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MSHO/MSC+
INSTITUTIONAL HEALTH RISK ASSESSMENT
&
CARE PLAN

Member Information		
Member Name:	Date of Birth:	Medica ID:
Facility Name:	Facility phone number:	Contact at facility (name, title, etc.):
Admission Date:	Room Number:	Medica Enrollment/Transfer Date:
Assessment and Care Plan Date:	Assessment Type: Select One	Date of the facility assessment:

☐ **I have reviewed the member's most recent facility assessment (MDS, etc.)**

☐ **The following assessment information was gathered by the care coordinator through interaction with the member/responsible party, facility staff, and chart review**

Member's Care Team (Interdisciplinary Care Team – ICT)	
Care Coordinator Name: Phone #:	Primary Physician: Clinic: Phone #: Fax #:
Legal Guardian/POA:	Legal Guardian/ POA Phone:
Authorized Rep (if different):	Authorized Rep Phone:
Other: Name and Relationship:	Other: Phone Number:

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FACILITY CHART REVIEW	
Is there an Advance Directive, Health Care Directive, or POLST in place? ☐ Yes ☐ No If no, was Advance Directive/Health Care Directive/POLST discussed with member/ responsible party: ☐ Yes ☐ No If no, reason:	Check all that apply: ☐ Do not resuscitate (DNR) ☐ Do not hospitalize (DNH) ☐ No tube feedings ☐ Comfort Care Only ☐ CPR ☐ Do not intubate (DNI) ☐ No IVs ☐ No antibiotics ☐ No hospice Comments:

Care Transitions – Has the member had any hospital admissions or ER visits in the last 6 months? ☐ Yes ☐ No

If yes, provide dates and comments:

Medication list reviewed: ☐

Member not prescribed any medications: ☐

Immunization and Preventative Care Review		
Vaccine/Immunization/Screening	**Is the member up to date?**	**If no or NA, include documentation why. Create goal in the Care Plan section below or indicate why no goal was created.**
Flu (*Annually)*	☐ Yes ☐ No ☐ NA	
Pneumococcal *(Immunize at age 65 if not done previously. Re-immunize once if 1st pneumovax was received more than 5 years ago & before age 65)*	☐ Yes ☐ No ☐ NA	
TDAP *(Once every 10 years)*	☐ Yes ☐ No ☐ NA	
Shingles (Shingrix) *(Ages 50+ get 2 doses)*	☐ Yes ☐ No ☐ NA	
COVID-19 *(2 or 3 dose primary series + booster)*	☐ Yes ☐ No ☐ NA	

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Primary Care Visit *(Annually)*	☐ Yes ☐ No ☐ NA	
Vision Exam *(Annually)*	☐ Yes ☐ No ☐ NA	
Dental Exam *(Annually)*	☐ Yes ☐ No ☐ NA	
Hearing Exam *(Annually)*	☐ Yes ☐ No ☐ NA	
Colon Cancer Screening *(Up to age 75)*	☐ Yes ☐ No ☐ NA	
Breast Cancer Screening *(Up to age 75)*	☐ Yes ☐ No ☐ NA	
Other:	☐ Yes ☐ No ☐ NA	

Activities of Daily Living (ADL)Functional Status	**Independent**	**Staff Assistance or Equipment Needed (need being met)**	**Assistance Needed (need NOT being met)**	**Comments – If assistance needed, how is this need being met? If unmet, what is the plan to address this need?**
Dressing	☐	☐	☐	
Grooming	☐	☐	☐	
Bathing	☐	☐	☐	
Toileting	☐	☐	☐	
Bed Mobility	☐	☐	☐	
Transfers	☐	☐	☐	
Ambulation	☐	☐	☐	
Eating	☐	☐	☐	
Other:		☐ Yes ☐ No ☐ NA	Comments:	

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Facility Chart Review Comments:

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MEMBER/RESPONSIBLE PARTY INTERVIEW

*If member is not able to complete, reach out to the responsible party to attempt to complete. If unable to reach the responsible party, complete utilizing a chart review.

If needs are identified, review facility care plan to verify a goal is addressing the need. If there is no goal present, create a goal in the Care Plan section below. If a goal is not created, document why.

Routine and Activities	Yes	No	Unable to answer	Chose not to answer
Are you satisfied with your daily routine?	☐	☐	☐	☐
If no, what would you like to see changed?				
What are the most important things to you (e.g. being social, music, family, etc.)?				

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What activities or things do you enjoy doing in your free time?

Is there anything you need to support or help you to do these activities?

Comprehensive Pain Assessment		
Are you experiencing any pain now or in the last two weeks?	☐ Yes	☐ No
If yes, has your pain affected your function or quality of life (e.g., activity level, mood, relationships, or sleep)?	☐ Yes	☐ No
If yes to either question above, what type of pain do you have (check all that apply)?		
Headache	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No
Nerve Pain	☐ Yes	☐ No

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Muscle/Joint Pain	☐ Yes	☐ No
Other Pain	☐ Yes	☐ No
If yes to any of the above, describe pain:		
Have you talked to your doctor or someone else about the cause of your pain?	☐ Yes Who: When:	☐ No
Have you talked to someone about how to handle your pain?	☐ Yes Who: When:	☐ No

*****Connect with facility staff and/or Medica Behavioral Health if there are concerns about the member's mental health

PHQ-9 or PHQ-9-OV Score:

*If PHQ-9 or PHQ-9-OV score is unavailable or if the score is 10 or above, complete the emotional health screening

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?	☐	☐	☐	☐

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In the past three months have you been limited in your social activities with family, friends, neighbors, or groups (not related to transportation)?	☐	☐	☐	☐

Additional Comments:

C0100 Brief Interview for Mental Status (BIMS) Score:

*If BIMS score is unavailable complete the cognitive status/communication screening

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 communicate your needs or concerns with providers?	☐	☐	☐	☐	☐	☐

Additional Comments:

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Substance Use	Yes	No	NA	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?	☐	☐	☐	☐	☐
Additional Comments:					

Tobacco Use	Yes	No	NA	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?	☐	☐	☐	☐	☐
Additional Comments:					

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)?	☐	☐	☐	☐

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Is anyone currently touching you in a way that makes you feel uncomfortable?	☐	☐	☐	☐
Is anyone currently emotionally abusive to you?	☐	☐	☐	☐
Additional Comments:				

Living Situation		**Check one**
Are you homeless or worried that you might be in the future?	Yes	☐
	No	☐
	Unable to answer	☐
	Chose not to answer	☐

Do you like where you live?	☐ Yes	☐ Unable to answer
	☐ No	☐ Chose not to answer
If no, what would you change?		

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Additional Comments:

☐ **I have assessed this member's desires and/or ability to relocate back to the community or another facility** (Note to Care Coordinator: If the member is interested in transitioning to another setting, the Care Coordinator is to communicate with the member/responsible party about resources and benefits available to them regarding transition planning and relocation. Document this conversation in the member's record.)

Food		**Check one**
In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	Yes	☐
	No	☐

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		**Check one**
Do you put off or neglect going to the doctor because of distance or transportation?	Yes	☐
	No	☐
	Unable to answer	☐
	Chose not to answer	☐

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Member/Responsible Party Screening Comments:

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CARE PLAN

***ATTACH FACILITY CARE PLAN**

I confirm that the Facility Care Plan:

☐ Incorporates the unique primary care, acute care, long-term care, mental health, and social service needs of the member;

☐ Identifies any risks to the member's health and safety and plans for addressing those risks; and

☐ Has a preventive focus, which may include but is not limited to such areas as maintaining or improving functional status, fall risk, nutritional needs, socialization needs, preventive care needs, and skin integrity/wound prevention

If the Facility Care Plan does not address any of the above, describe below:

Facility Care Plan was reviewed, and I agree all identified needs have goals identified ☐

Facility Care Plan was reviewed, and member identified additional goals listed below ☐

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Rank by Priority	My Goals	Interventions	Target Date	Monitoring Progress/Goal Revision Date	Date Goal Achieved/Not Achieved (Month/Year)
☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					

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Additional comments, update, and/or notes about goals:

Barriers to meeting goals:

Is there anything additional you would like to discuss today? ☐ Yes ☐ No

If yes, explain:

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CARE COORDINATOR ACTIVITIES

Care Coordinator's Actions:

☐ I have met with the member and/or responsible party, explained the Care Coordinator role and addressed member concerns

☐ I have discussed member's assessment and care plan with facility staff

☐ I have requested to be invited to member care conferences

☐ I have attended the most recent care conference or reviewed care conference notes

Date of most recent care conference:

☐ I have provided the Nursing Facility Chart Coverage Guide to facility staff

☐ I have sent the Institutional Post Visit Letter to facility staff and the member/member representative

☐ I have sent the PCP letter to the member's primary care provider

FOLLOW-UP MEETING PLAN

☐ Every 6-months

☐ Other (specify):

Comments:

Care Coordinator Signature:

Date:

Care Coordinator Name and Credentials:

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