping | |  |  | |  |  |
| Managing Medications | |  |  | |  |  |
| Money Management | |  |  | |  |  |
| Transportation | |  |  | |  |  |

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| **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. | | | | | | | |
| **Rate the following question:** | | | | | | | |
| How would you rate your health? | Excellent | Good | Fair | Poor | Unable to answer | Chose not to answer | N/A |
| **Rate the following questions:** | | | **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)? | | |  |  |  |  |  |

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| **Cognitive Status/Communication Screening**  C0100 Brief Interview for Mental Status (BIMS) Score:  If score not available, complete the Cognitive Status/Communication Screening. | | | | | | | |
| **Rate the following questions:** | **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? |  |  |  |  |  |  |  |

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| **Pain Screening** | **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? |  |  |  |  |

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| **Substance Use** | **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? |  |  |  |  |  |

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| **Tobacco Use** | **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? |  |  |  |  |  |

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| **Safety** | | | **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? | | |  | |  | |  | |  |
| **Living Situation** | | | | | | | | **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? | | | | | | | | | |

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| **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 |  |  |  |  |
| Care Coordinator has assessed the member’s desire and/or ability to relocate back to the community or another facility. Yes  Notes: | | | | |
| If the member is interested in transition to another setting, the Care Coordinator provided resources and benefits available regarding transition planning and relocation. Yes No N/A  If no, explain: | | | | |
| Was a referral for services made? Yes No N/A  If no, explain: | | | | |

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| **Food** | **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 |
| **Transportation** | **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? |  | |  | |  | |  | |  | |
| **If the member indicated they need support access to food and/or transportation, the Care Coordinator will complete these follow up actions:**    N/A, no needs identified. | | | | | | | | | | |

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| **Comments:** |