BlueCross BlueShield
Minnesota

Transitional Health Risk Assessment
MSHO/SecureBlue & MSC+ Blue Advantage

Completion of this form, as described, will meet requirements for a Health Risk Assessment (HRA) and a supplement to the existing care plan for newly enrolled MSHO/SecureBlue & MSC+ Blue Advantage members who have had an LTCC or MnCHOICES assessment within the past 365 days. This form should be completed within 30 days of enrollment for MSHO/SecureBlue EW and non-EW members and MSC+ EW members. MSC+ non-EW members are allowed 60 days for completion of this form. This form is to be attached to the most recent LTCC and care plan or MnCHOICES assessment summary and CSSP. A new LTCC and Collaborative Care Plan must be done if there is not a current one to review and update within the past 365 days. Please refer to the MSC+ or MSHO guidelines for details.

Note: The next annual reassessment is due 365 days from the date of the last full LTCC attached to this form.

I. PERSONAL INFORMATION

Name	PMI Number	Birth Date

Address (Street, City, ST, ZIP) | Phone ( )

Physician   Phone   Clinic

Address (Street, City, ST, ZIP)

II. ASSESSMENT/ PREVENTIVE CARE/CARE PLAN:

Blue Plus enrollment date: Date of last LTCC/HRA:
Date of last CSP/collaborative care plan:

Transitional Health Risk Assessment was completed with member: In person ☐   Via phone ☐

Health Risk Assessment /LTCC was reviewed with member and updated as needed:
Date Reviewed: Update Required: ☐Yes ☐No
(The Care Coordinator must-review the entire attached LTCC for correctness and completeness. Record any changes with dates on the LTCC form and submit an updated LTC Screening Document per the Guidelines instructions for product changes.)

CSP/Collaborative Care Plan was reviewed and updated as needed: Date Reviewed:
Update Required: ☐Yes ☐No
(The Care Coordinator must review the entire CSP/CCP with the member or representative and document changes directly on the CSP/CCP including date of review and change.)

Discuss with member if they would like a referral to a Health Coach: A Blue Plus Health Coach can assist members or their caregivers by providing education and support for chronic conditions or complex situations such as catastrophic illness, high medical costs, frequent hospitalizations, etc.

☐Yes ☐No   Other

If yes, send in form 6.09 Medical management Referral from the Care Coordination portal.

☐ Discussed MSHO Supplemental Benefits (MSHO members only) *Resources available on the Care Coordination portal*Comments:

☐ Discussed SecureBlue MSHO enrollment (MSC+ members only)
Comments:

Complete the remaining elements with the member's input if not addressed on the current CSP

Have preventive care issues been addressed? (e.g. immunizations, tobacco and alcohol use, fall risk, medication and nutrition)? ☐Yes ☐No

If No, explain issues which need to be addressed:

_____

Immunizations? ☐ Flu ☐ Pneumonia ☐ Tetanus

Does the member need help to coordinate an Annual Physician/Provider Visit for Primary and Preventive Care?
☐Yes ☐No ☐ NA Comments:

 Discuss with member the date of their last physician/provider visit? Date:_____ Comments:

Discuss the following Pain Screening questions with the member:
1. Has member reported experiencing pain in the past 2 weeks? ☐Yes ☐No
2. Has member's pain affected their function or quality of life (e.g., activity level, mood, relationships, sleep or work)? ☐Yes ☐No
3. Frequency of pain: How often does member experience pain (more than once a day, once per day or less than once per day)?
4. At its worst, how severe is the member's pain (1 to 10 with 10 being the worst)?

5. Has member talked to their doctor about how to handle their pain? ☐Yes ☐No

Health Related Goals (required):

Rank by Priority	Member Goals	Support Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					

Advance Directive

	YES	NO
Does member have an Advanced Directive?	☐	☐
If No, would the member like information?	☐	☐

_____   _____
SIGNATURE & TITLE OF PERSON COMPLETING THIS FORM   DATE