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

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| Assessment Date:       | [ ] MSC+ [ ] MSHO |
| **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 [ ] NoIf no, provide reason:      |
| Discussion with nursing home staff? [ ] Yes [ ] NoName, Discipline, Date:      |
| Is there an Advanced Directive, Health Care Directive, and/or POLST on file? [ ] Yes [ ] NoWas the Advanced Directive, Health Care Directive, and/or POLST discussed with member/representative? [ ] Yes [ ] NoIf not discussed, provide reason:      |
| Hospital/ER Visits in the past year? [ ] Yes [ ] NoIf yes, provide dates and reasons:      |
| Discussed Transitions of Care? [ ] Yes [ ] NoIf not discussed, provide reason:      |
| Date of most recent MDS:      Care Coordinator reviewed MDS? [ ] Yes [ ] NoCopy of MDS received and attached to IHRA? [ ] Yes [ ] No |
| Date of most recent nursing home care plan:      Care Coordinator reviewed facility care plan? [ ] Yes [ ] NoCopy of facility care plan received and attached to IHRA? [ ] Yes [ ] No |
| Current diagnosis/problem list attached? [ ] Yes [ ] NoIf not attached, list diagnoses/problem:      |
| Current medication list attached? [ ] Yes [ ] No [ ] Not applicable, no medicationsIf 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 | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| Flu | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| Pneumococcal | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| TDAP | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| Shingles | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| COVID-19 | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| Hearing Exam | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| Vision Exam | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| Dental Exam | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| Colon Screening | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| Breast Cancer Screening | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| Other:       | [ ] Yes [ ] No [ ] Unknown | [ ] Yes [ ] No |       |
| Activities of Daily Living (ADLs)/Instrumental Activities 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 | [ ]  | [ ]  | [ ]  |       |
| 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? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **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? | [ ]  | [ ]  | [ ]  | [ ]  |
| **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? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **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? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **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?       |
| 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 [ ] No |
| **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 [ ] Not applicableIf no, explain:       |
| **Was a referral for services made?**[ ] Yes [ ] No [ ] Not applicableIf no, explain:       |
| **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. |

Comments: