

HRA Form

Plan :	VPHP - VIRGINIA PREMIER
Program :	Medicare
LOB :	DSNP
Region :	TIDEWATER
Aligned :	Y
Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	MICHAEL MARSHALL
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1971-07-04
Evaluation Date :	
Visit Type :	

Demographics

Name	MICHAEL MARSHALL
Gender	Male
Address	1303 HIGHLAND AVE
City	PORTSMOUTH
State	VA
Zip	237049999
Date of Birth	1971-07-04
Age(as of date)	49
Marital Status	Separated
Member Identification Number	11014780
HICN	9ET4E35WD74
Phone Number	7573925886
Cell Number	
Email	
Emergency Contact	Christina Marshall (wife)
Phone Number	7573925886
Primary Care Physician	BIKOWSKI, RICHARD MICHAEL
Phone Number	7573976344
PCP Address	825 Fairfax Ave
PCP City	Norfolk

PCP State	VA
PCP Zip	235071914
PCP County	
Office ID	P0060136
Office Name	PORTSMOUTH FAMILY MEDICINE

1. Race

Answer: African American

Patient's Ethnicity

Answer:

2. Preferred language

Answer: English

Covid Screening

In the last 14 days, have you:

Traveled internationally?

Answer: No

Had known exposure to anyone diagnosed with Corona virus (COVID-19)

Answer: No

Had close contact with someone who has traveled to a high risk area?

Answer: No

Developed Fever?

Answer: No

Developed Cough?

Answer: No

Developed Flu like symptoms?

Answer: No

Developed Shortness of breath?

Answer: No

Self-Assessment and Social History

3. How much school have you completed?

Answer: Completed 8th grade

4. When you get written information at a doctor's office would you say it is

Answer: Very difficult

<b>5. When you read the instructions on a prescription bottle would you say that it is</b> <i>Answer: Very difficult</i>
<b>6. How confident are you in filling out medical forms by yourself?</b> <i>Answer: Not at All Confident</i>
<b>7. How would you rate your health compared to other persons your age?</b> <i>Answer: Fair</i>
<b>8. During past 3 months, has your physical and or emotional health limited your social activities with family, friends, neighbours or groups?</b> <i>Answer: Sometimes</i>
<b>9. Where do you currently live?</b> <i>Answer: Home</i> <i>Comment: 1 level</i>
<b>10. Do you have someone you can rely on to help if you are sick or have problems you need to discuss?</b> <i>Answer: Yes</i>
<b>11. Who do you currently live with?</b> <i>Answer: Family</i>
<b>12. Are you currently a caregiver for someone?</b> <i>Answer: No</i>
<b>13. Tobacco use</b> <i>Answer: Never</i>
<b>14. Alcohol Use</b> <i>Answer: Never</i>
<b>15. Do you or have you used recreational drugs or pain medication?</b> <i>Answer: No</i>
<b>16. Do you have a Healthcare Proxy?</b> <i>Answer: No</i>
<b>17. Do you have a Durable Power of Attorney?</b> <i>Answer: No</i>
<b>18. Do you have an Advance Directive?</b> <i>Answer: No</i>
<b>Within the past 12 months we worried whether our food would run out before we got money to buy more. Was that _____ for your household?</b> <i>Answer:</i>

Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Was that \_\_\_\_\_ for your household?

Answer:

Activities of Daily Living

19. Do you have any difficulty with the following activities?

A. Getting in or out of bed

Answer: No

B. Getting in or out of chairs

Answer: No

C. Toileting

Answer: No

D. Bathing

Answer: No

E. Dressing

Answer: No

F. Eating

Answer: No

G. Walking

Answer: No

H. Going up or down stairs

Answer: No

Medical History

20. Do you use any assistive devices? (Check device or none if no devices used)

Answer: None

Comment:

21. Are you currently seeing any specialists?

Answer: Yes

Medical Specialty	Specialist	For
Psychiatrist	Depression/Anxiety/ Insomnia	
Gastroenterologist		Gastritis

22. In the past 12 months how many times have you?

<div><div><b>A. Seen your PCP</b> <i>Answer:</i> 3 <i>Comment:</i> PCP visit avg Q3-6months, last visit Dec 2020</div><div><b>B. Visited the Emergency Room</b> <i>Answer:</i> 1  <b>If one or more, describe</b> <i>Answer:</i> Nov 2020--ER visit for Abdominal pain r/t Gastritis</div><div><b>C. Stayed in the hospital overnight</b> <i>Answer:</i> None</div><div><b>D. Been in a nursing home</b> <i>Answer:</i> None</div><div><b>E. Had Surgery</b> <i>Answer:</i> None</div></div>
<div><div><b>23. Have you ever been hospitalized prior to the last 12 months?</b> <i>Answer:</i> No</div></div>
<div><div><b>24. In the past year have you received health services from any of the providers below:</b>  <div><b>Physical Therapist</b> <i>Answer:</i> No</div><div><b>Occupational Therapist</b> <i>Answer:</i> No</div><div><b>Dietician</b> <i>Answer:</i> No</div><div><b>Social Worker</b> <i>Answer:</i> No</div><div><b>Pharmacist</b> <i>Answer:</i> No</div><div><b>Speech Therapist</b> <i>Answer:</i> No</div><div><b>Chiropractor</b> <i>Answer:</i> No</div><div><b>Personal Care Worker (HHA, CNA, PCA)</b> <i>Answer:</i> No</div><div><b>Meals on Wheels</b></div></div></div>

Answer: No

25. In the past two years have you received any of the treatments below?

Chemotherapy

Answer: No

Catheter Care

Answer: No

Oxygen

Answer: No

Wound Care

Answer: No

Regular Injections

Answer: No

Tube Feedings

Answer: No

Family History

26. Family History

Answer: Yes

Comment: Unknown

Family Member	Medical Condition	Cause of Death
Mother	multiple CVA's, HTN, DM	

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No
Breast Exam/Mammography	Not Applicable
Cervical Screening	Not Applicable
Bone Density	No
Prostate Exam/PSA	No
If Diabetic Eye Exam	Not Applicable
If Diabetic Foot Exam	Not Applicable
If Diabetic Hgb A1c screen	Not Applicable
Lipid Panel	Yes

28. Last colonoscopy if more than 2 years ago

Answer: > 10 years ago

29. Screen for abnormal glucose / diabetes - age 40 - 70

Answer: Yes

30. One time screen for Abdominal Aortic Aneurysm if male with history of smoking, age 65 - 75

Answer: NA

31. One time screen for Hepatitis C if born between 1945 - 1965

Answer: NA

32. Do you get Flu Vaccine each year?

Answer: No

33. Have you been vaccinated for Pneumonia?

Answer: No

34. Have you been vaccinated for Herpes Zoster?

Answer: No

Allergies / Medications

35. Allergies

Answer: No

Medications

Dose Date	Label Name	Dose / Units	Route	Frequency	Status
2021-02-05	Paxil	50mg	PO = By Mouth	QD	Taking
2021-02-05	Trazadone	50mg	PO = By Mouth	HS	Taking

36. Over the Counter Medications / Supplements

Answer: yes

Date	Description	Dose/Units	Route	Frequency
2021-02-05	Probiotic	1 tab	PO = By Mouth	QD
2021-02-05	Multivitamin	1 tab	PO = By Mouth	QD

37. Chronic Use of

Answer: None

Comment:

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?

Answer: No

2. Do you sometimes not pay enough attention to your medication?

Answer: No

3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?

Answer: Yes

4. When you feel better do you sometimes stop taking your medicine?

Answer: No

5. Sometimes if you feel worse when you take your medicine do you stop taking it?

Answer: No

6. Do you sometimes forget to refill your prescription on time?

Answer: No

Review of Systems and Diagnoses

EYES

Eye Problems (Glaucoma, Cataracts, Macular Degeneration, Blindness, Retinal Detachment, Other)

Answer: No

Do you wear glasses or contacts?

Answer: No

Do you have problems seeing at night?

Answer: No

EARS

Ear Problems (Hard of hearing, Deaf, Vertigo, Ear Infections)

Answer: No

NOSE

Nose Problems (Nose Bleeds, Sinus infections, Other)

Answer: No

MOUTH AND THROAT

Mouth and Throat Problems (Difficulty Chewing, Difficulty Swallowing, Bleeding Gums, Other )

Answer: No

NECK

Neck Problems (parotid Disease, Carotid Stenosis, Other)

Answer: No

RESPIRATORY

Respiratory Problems (COPD, Emphysema, Asthma, Chronic Bronchitis Pneumonia, Other)

Answer: No

CARDIOVASCULAR

Cardiovascular (Hypertension, Angina, Ischemic Heart Disease(CAD), Myocardial Infarction, Other)

Answer: No

GASTROINTESTINAL

Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other)

Answer: Yes

Diagnoses

Other

Describe

Answer: Active

Supported by

Answer: History, Symptoms

Other

Answer: Gastritis (followed by Gastroentrolgy

History of blood in stool

Answer: No

History of black stools

Answer: No

History of Heartburn / Dyspepsia

Answer: No

History of Vomiting or Regurgitation

Answer: No

History of pain after eating

Answer: No

History of Jaundice

Answer: No

Do you follow a special diet?

Answer: No

Do you have frequent abnormal abdominal pain?

Answer: No

Do you have intermittent nausea or vomiting?

Answer: No

Do you have trouble with constipations?

Answer: No

Does diarrhea limit your ability to get out of the room or socially?

Answer: No

Do you see blood in your urine?

Answer: No

Do you have Frequent Stomach Pain

Answer: No

Bowel Movements

Answer: Normal

Abdominal Openings

Answer: No

Rectal Problems

Answer: No

Last Bowel Movement

Answer: 1-3 days ago

NEURO-PSYCH

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

Answer: Yes

Diagnoses

Depression

Describe

Answer: Active

Supported by

Answer: Use of antidepressant medication

Major

Answer: Yes

Supported by

Answer: Chronic use of antidepressant medication beyond 6 months

Generalized Anxiety Disorder

**Describe**

Answer: Active

**Supported by**

Answer: Symptoms, Antianxiety medication

**Other**

**Describe**

Answer: Active

**Supported by**

Answer: History, Symptoms, Medications

**Other**

Answer: Insomnia ()Trazadone)

**Are you nervous, anxious, feel on the edge or often feel stressed?**

Answer: Yes

**Do you worry too much about different things?**

Answer: No

**Do you feel afraid that something bad might happen?**

Answer: No

**History of headaches**

Answer: No

**History of auditory hallucinations**

Answer: No

**History of visual hallucinations**

Answer: No

**History of psychotic behavior**

Answer: No

**History of episodes of delirium**

Answer: No

**Do you follow a special diet?**

Answer: No

**Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?**

Answer: No

**Do you have trouble swallowing your food?**

Answer: No

**Do you have trouble making people understand you when you speak?**

Answer: No

**Do you trouble understanding what people say to you?**

Answer: No

Do your hands shake?

Answer: No

Do you have convulsions and seizures?

Answer: No

Do you have trouble with your memory?

Answer: No

Do you have trouble finding words?

Answer: No

Do you have trouble sleeping?

Answer: Yes

Have you lost your appetite

Answer: No

Do you hear voices or see things that other people do not

Answer: No

Do you have highs and lows

Answer: Yes

Do you ever feel like someone is out to get you

Answer: No

How often do you go out to meet with family or friends

Answer: Often

GPCOG Score or MMSE Score

GPCOG Score	
or MMSE Score	

If GPCOG or MMSE is not done, is

Patient oriented to person

Answer: Yes

Patient oriented to place

Answer: Yes

Patient oriented to time

Answer: Yes

Recall

Answer: Poor

Patient describes recent news event

Answer: Partially
<b>Affect</b> Answer: Normal
<b>Over the past 2 weeks, how often have you been bothered by any of the following problems?</b>  <b>Little interest or pleasure in doing things</b> Answer: Several Days  <b>Feeling down, depressed or hopeless</b> Answer: Several Days  <b>PHQ 2 Score : &lt;3</b>
<b>Speech</b> Answer: Normal
<b>Finger to Nose</b> Answer: Normal
<b>Heel (Shin) to Toe</b> Answer: Comment: Virtual, limited exam
<b>Thumb to Finger Tips</b> Answer: Normal
<b>Sitting to Standing</b> Answer: Normal
<b>Facial / Extremity Movement</b> Answer: Normal
<b>Gait</b> Answer: Normal
<b>GENITOURINARY</b>  <b>Genitourinary Problems (Overactive Bladder, Urinary Incontinence Stress Incontinence, Benign Prostatic Hypertrophy, Others)</b> Answer: No
<b>MUSCULOSKELETAL</b>  <b>Musculoskeletal Problems (Spinal Stenosis, Rheumatoid Arthritis, Gout, Osteoporosis,</b>

Others)

Answer: Yes

Diagnoses

Osteoarthritis

Describe

Answer: Active

Supported by

Answer: Symptoms

Which joints

Answer: Bilat knees, Lt Hip

History / Finding of non- extremity Fracture

Answer: No

History / Finding of Hip Fracture / Dislocation

Answer: No

History / Finding of Vertebral Fracture

Answer: No

Do you have any swelling of your joints?

Answer: No

Do you experience stiffness in the morning or during the day?

Answer: Yes

Do you have pain in your joints?

Answer: No

Do you have a problem straightening any joints?

Answer: No

Does pain and or swelling in your joints limit your activities?

Answer: No

Have you broken bones(fractures) in any parts of your body?

Answer: No

Do you have constant pain in your bones?

Answer: No

Have you had an amputation?

Answer: No

INTEGUMENT

Integument Problems (Eczema, Psoriasis, Dermatitis, Urticaria, Other)

Answer: No

ENDOCRINE

Endocrine Problems

Answer: No

Have you lost weight in the past 6 months?

Answer: None

HEMATOLOGY / IMMUNOLOGY / INFECTIOUS DISEASE

Hematology / Immunology / Infection Disease Problems (Anemia, easy bruising or abnormal bleeding Thrombocytopenia , Other)

Answer: No

CANCER

Diagnosis of Cancer

Answer: No

Pain

Does the patient experience pain?

Answer: No

Vital Signs

Vital Signs

Blood Pressure	
Pulse	
Respiratory Rate	
Temp	
Pulse Oximetry	
Pain Scale /10	0

BMI

Comment:

Patients Height	5 feet 6 inch
Patients Weight	163 lbs
BMI	26.3

Exam Review

Constitutional

<b>General appearance:</b> <i>Answer:</i> Normal
<b>Head and Face</b>
<b>Examination of head and face:</b> <i>Answer:</i> Normal
<b>Palpation of the face and sinuses:</b> <i>Answer:</i> <i>Comment:</i> Virtual, limited exam
<b>Eyes</b>
<b>Inspection of conjunctiva and lids:</b> <i>Answer:</i> Normal
<b>Examination of pupils and irises:</b> <i>Answer:</i> <i>Comment:</i> Virtual, limited exam
<b>Ears, Nose, Mouth and Throat</b>
<b>External Inspection of ears and nose:</b> <i>Answer:</i> Normal
<b>Otoscopic examination:</b> <i>Answer:</i> <i>Comment:</i> Virtual, limited exam
<b>Assessment of hearing:</b> <i>Answer:</i>
<b>Inspection of nasal mucosa, septum and trubينات:</b> <i>Answer:</i>
<b>Inspection of lips, teeth and gums:</b> <i>Answer:</i>
<b>Examination of oropharynx:</b> <i>Answer:</i>
<b>Neck</b>
<b>Examination of neck:</b> <i>Answer:</i> Normal

<div>Examination of thyroid: <div>Answer: Comment: Virtual, limited exam</div></div>
<div>Pulmonary</div> <div>Assessment of respiratory effort: <div>Answer: Normal</div></div> <div>Percussion of chest: <div>Answer: Comment: Virtual, limited exam</div></div> <div>Palpation of chest: <div>Answer:</div></div> <div>Auscultation of lungs: <div>Answer:</div></div>
<div>Cardiovascular</div> <div>Palpation of heart: <div>Answer: Comment: Virtual, limited exam</div></div> <div>Auscultation of heart: <div>Answer:</div></div> <div>Carotid Arteries: <div>Answer:</div></div> <div>Abdominal Aorta: <div>Answer:</div></div> <div>Pedal Pulses: <div>Answer:</div></div> <div>Examination of Arterial Pulses: <div>Answer:</div></div> <div>Examination of Edema / Varicosities: <div>Answer:</div></div>
<div>Lymphatic</div> <div>Palpation of cervical nodes (neck) <div>Answer: Comment: Virtual, limited exam</div></div>

<b>Palpation of preauricular nodes (in front of the ears)</b> <i>Answer:</i>
<b>Palpation of Submandibular nodes (under jaw line/chin)</b> <i>Answer:</i>

<b>Musculoskeletal</b>
<b>Examination of gait and station:</b> <i>Answer:</i> Normal
<b>Inspection/palpation of digits and nails:</b> <i>Answer:</i> <i>Comment:</i> Virtual, limited exam
<b>Inspection/palpation of joints, bones and muscles:</b> <i>Answer:</i>
<b>Assessment of range of motion:</b> <i>Answer:</i>
<b>Assessment of stability:</b> <i>Answer:</i>
<b>Assessment of muscle strength/tone:</b> <i>Answer:</i>

<b>Skin</b>
<b>Inspection of skin and subcutaneous tissue:</b> <i>Answer:</i> Normal
<b>Palpation of skin and subcutaneous tissue:</b> <i>Answer:</i> <i>Comment:</i> Virtual, limited exam

<b>Neurologic</b>
<b>Indicate specific cranial nerve tested</b> <i>Answer:</i> CN (3, 4, 6), (5, 7, 8, 10, 11, 12)--appears WNL (virtual)
<b>Indicate cranial nerve deficits found</b> <i>Answer:</i> Virtual, limited exam
<b>Romberg Test</b> <i>Answer:</i> <i>Comment:</i> Virtual, limited exam

<b>Examination of reflexes:</b> <i>Answer:</i>
<b>Examination of sensation:</b> <i>Answer:</i>
<b>Coordination:</b> <i>Answer:</i>

<b>Diabetes</b>
<b>Foot Exam:</b> <i>Answer:</i> <i>Comment:</i> N/A

<b>Psychiatric</b>
<b>Description of patient's judgement / insight:</b> <i>Answer:</i> Abnormal <i>Comment:</i> Some cognitive/mental health issues
<b>Orientation of person, place and time:</b> <i>Answer:</i> Normal
<b>Recent and remote memory:</b> <i>Answer:</i> Abnormal
<b>Mood and affect:</b> <i>Answer:</i> Normal

Screenings Needed									
Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	No	Select			No			Virtual exam, no screenings	
HBA1C	No	Select			No				
MICROALBUMIN	No	Select			No				

FOBT	No	Select			No				
DEXA	N/A	Select			No				
PAD	No	Select			No				
LDL	No	Select			No				

Mini-Cog

Word List Version	1
Person's Answers	
Word Recall	0
Clock Draw	0
Total Score	0
Comment: No mini-Cog, minimum verbal due to cognitive & mental health issues	

Home Safety & Personal Goals

40. In the past year how many times have you Fallen?

Answer: None

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?

Answer: No

b. Do you have electrical cords running across floors, in doorways or under a rugs?

Answer: No

c. Do you have no slip mats on the shower floor or bath tub?

Answer: No

d. Do have adequate lighting in hallways and on the stairs?

Answer: Yes

e. Do you have handrails on staircases?


Answer:

Comment: 1 level

f. Is your hot water heater set for a maximum of 120 degrees?

Answer: Yes

<p><b>g. Do you have smoke detectors on each level of the house and in all sleeping a rooms?</b></p> <p><i>Answer: Yes</i></p> <p><b>h. Do you have carbon Monoxide detectors on each level of the house?</b></p> <p><i>Answer: Yes</i></p> <p><b>i. Have used established an escape route in the event of fire?</b></p> <p><i>Answer: Yes</i></p>
<p><b>42. Are there things about yourself you wish you could change or improve?</b></p> <p><i>Answer: Minimum verbal responses due to mental health &amp; cognitive issues</i></p>
<p><b>43. Is there anything that you could do to improve your quality of life?</b></p> <p><i>Answer:</i></p>
<p><b>44. Have you ever physically or felt emotionally abused by someone</b></p> <p><i>Answer: No</i></p>
<p><b>45. Feeling like harming others or yourself</b></p> <p><i>Answer: No</i></p>
<p><b>46. Are you afraid of anyone or is anyone hurting you?</b></p> <p><i>Answer: No</i></p>

Patient Summary	
Assessors Comments	<p>Annual Health Assessment, some responses by member (Michael) but most responses provided by wife( Christina ). Although they are legally separated, she assist with medical &amp; business affairs.</p> <p>Disability for Mental health &amp; cognitive issues</p> <p>Virtual exam, therefore some blank responses due to limited exam info</p> <p><b>**Verification: Name/DOB</b></p>
Member informed of acknowledgment	true
Date/Time of Service/ Evaluation :	2021-02-05T11:17
Time exam finished	2021-02-05T23:50
Provider Signature	<div><div>Temeka Gillespie</div><div><div>Digitally signed by Temeka Gillespie, FNP 2021-02-05, 14:12</div></div></div>
Addendum	<div></div>

Member Acknowledgment	I have been advised by the evaluator and understand that the services performed by the evaluator are limited to the evaluation performed today; the evaluator has no further duties to me once the evaluation performed today is completed ; the evaluator is not liable for abandonment my refusing to provide me treatment or continuing care to me beyond this evaluation; and I should contact my primary care or treating physician for all questions and concerns regarding medical care and treatment or, in the event of an emergency, call 911
Disclosure Statement	<div>Your health plan has asked Focus Care to conduct, on its behalf, health assessments on its patients. The health assessment includes questions to help your health plan learn more about your current health status, including potential health risks. This information will help your health plan and your physician help you maintain or achieve your best state of health.</div> <div>Generally, your personal health information (PHI) may only be used and disclosed by us with your express written authorization. Focus Care has implemented several security measures to protect your PHI from being released orally, in writing, or electronically. Additional information about these safeguards are available upon request.</div> <div>Treatment Purposes. We may disclose medical information about you to other health care providers who are or will be involved in taking care of you. For example, the results of your health assessment will be sent to your health plan. Your health plan will use this information to identify your health needs and offer available programs to you. Your health plan shares your completed health risk assessment with your physician.</div> <div>Payment Purposes. We may use or disclose your medical information for payment purposes. It is necessary for us to disclose your completed health assessment to your health plan so that we may bill and receive payment for this service.</div> <div>Health Care Operations. We may use and disclose your personal health information in order for us to conduct our healthcare business, which is administration of the health assessment on behalf of your health plan.</div> <div>Other uses and disclosures of your PHI will be made only with your written authorization unless otherwise permitted or required by law. The use or disclosure will be made in compliance with the law and will be limited to the requirements of such law.</div>

	<p>In addition, we may release your personal health information to third party 'business associates' who perform various activities for us, such as billing or electronic transmissions of PHI. Whenever our arrangement with a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.</p>
	<p>Your agreement to participate with the health assessment implies your consent to provide the results of your health assessment to your health plan.</p>