MSC+/MSHO Institutional Health Risk Assessment

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 ☐No
If no, provide reason:

Discussion with nursing home staff? ■Yes ■No
Name, Discipline, Date:

Is there an Advanced Directive, Health Care Directive, and/or POLST on file? ■Yes ■No

Was the Advanced Directive, Health Care Directive, and/or POLST discussed with member/representative? ☐Yes ☐No
If not discussed, provide reason:

Hospital/ER Visits in the past year? ☐Yes ☐No
If yes, provide dates and reasons:

Discussed Transitions of Care? ☐Yes ☐No
If not discussed, provide reason:

Date of most recent MDS:

Care Coordinator reviewed MDS? ☐Yes ☐No

Copy of MDS received and attached to IHRA? ☐Yes ☐No

Date of most recent nursing home care plan:

Care Coordinator reviewed facility care plan? ☐Yes ☐No

Copy of facility care plan received and attached to IHRA? ☐Yes ☐No

Current diagnosis/problem list attached? ☐Yes ☐No
If not attached, list diagnoses/problem:

Current medication list attached? ☐Yes ☐No ☐Not applicable, no medications
If 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.

	Excellent	Good	Fair	Poor	Unable to answer	Chose not to answer	N/A
How would you rate your health?	☐	☐	☐	☐	☐	☐	☐

	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 applicable
If no, explain:

Was a referral for services made?
☐Yes ☐No ☐Not applicable
If 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?	☐	☐	☐	☐	☐	☐

	Yes	No	Unable to answer	Chose not to answer
Outside of mealtimes, can you get something to eat or grab a snack when you get hungry?	☐	☐	☐	☐

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: