 **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  No  Date: |
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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  No  If 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 |
| 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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