 **MSC+/MSHO Institutional Health Risk Assessment**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How would you rate your health? | | | Excellent | | | | Good | | | | | Fair | | | | | | Poor | | | | | | Unable to answer | | | | | | | | | | Chose not to answer | | | | | | | | | N/A |
|  | | | | | | | | | | | | 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? | | | | | |  | | | |  | | | | | | | | | |  | | | | | | | |  | | | | | | | |  | | | | |  | | |
| Outside of mealtimes, can you get something to eat or grab a snack when you get hungry? | | | | | | Yes | | | | | | | | | | No | | | | | | | | | | | Unable to answer | | | | | | | | | | | | Chose not to answer | | | | |
| **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: