Health Risk Assessment

INSTRUCTIONS

The Healthy Michigan Plan is very interested in helping you get healthy and stay healthy. We want to ask you a few questions about your current health and encourage you to see your doctor for a check-up as soon as possible after you enroll with a health plan, and at least once a year after that. Take this form with you when you go. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan and your health plan can help you with a ride to and from this appointment. Your doctor and your health plan will use this information to better meet your health needs. The information you provide in this form is personal health information protected by federal and state law and will be kept confidential. It CANNOT be used to deny health care coverage.

If you need assistance with completing this form, contact your health plan. You can also call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656 if you have questions.

Instructions for completing this Health Risk Assessment for Healthy Michigan Plan:

- Answer the questions in sections 1-3 as best you can. You are not required to answer all of the questions.
- Call your doctor's office to schedule an annual check-up appointment. Take this form with you to your appointment.
- Your doctor or other primary care provider will complete section 4. He or she will send your results to your health plan.

After your appointment, keep a copy or printout of this form that has your doctor's signature on it. This is your record that you completed your annual Health Risk Assessment.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

HEALTHY MICHIGAN PLAN

Health Risk Assessment

Mandatory

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First Name, Middle Name, Last Name, and Suffix				Date of Birth (mm/dd/yyyy)
Mailing Address			Apartment or Lot Number	**mihealth** Card Number
City	State	Zip Code	Phone Number	Other Phone Number

SECTION 1 - Initial assessment questions (check one for each question)

1. **In general, how would you rate your health?** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. **In the last 7 days, how often did you exercise for at least 20 minutes in a day?**
   ☐ Every day ☐ 3-6 days ☐ 1-2 days ☐ 0 days

   Exercise includes walking, housekeeping, jogging, weights, a sport or playing with your kids. It can be done on the job, around the house, just for fun or as a work-out.

3. **In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day?**
   ☐ Every day ☐ 3-6 days ☐ 1-2 days ☐ 0 days

   Each time you ate a fruit or vegetable counts as one serving. It can be fresh, frozen, canned, cooked or mixed with other foods.

4. **In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?** ☐ Never ☐ Once a week ☐ 2-3 times a week ☐ More than 3 times during the week

   1 drink is 1 beer, 1 glass of wine, or 1 shot.

5. **In the last 30 days have you smoked or used tobacco?** ☐ Yes ☐ No

   If YES, Do you want to quit smoking or using tobacco?
   ☐ Yes ☐ I am working on quitting or cutting back right now ☐ No

6. **In the last 30 days, how often have you felt tense, anxious or depressed?**
   ☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

7. **Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax?** ☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

   This includes illegal or street drugs and medications from a doctor or drug store if you are taking them differently than exactly how your doctor told you to take them.

8. **The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year?** ☐ Yes ☐ No

9. **A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last checkup?** ☐ Within the last year ☐ Between 1-3 years ☐ More than 3 years

Take this form to your check-up and complete the rest of the form with your doctor at this appointment.

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First Name, Middle Name, Last Name, and Suffix

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mihealth Card Number

SECTION 2 - Annual appointment

A routine checkup is an important part of taking care of your health. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan and your health plan can help you with a ride to and from this appointment.

What month did you first schedule this appointment? _____ (Month)

Date of appointment: _____ (mm/dd/yyyy)

At my appointment, I would most like to talk with my doctor about:

An annual appointment gives you a chance to talk to your doctor and ask any questions you may have about your health including questions about medications or tests you might need.

Section 3 - Readiness to change

Your Healthy Behavior

Small everyday changes can have a big impact on your health. Think about the changes you would be most interested in making over the next year. Look at the list below and **CHOOSE ONE or MORE**:

- ☐ Exercise regularly, eat better, and/or lose weight
- ☐ Cut back or quit smoking or using tobacco
- ☐ Get a flu shot
- ☐ Return to the doctor to get tested for high blood pressure, high cholesterol and diabetes OR if I already have any of them, return to the doctor for check-ups for these conditions
- ☐ Cut back or quit drinking alcohol
- ☐ Seek treatment for drug or substance abuse
- ☐ I will commit to keep up all of the healthy things I do now
- ☐ Other:

Changes like drinking water rather than soda or walking every day can help you stay healthy or help you better control illnesses you may already have. You can learn new ways to handle stress or quit smoking. Remember, even small changes can be difficult and take a long time. It may be helpful to get support from your family, friends, community or your doctor. Your health plan may have programs that can help you.

Now that you have selected your healthy behavior(s) above, answer questions 1 - 3. For each question, use the scale provided and pick a number from 0 through 5.

1. Thinking about your healthy behavior(s), do you want to make some small lifestyle changes in this area to improve your health?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I don't want to make changes now		I want to learn more about changes I can make		Yes, I know the changes I want to start making	

2. How much support do you think you would get from family or friends if they knew you were trying to make some changes?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I don't think family or friends would help me		I think I have some support		Yes, I think family or friends would help me	

3. How much support would you like from your doctor or your health plan to make these changes?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I do not want to be contacted		I want to learn more about programs that can help me		Yes, I am interested in signing up for programs that can help me	

"COMPLIANT" - 2 Pages

Mandatory: First Name, Middle Name, Last Name, and Suffix	Mandatory: mihealth Card Number

Section 4 – To be completed by your primary care provider

Primary care providers should fill out this form for Healthy Michigan Plan beneficiaries enrolled in Managed Care Plans only. Fill in the Member Results, select a Healthy Behavior statement in discussion with the member, and sign the Primary Care Provider Attestation. Blood pressure, BMI and tobacco use status will be known from the appointment. For all other Member Results, marking the result as unknown and indicating whether the screening or immunization is recommended satisfies the requirements for a complete Health Risk Assessment. All three parts of Section 4 must be filled in for the attestation to be considered complete.

Member Results

Blood Pressure	Mandatory: Please enter BP (Systolic/Diastolic) _____ (xxx/xxx mmHg)	Patient diagnosed with hypertension? ☐ Yes ☐ No Mandatory: Y/N
BMI Height, Weight, BMI: Value must be entered for each one	_____Ht _____Wt. BMI _____ (xx.x)	In the context of all relevant clinical factors, does this BMI indicate need for weight management? ☐ Yes ☐ No Mandatory: Y/N
Tobacco Use Status Mandatory: Please Check One	☐ Never used tobacco ☐ Previous tobacco user ☐ Current tobacco cessation ☐ Starting tobacco cessation ☐ Tobacco user	
Cholesterol If Cholesterol is known (Yes), then you must answer the following: *Y/N if patient is diagnosed w/high cholesterol *Date of most recent Cholesterol test results. Also, a value must be entered for: *Total Cholesterol ***OR*** LDL & HDL *Triglycerides (optional) **If Cholesterol is NOT known (No), then you must check one of the following:** *Screening Not Recommended *Screening Ordered	Cholesterol known? ☐ Yes ☐ No Mandatory: Y/N If cholesterol known is **Yes**: Total cholesterol: _____ Date of most recent test results: If cholesterol known is **No**: ☐ Screening not recommended ☐ Screening Ordered	Patient diagnosed with high cholesterol? ☐ Yes ☐ No Mandatory: Y/N-Must Answer IF Cholesterol Is Known LDL: _____ HDL: _____ Triglycerides: _____
Blood Sugar **If BS is known (Yes), then you must enter the following:** *Y/N if patient is diagnosed with Diabetes. *FBS *and/or* A1C *Date of most recent BS test results. **If BS is NOT known (No), then you must check one of the following:** *Screening Not Recommended *Screening Ordered	Blood sugar known? ☐ Yes ☐ No Mandatory: Y/N If blood sugar known is **Yes**: Date of most recent test results: If blood sugar known is **No**: ☐ Screening not recommended ☐ Screening Ordered	Patient diagnosed with diabetes? ☐ Yes ☐ No Mandatory: Y/N-Must Answer IF Blood Sugar Is Known FBS (xxx mg/dl): _____ A1C (xx.x%): _____
Influenza Vaccine If the patient had his/her Influenza Vaccination, then you must enter: *Date of most recent vaccination If the patient did NOT have his/her Influenza Vaccination, then you must check one of the following: *Vaccination Not Recommended *Vaccination Recommended	Annual Influenza Vaccination? ☐ Yes ☐ No Mandatory: Y/N If Influenza vaccination is **Yes**: Date of most recent vaccination: _____ If Influenza vaccination is **No**: ☐ Vaccination not recommended ☐ Vaccination recommended	

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Mandatory: Please Choose only ONE of the following statements.

Healthy Behaviors - Choose one of the following statements (**1** - **4**)

☐ **1. Patient does not have health risk behaviors that need to be addressed at this time.**

☐ **2. Patient has identified at least one behavior to address over the next year to improve their health (choose one or more below):**

Mandatory: If you check Statement 2, please also check one or more of these statements.

- ☐ ***Increase physical activity, learn more about nutrition and improve diet, and/or weight loss***
- ☐ ***Reduce/quit tobacco use***
- ☐ ***Annual influenza vaccine***
- ☐ ***Agrees to follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes***
- ☐ ***Reduce/quit alcohol consumption***
- ☐ ***Treatment for Substance Use Disorder***
- ☐ ***Other: explain*** _____

☐ **3. Patient has a serious medical, behavioral or social condition(s) which precludes addressing unhealthy behaviors at this time.**

☐ **4. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.**

Primary Care Provider Attestation

I certify that I have examined the patient named above and the information is complete and accurate to the best of my knowledge. I have provided a copy of this Health Risk Assessment to the member listed above.

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Print Name (First Name, Last Name)	National Provider Identifier (NPI)
Signature	**Date**

Mandatory

Mandatory

Submission Instructions:

- Submit completed forms in the secure manner specified by the member's Managed Care Plan.

Authority: MCL 400.105(d)(1)(e)

Completion: Of this form provides information to better meet the health needs of Healthy Michigan Plan beneficiaries in Managed Care Plans.

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