 **MSHO/MSC+**

 **INSTITUTIONAL HEALTH RISK**

 **ASSESSMENT/SUPPORT PLAN**

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| **Initial** [ ]  | **Annual** [ ]  | **6 month** [ ]  | **Other** [ ]  | **Select Product: MSHO** [ ]  **MSC+** [ ]  | **IHRA Date:** Click or tap to enter a date. |
| **Member Name**       | **DOB**       | **Member ID**      |
| **Facility**      | **Facility Phone**       |
| **County**      | **Primary Care Clinic**      |
| **SNR 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: Click or tap to enter a date.      |
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| Met with family or authorized representative Date: Click or tap to enter a 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 [ ]  NoDate:       |
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| **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 [ ]  NoIf yes, date:       |       |
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| **ADL** | **Independent** | **Assistance Needed** | **Dependent** |
| **Dressing/Grooming** | [ ]  | [ ]  | [ ]  |
| **Bathing** | [ ]  | [ ]  | [ ]  |
| **Toileting**  | [ ]  | [ ]  | [ ]  |
| **Bed Mobility**  | [ ]  | [ ]  | [ ]  |
| **Transfer**  | [ ]  | [ ]  | [ ]  |
| **Ambulation**  | [ ]  | [ ]  | [ ]  |
| **Feeding**  | [ ]  | [ ]  | [ ]  |
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| **IADL** | **Independent** | **Assistance Needed** | **Dependent** |
| **Phone Calling**  | [ ]  | [ ]  | [ ]  |
| **Shopping** | [ ]  | [ ]  | [ ]  |
| **Meal Preparation**  | [ ]  | [ ]  | [ ]  |
| **Light Housekeeping** | [ ]  | [ ]  | [ ]  |
| **Managing Medications** | [ ]  | [ ]  | [ ]  |
| **Money Management**  | [ ]  | [ ]  | [ ]  |
| **Transportation**  | [ ]  | [ ]  | [ ]  |
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| **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)?** | [ ]  | [ ]  | [ ]  | [ ]  |

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| **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?**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

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| **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?** | [ ]  | [ ]  | [ ]  | [ ]  |

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| **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?**  | [ ]  | [ ]  | [ ]  | [ ]  |

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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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| **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?**  | [ ]  | [ ]  | [ ]  | [ ]  |

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

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| Additional update/notes about my goals:       |
| Barriers to meeting any goals:       |
| Initial/Annual:       |
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| **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
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| Discussed TOC Date: Click or tap to enter a date.      |
| Member is interested in relocation services and referral has been made to relocation provider Date: Click or tap to enter a date.      |
| Discussion with Facility Staff Name:       Discipline:       Date: Click or tap to enter a date.      |
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| Notes:       |
| Care Coordinator:       Credentials:      Delegated Entity/Agency:       Date:       |
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