

Attachment- Health Risk Assessment Call Script

Introduction

INITIAL CONTACT- Talking to the health plan Member

[see "Close" instructions at end if member not home or if answering machine picks up]

Good Morning/afternoon, my name is your first name. I'm calling on behalf of _____ Health Plan. May I speak to member's full name please? Hi Mr./Ms last name. This call may be recorded for quality assurance and I know that your time is valuable so it should only take a few minutes.

You recently became a member of _____ Health Plan -- your effective date was [month and day]. Welcome to the Plan. We want to give you a brief orientation about your benefits and ask you a few questions about your overall health so we can better meet your health care needs.

Benefits

The plan will cover visits to hospitals, primary care, specialty care mental health professionals and prescriptions. The provider directory in your welcome kit will list providers and locations where you can receive these services. As a _____ Health Plan member you will also receive added benefits such as free access to our nurse advice line, 24 hours a day, 7 days a week. We can also help you with transportation if you're having trouble getting to the doctor and if you are eligible for this service. We provide programs for pregnant members and for those with medical conditions such as high blood pressure, diabetes and asthma.

To help you meet your medical needs, _____ Health Plan would like some medical information on you. As part of this call, I need to ask you some questions related to your general health history. This information will be kept strictly private, and will not be shared with any other parties. I am going to begin asking you questions regarding your medical status. If at any time you have questions, please feel free to stop me. It will take about ___ minutes. Do you have time to do that now or would you like to schedule a time that is more convenient for you?

If Yes -- continue with interview

If No -- Schedule call back time for assessment

HRA Questions

1. Are you having any difficulty understanding me? Yes No

If Yes, explain how you compensated:

2. What is your primary language? English Spanish Other (Specify)

3. What is your preferred language? _____

Exact time:

____:____ am/pm

Enter the time the interview begins (i.e. 2:53 PM).

Verification Information

4. May I ask, do you still live on street name, Mr./MS last name? Yes No

Member Assessment And Monitoring

5. How many times have you moved in the past year? _____ times
6. May we continue to use this phone number or is there are better number to contact you? This number Other, better number (Specify): _____
7. What is your marital status? Married Not Married Separated Divorced
Widowed Other: _____
8. What is your current living arrangement? Alone With spouse/significant other
Live with other family member
9. What is your religion? Catholic Protestant Jewish Islamic Buddhist
Hindu None Other: _____
10. Mr./Ms last name may I ask for the name of your primary care provider (doctor)?
Please record Name of physician: _____

If member does not have a PCP, offer to help select a PCP as follows:

If you need to choose or change your primary care provider, I can transfer you at the end of this call to our member services team, who can help you with that.

HRA Information

Now I'm going to ask you some questions about your overall health status; I will be recording our conversation for quality assurance, please remember that we will not share this information with any other parties who are not involved in your health care. Honest and accurate information will help us meet your medical needs, but if you have personal reasons for not answering a question, please let me know by saying, "skip" and we'll proceed to the next question. Are you ready Mr./Mrs. name?

11. In general would you say your health is Excellent Very Good Good Fair, or Poor?
12. Compared to one year ago, how would you rate your health in general now?
Much better Somewhat better About the same Much worse
13. During the past 4 years have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
- a. Cut down on the amount of time you spent on work or other activities? Yes No
- b. Accomplished less than you would like? Yes No
- c. Were limited in the kind of work or other activities? Yes No
- d. Had difficulty performing the work or other activities (for example, it took extra time?)
Yes No
- e. Bodily pain that has contributed to interference with work or other activities? Yes
No
14. What is your height? _____ ft. _____ in. and _____ lbs.
15. Do you currently use tobacco products? Yes No, If No, Did you ever?
No, Yes,
If Yes, How much? _____ How long? _____ When did you quit? _____
16. How often do you drink alcoholic beverages?
Never Daily/How many? ____ Weekly/How many? ____ Monthly/How many?

17. Do you drive?

Yes No,

If No, Did you ever drive? No Yes,

If Yes, When and why did you stop? _____ How often do you drive?

Daily Weekly Monthly

18. In the past 2 years, has your driver's license been suspended or revoked? Yes

No, If Yes, When? _____

Why? _____

19. Have you been to the emergency room in the past year?

No Yes, If Yes, How many times have you been to the emergency room in the past year? _____ Once Twice More than three times

20. In the previous 12 months, have you stayed overnight as a patient in a hospital?

Yes No,

If Yes, How many times have you stayed overnight as a patient in a hospital?

Once Twice More than three times

21. In the previous 12 months, have you stayed overnight as a patient in a hospital due to mental health issues. No Once Twice More than three times

22. In the previous 12 months, how many times did you visit a physician or clinic? Not at all Once Twice or Three Times Four to Six times More than six times

23. How many times in the past 6 months have you had an episode of fainting, lost your balance, slipped or tripped over something or had any sort of accident that resulted in falling or dropping to the ground? _____ time(s)

If one (1) or more times, ask: Did you get hurt? Yes No,

If Yes, ask: What has been your most serious injury or problem due to a fall? Bruises Discomfort Head Injury Back/Vertebrae Fracture Wrist/Arm Fracture Leg Fracture Cuts Other: _____

24. Do you ever limit your activities, what do you or where you go, because you are afraid of falling? Yes No

25. Is there a friend, relative or neighbor who would take care of you for a few days if necessary? Yes No,

If Yes, What is the phone number of this person? (____) _____

26. Do you receive any public assistance, public programs, or community resources?

Yes No, If Yes, What kind? Indicate type below:

	Yes	No		Yes	No
Meals on Wheels			Food Pantry		
Food Stamps			Transportation		
Social Services			Other: _____		

27. What is the highest level of education or degree you obtained? Elementary School

High School Diploma G.E.D. Associates Bachelors Post-graduate

Other (Specify) _____

28. Do you use any of the following medical equipment?

Member Assessment And Monitoring

Equipment	Yes	No	Equipment	Yes	No
Wheelchair			Oxygen Equipment		
Walker			Hospital Bed		
Power Operated Mobility Device i.e. scooter			Kidney Dialysis		
			Other (Specify): _____		

29. Are you receiving home health services)? Yes No

30. How many medications do you take on a daily basis? _____

Existing Conditions

- | | | | |
|-------------------------------|--|---|--|
| a. Insulin Dependent Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | j. Organ Transplant | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Blood Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | k. AIDS (Acquired Immune Deficiency Disorder) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Heart Disease/Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | l. Mental or Nervous System Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Congestive Heart Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | m. Alzheimer's/Dementia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Stroke/TIA | <input type="checkbox"/> Yes <input type="checkbox"/> No | n. Cancer (other than skin) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. "Mini" Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | o. COPD | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Kidney Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | p. Other (specify): _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Renal Insufficiency | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| i. Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Depression Screen

31. Over the last two weeks how often have you been bothered by any of the following problems?

- | | | | | |
|--|-------------------------------------|---------------------------------------|---|---|
| a. Little interest or pleasure in doing things | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than seven days | <input type="checkbox"/> Nearly every day |
| b. Feeling down, depressed or hopeless | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than seven days | <input type="checkbox"/> Nearly every day |
| c. Trouble falling asleep, staying asleep, or sleeping too much | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than seven days | <input type="checkbox"/> Nearly every day |
| d. Feeling tired or having little energy | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than seven days | <input type="checkbox"/> Nearly every day |
| e. Poor appetite or eating too much | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than seven days | <input type="checkbox"/> Nearly every day |
| f. Feeling bad about yourself, that you are a failure, or that you have let yourself or your family/friends down | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than seven days | <input type="checkbox"/> Nearly every day |
| g. Trouble concentrating | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than seven days | <input type="checkbox"/> Nearly every day |
| h. Moving or speaking more slowly than normal | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than seven days | <input type="checkbox"/> Nearly every day |
| i. Thinking you would be better off dead | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than seven days | <input type="checkbox"/> Nearly every day |

32. Are you receiving counseling for depression?

Yes No

33. Are you taking medication for depression?

Yes No

Functional Screen

34. Can you tell me what best describes your performance of the following tasks?

Questions	Independent	Partially Dependent	Dependent
a. Taking your medications			
b. Managing your day to day finances			
c. Doing housework			
d. Doing your laundry			
e. Shopping for groceries			
f. Preparing your meals			
g. Getting around inside your home			
h. Feeding yourself			
i. Getting in or out of bed or a chair			
j. Bathing/caring for personal hygiene			
k. Dressing yourself			
l. Using the toilet			

Cognition

35. What is the best action to take in any emergency? Appropriate Response
 Inappropriate Response

36. Who is the President of the US? Appropriate Response Inappropriate Response

37. What is the current date/year? Appropriate Response Inappropriate Response

Close

"Thank you so much for your time Mr./Ms last name. Welcome to _____ Health Plan."

If this is not a New York Access Member, please say the following: "We're happy to have you as a member. My name is your first name, have a wonderful day."

If this is New York Access Member, please say the following to member:
 "Based on the assessment completed today, it appears you may be eligible for additional services from WellCare's Advocate Complete Program. Are you interested in speaking to one of our enrollment nurses who will provide you additional information regarding program eligibility and benefits?" Yes No

If Yes, say: "A WellCare nurse will call you to schedule a home visit to further explain the program and evaluate you for eligibility. Once again, thank you for your time. Your HealthCare is important to us. Thank you again. We're happy to have you as a member.

My name is <your first name>, have a wonderful day."