**UCare I-SNP Health Risk Assessment (HRA) Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **Member Name:** |  | **Member DOB:** |  |
| **Member Phone #:** |  | **Marital Status:** |  |
| **ISNP Enrollment Date:** |  | **UCare ID #:** |  |
| **Care Coordinator (Name, Phone #):** |  | **ISNP Care Delegate Organization:** |  |
| **Completion Date of HRA:** |  |  |  |
| **Type of HRA:** | **Initial**  **Annual Reassessment  Change of Condition** | **HRA Visit Type** | In Person  Real-time interactive Telehealth  Phone Call |
| **Sources of information for HRA:** |  | **Primary Language** |  |
| **Interpreter Needed?**  **Yes  No**  **Name and number of Interpreter (If applicable):** **Click or tap here to enter text.** |  | **Primary Care Provider (Name, Phone #):** |  |
| **Facility Name:** |  | **Facility Phone #:** |  |
| **Facility Address** |  | | |
| **Current Housing Type:** | **Nursing Facility**  **Assisted Living**  **Memory Care Unit** |  |  |
|  | Choose an item. |  |  |

**\*Member will be able to select one or more of the above options**

1. **What sex was originally listed on your birth certificate?**

Male  Female  Intersex  X  Unknown  Choose not to disclose.

1. **What is your current gender identity**?

Agender  Male  Female  Genderqueer, Gender Fluid, Gender Non-Binary Transgender male/trans man/female-to-male  Transgender female/trans woman/male-to-female

Additional gender category or other, please specify: Click or tap here to enter text.

Choose not to disclose.

1. **What are your pronouns? Member will be able to select one or more the following options:**

He/him/his  She/her/hers  They/them/theirs   None  Other, please specify

Choose not to disclose

1. **Do you think of yourself as**:

Asexual  Bisexual  Gay  Heterosexual/Straight  Lesbian  Pansexual  Queer

Questioning  Other, please specify: Click or tap here to enter text.  Do not know  Choose not to disclose

1. **In general, how would you rate your overall health?**

Excellent  Good  Fair  Poor  Unable to respond

1. **Do you have any of the following health conditions?** *(Mark all* that *apply)*

Heart disease  Stomach/bowel disease  Allergies/sinus issues

Lung disease  Blood disorders/anemia  Other : Click or tap here to enter text.

Arthritis  High blood pressure

Diabetes  Memory issues

Kidney disease  Depression

Thyroid disease  Disease that affects your nervous system

1. **Are you experiencing any pain now or in the last month?** *(If the answer is no, skip this section)*

Yes  No  Unable to respond

* 1. **In the past week, have you had pain that stops you from performing daily functioning and activities?**

No A little bit  Somewhat  Quite a bit  Very much

* 1. **What is the worst pain you have experienced in the past week?**

Mild  Moderate  Severe

* 1. **How long have you had this pain?**  One week  One month  As long as I can remember
  2. **Have you talked to your primary care provider about your pain?**  Yes  No
  3. **How are you managing your pain?**

Pain medication  Physical therapy  Heat/cold  Rest

Other: Click or tap here to enter text.

* 1. **If you are using pain medication, do you feel that you are able to manage your pain using your current regimine?** Yes No  N/A
  2. **Does your pain impact your quality of life (activity level, mood , relationships)?** Yes  No

Comments: Click or tap here to enter text.

1. **In the last 30 days have you experienced any of the following changes in your overall health?**

**a. New illness/injury:** Yes  No

**b. Decline in daily activities:** Yes  No

**c. New concern about a chronic condition:** Yes  No

**d. Increase/change in family/caregiver concerns:** Yes  No

Comments: Click or tap here to enter text.

1. **In the last 6 months have you experienced any of the following?**

**a. Fall(s)** Yes  No

**b. Reoccurring infections** Yes  No

**c. Unexplained weight loss / weight gain** Yes  No

**d. Change in ability to think clearly / memory loss** Yes  No

**e. Mood changes** Yes  No

**f. Bladder or bowel incontinence** Yes  No

Comments: Click or tap here to enter text.

1. **In the last 6 months have you stayed overnight as a patient in the hospital?** Yes No

**a. If yes, about how many times?** 1 Time  2 – 3 Times  4 + Times

1. **In the last 6 months have you gone to an emergency room?**  Yes  No

**a. If yes, about how many times?** 1 Time  2 – 3 Times  4 + Times

**b. Was your last emergency room visit within the last 30 days?**  Yes  No

1. **Do you have any difficulty with any of the following?**

**a. Vision** Yes  No

**b.Hearing** Yes  No

Comments: Click or tap here to enter text.

1. **Medications**

**a. How many different medications, including over the counter medications, do you take each day?**

0  1-3  4-6 7-10  11 +

**b. How many times a day do you take medications?**

2  3  4  > 4

**c. Do you feel the medications help you?**

Yes  Sometimes  No  Unable to respond

1. **Preventative Care** *(check all services received in the past year)*

Flu vaccine  Colonoscopy

Eye Exam  Mammogram (women)

Pneumonia vaccine  Prostate exam (men)

Shingles vaccine

Comments: Click or tap here to enter text.

**Food/Nutrition**

**Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or Never True for you and your household in the last 12 months**

1. **Within the past 12 months, you worried that your food would run out before you got money to buy more**

Often true  Sometimes true  Never true

Comments: Click or tap here to enter text.

1. **Within the past 12 month, the food you bought just didn’t last and you didn’t have money to get more.**

Often true  Sometimes true  Never true

Comments: Click or tap here to enter text.

1. **Are you on any special diets?**  Yes  No Comments: Click or tap here to enter text.
2. **Do you need any assistance completing the following activites?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Activity** | **No** | **Yes** | **Activity** | **No** | **Yes** |
| **Bathing** |  |  | **Laundry** |  |  |
| **Dressing** |  |  | **Housekeeping** |  |  |
| **Grooming** |  |  | **Managing medications** |  |  |
| **Toileting** |  |  | **Using the phone** |  |  |
| **Transfers** |  |  | **Scheduling appts & transportation** |  |  |
| **Eating** |  |  | **Managing money** |  |  |
| **Walking** |  |  | **Shopping** |  |  |
| **Food prep** |  |  | **Leaving your residence** |  |  |

1. **What is your living situation today?**

I have a steady place to live

I have a place to live today, 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, abondoned building, bus or train station or in a park

1. **Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY**

Pest 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

None of the above

1. **Are there any environmental safety concerns?**

*(If in a Skilled Nursing Facility, skip this section)*

a. Scatter rugs  Yes  No

b. Clutter  Yes  No

b. Tub/shower (non-slip flooring, grab bars, lip at shower entry)  Yes  No

Comments: Click or tap here to enter text.

1. **Have you used or are you currently using any of the following equipment?** *(Mark all that apply)*

Oxygen

C-Pap

Nebulizers

Walker

Wheelchair

Cane

Hospital Bed

Hearing Aid

Glasses / Contact Lenses

Other : Click or tap here to enter text.

1. **In the past week, how would you rate your motivation to be active?**

High  Medium  Low  Unable to respond

1. **Do you perform any type of exercise?**

Yes No

Comments: Click or tap here to enter text.

1. **How satisfied are you with your life?**

Very  Not very satisfied  Not at all satisfied  Unable to respond

1. **Over the past two weeks how often have you been bothered by the following problems?**

*(If unable to respond skip this section)*  Unable to respond

**a. Little Interest or pleasure in doing things:**

Not at all  Several days  More than half of the week  Nearly every day**b. Feeling down, depressed or hopeless:**

Not at all  Several days  More than half of the week  Nearly every day

**c. Lack of energy:**

Not at all  Several days  More than half of the week  Nearly every day

1. **Do you have family or friends that provide support?**

Yes  No  Unable to respond

Comments: Click or tap here to enter text.

1. **Are you concerned about your safety?**

Yes  No  Unable to respond

Comments: Click or tap here to enter text.

1. **Are you able to practice your religion or attend religious services as often as you’d like?**

Yes

No

Does not attend religious services

Comments: Click or tap here to enter text.

1. **What type of transportation do you use?**

Comments: Click or tap here to enter text.

1. **In the past 12 months, has the lack of reliable transportation kept you from medical appointments, work or from getting things needed for your daily living?**  Yes  No
2. **Do you have an Advance Healthcare Directive****?**  Yes  No

If yes, indicate the date it was completed:Click here to enter text.

If yes, indicate where it is on file: Click here to enter text.

Comments: Click or tap here to enter text.

* 1. **Was an Advance Directive / Health Care Directive Discussed?** Yes  No

If no, state reason: Click or tap here to enter text.

1. **Was written information provided on how to safely dispose of medications?** Yes  No

If no, state reason: Click or tap here to enter text.

**Comments/Care Plan Implications/Observations made by the Interviewer/Clinical Nurse Coordinator:**

|  |
| --- |
| Click here to enter text. |

**LEVEL OF RISK**

**PROTOCOL:** As part of the Health Risk Assessment assign a level of risk noting high, moderate, low as the first step in planning, developing, and implementing a personalized plan of care.

**PURPOSE:** The purpose of risk stratification is to segment I-SNP members into distinct groups of similar complexity and care needs to assist in the determination of the level of intensity of services needed to avoid adverse events and keep the individual stabilized to the highest feasible level of functioning.

**Indicate Member’s risk level based on descriptions below:  High  Moderate  Low**

|  |  |  |  |
| --- | --- | --- | --- |
| **RISK** | **CRITERIA** | **LEVEL OF FRAILITY1** | **VISIT FREQUENCY** |
| **HIGH** | - Acute change in condition from baseline in past 30 days  - New illness or injury  - Unstable chronic condition w/symptoms that are reported as difficult to manage by the I-SNP member and as recorded in the medical record  - Functional status change in last 30 days  - Readmission in last 30 days  - TCU admission  - ER visit in last 30 days  - Medications change in last 30 days  - Receiving treatments w/significant risk  - History of an infection in past two weeks requiring a higher level of services/ medication management. | Presumed frail, given:   * Fatigue with PHQ > 10 * Incontinence of bowel * Loss of weight ongoing * Physical help for all activities | At minimum: Monthly contact with a member of the ICT.  Suggestion:  Weekly contact either face to face or telephonically with member or other participant of the ICT. |
|  |  |  |  |
| **MODERATE** | - Unexplained falls  - Recurrent infections (UTI’s, skin infections)  - Unexplained or continued weight loss  - Current wound care treatment  - Expected decline nearing a new level of dependence  - Significant cognitive disabilities/behaviors  - Taking > 10 meds | Presumed to be pre-frail, given:   * Reports fatigue * Bladder incontinence * Nutrition compromised due to mechanical issues * Assistance with self -care/dressing * Device assistance with walking | At minimum: Monthly contact with a participant of the ICT.  Suggestion:  Monthly contact either face to face or telephonically with member. |
|  |  |  |  |
| **LOW** | - Patient able to compensate for chronic conditions  - Requires little assistance  - Stable condition/environment  - Taking < 10 meds  - Little need for assistance  - Relatively intact cognitive status | Considered to be non-frail, given:   * Independent ambulation * Independent in dressing * Regular diet/no weight loss * No incontinence of either bowel or bladder | At minimum: Monthly contact with a participant of the ICT.  Suggestion:  Quarterly contact either face to face or telephonically with member. |

***1****The frail levels are as described by Ellen W Kaehr MD and in the Frail-NH tool*

**SIGNATURE OF CARE COORDINATOR (include credentials)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_