

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 | | **Member ID:** | | 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 CSSP/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. Include date for any corrections. If significant changes are identified which would result in a change in case mix, proceed to completing a new LTCC. CC must enter an LTC Screening Doc per the Guidelines instructions for product changes.)  **Urgent issues needing immediate follow-up?** Yes No If yes, please describe:  **CSSP/Collaborative Care Plan was reviewed and updated as needed:** Date Reviewed:  Update Required: Yes No  (The Care Coordinator must review the entire CSSP/CCP with the member or representative and document changes directly on the CSSP/CCP including date of review and change.)  **Discuss with member if they would like a referral to a Case Manager:** A Blue Plus Case Manager can assist members or their caregivers by providing short-term 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 the Complex-Disease-Behavioral CM Referral form from the Care Coordination website.  Discussed MSHO Supplemental Benefits (MSHO members only) \*Resources available on the Care Coordination website \*Comments:  Discussed SecureBlue MSHO enrollment (MSC+ members only)  Comments: | | | | | | | |
| **Complete the remaining elements with the member’s input if not addressed on the current CSSP** | | | | | | | |
| 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**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does member have an Advanced Directive? | | | YES | NO |
| If No, would the member like information? | | | YES | NO |
| SIGNATURE & TITLE OF PERSON COMPLETING THIS FORM |  | DATE | | |