MSHO/MSC+ INSTITUTIONAL HEALTH RISK ASSESSMENT/SUPPORT PLAN

Initial ☐	Annual ☐	6 month ☐	Other ☐	Select Product: MSHO ☐ MSC+ ☐	IHRA Date
Member Name		**DOB**		**Member ID**	
Facility			**Facility Phone**		
County			**Primary Care Clinic**		
SNF Admission Date			**Physician Name**		
Enrollment / Transfer Date			**Physician Phone #**		

Member or member's authorized rep participated in the development of the care plan ☐ **Yes** ☐ **No**

Members of the Interdisciplinary Care Team that participated in the care plan development

Member First Name:	Member Last Name:
Care Coordinator Name:	Primary Care Provider Name:
Name:	Relationship to Member:
Name:	Relationship to Member:
Name:	Relationship to Member:
Name:	Relationship to Member:
Name:	Relationship to Member:

Met with member, reviewed Care Coordinator Role, addressed member concerns (if any) Date:

Met with family or authorized representative Date:

Reviewed the members Advanced Directive and/or POLST on file? ☐ Yes ☐ No ☐ Not applicable (if member/family inappropriate)

Hospital / ER Visits past year? ☐ Yes ☐ No

Date of last MDS:

(Please review Minimum Data Set (MDS) or other current comprehensive health assessment and attach interdisciplinary Care Team (ICT) list in members file or list team members below)

Nursing home plan of care attached in member's file: ☐ Yes ☐ No

Date:

Preventive Care	Is Member up to date	Recommendation made to NH staff members/PCP?	Notes
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 Cancer Screening	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No	
Breast Cancer Screening	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No	
Other:	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No If yes, date:	

ADL	Independent	Assistance Needed	Dependent
Dressing/Grooming	☐	☐	☐
Bathing	☐	☐	☐
Toileting	☐	☐	☐
Bed Mobility	☐	☐	☐
Transfer	☐	☐	☐
Ambulation	☐	☐	☐
Feeding	☐	☐	☐

IADL	Independent	Assistance Needed	Dependent
Phone Calling	☐	☐	☐
Shopping	☐	☐	☐
Meal Preparation	☐	☐	☐
Light Housekeeping	☐	☐	☐
Managing Medications	☐	☐	☐
Money Management	☐	☐	☐
Transportation	☐	☐	☐

Emotional Health	Excellent	Good	Fair	Poor	Unable to answer	Chose not to answer
How would you rate your emotional health?	☐	☐	☐	☐	☐	☐

	Yes	No	Unable to answer	Chose not to answer
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	Excellent	Good	Fair	Poor	Unable to answer	Chose not to answer
How well would you say your memory is?	☐	☐	☐	☐	☐	☐
How well would you say you are able to communication your needs or concerns with providers?	☐	☐	☐	☐	☐	☐

Substance Use	Yes	No	Unable to answer	Chose not to answer
Do you use any substances such as, but not limited to, alcohol, marijuana, cocaine, or amphetamines?	☐	☐	☐	☐
Do you have any concerns about your use?	☐	☐	☐	☐

Tobacco Use	Yes	No	Unable to answer	Chose not to answer
Do you use tobacco products (including cigarettes, cigars, smokeless tobacco)?	☐	☐	☐	☐
Would you like assistance to quit?	☐	☐	☐	☐

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?	☐	☐	☐	☐

Safety	Yes	No	Unable to answer	Chose not to answer
Is anyone currently mismanaging your money or stealing from you?	☐	☐	☐	☐
Is anyone currently hurting your 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?	☐	☐	☐	☐

Medication/treatment include:			
Diagnosis/Problem List	**Medication**	**Dose**	**Notes**

Rank by Priority	My Goals	Intervention	Target Date	Monitoring Progress/Goal Revision Date	Date Goal Achieved/Not Achieved (Month/Year)
☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					

Additional update/notes about my goals:

Barriers to meeting any goals:

Initial/Annual:

My follow up plan:

Care Coordinator follow-up will occur:

☐ Once a month ☐ Every 3 months ☐ Every 6 months ☐ Other:

Purpose of Care Coordinator contact:

I can contact my Care Coordinator to help me with my medical, social, or everyday needs. I should contact my Care Coordinator when:

- Changes happen with my health
- I have a scheduled procedure or surgery, or I am hospitalized
- I need help finding a specialist
- I need help learning about my medications
- I would like information to help myself and my family make health care decisions
- I would like changes to my care plan or my services and supports
- I would like to talk about other service options that can meet my needs
- I am dissatisfied with one or more of my providers

Discussed TOC Date:

Member is interested in relocation services and referral has been made to relocation provider Date:

Discussion with Facility

Staff Name: Discipline: Date:

Notes:

Care Coordinator: Credentials:

Delegated Entity/Agency: Date: