

# Health Risk Assessment

## INSTRUCTIONS

The Saint Joseph Health System Accountable Care Organization (SJHS ACO) is a partnership between School City of Mishawaka (SCM) and Select Health Network (SHN), to maintain and improve your health. Our primary goal is achieving **Better Health, Better Care at a Lower Cost**.

An initial step in achieving this goal is engaging members' participation in maintaining and improving their health. As a starting point, the SJHS ACO will offer all SCM health plan enrollees and their spouses the opportunity to participate in an annual wellness screening. This will include a wellness physical with a primary care provider (PCP) and the completion of a Health Risk Assessment (HRA). These activities are voluntary.

Members are eligible to receive up to a \$300 premium contribution refund annually. Each covered employee and covered spouse are eligible for a \$150 refund after the annual physical has occurred and the completed HRA has been received. The health plan premium contribution will be refunded to active members in October of 2025. Employees who are no longer on the health plan in October 2025 will not be eligible for the premium refund. Allowable annual wellness appointments should be completed between July 1, 2024, and June 30, 2025. Both the physical exam and the HRA form must be completed and submitted before July 1, 2025.

The annual wellness screening (physical exam and labs) is a covered benefit of your health plan, which is administered by Auxiant.

The information you provide in this HRA is personal health information and is protected by federal and state law. Your information will be kept confidential. It CANNOT be used to deny health care coverage. Please refer to the HIPAA information in the health plan document for more information regarding HIPAA Privacy Rights, and the notice at the end of this material.

### Instructions for completing this HRA for your SJHS ACO Plan:

- Complete demographic information
- All sections in **GREEN** are to be completed by the member
- All sections in **BLUE** are to be completed by the primary care provider
- Answer the questions in sections 1 and 2 as best you can.
- Call your PCP to schedule an annual wellness physical. Be sure to take this form with you to your appointment.
- Your PCP will complete section 3. He or she will send your completed HRA via secure fax to Select Health Network @ 574.283.5950, Attn: SHN Quality Improvement SCM HRA.
- For any questions regarding the HRA completion or submission, please contact the Select Health Network Quality Improvement department @ 574.283.5946.

After your appointment, keep a copy of this form that includes your PCP's signature. This is your record that you completed your annual Health Risk Assessment.

## Health Risk Assessment

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

### SECTION 1 – Initial Assessment questions (check one for each question)

1. **Have you ever had an allergic reaction to a penicillin antibiotic (examples include penicillin, amoxicillin, ampicillin, Augmentin)?**      Yes    No
2. **In general, how would you rate your health?**      Excellent    Very Good    Good    Fair    Poor
3. **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.*

4. **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.*

5. **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.*

6. **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

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

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



*This includes medications from a doctor or drug store if you are taking them differently than exactly how your doctor told you to take them, or any drug obtained from a source other than a doctor or a drug store.*

9. **Have you had a flu shot in the last year?**      Yes    No
10. **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 provider at this appointment.

FIRST NAME, MIDDLE NAME, LAST NAME, DOB

## SECTION 2 – 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**:

- |   |   |
|---|---|
| <input type="checkbox"/> Exercise regularly, eat better, and/or lose weight   | <input type="checkbox"/> Cut back or quit drinking alcohol                        |
| <input type="checkbox"/> Cut back or quit smoking or using tobacco  | <input type="checkbox"/> Seek treatment for drug or substance abuse               |
| <input type="checkbox"/> Get a flu shot   | <input type="checkbox"/> I will commit to keep up all the healthy things I do now |
| <input type="checkbox"/> 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 | <input type="checkbox"/> Receive a flu shot at work                               |
|   | <input type="checkbox"/> Learn more about how my insurance works                  |
|   | <input type="checkbox"/> 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.*

FIRST NAME, MIDDLE NAME, LAST NAME, DOB



Now that you have selected your healthy behavior(s) above, answer questions 1 - 4. For each question, use the scale provided and pick a number from 1 to 3. All questions must be answered for this section to be complete.

1. Thinking about your healthy behavior(s), what is your interest level to make some small lifestyle changes in this area to improve your health?

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

3. How much support do you think you would get from School City of Mishawaka and coworkers if they knew you were trying to make some changes?

4. What type of support would you like from your doctor or your health plan to make these changes?

1	2	3
Somewhat Interested	Interested	Very Interested
1	2	3
No Support	Some Support	Full Support
1	2	3
No Support	Some Support	Full Support
1	2	3
Mailings	Phone Calls/Text Messages	In Person

I understand that SCM, SJHS ACO, Select or Auxiant are not providing medical advice, and that I should not change medication or prior medical advice without consulting a physician.

Patient Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

Patient Name (Printed): \_\_\_\_\_

FIRST NAME, MIDDLE NAME, LAST NAME, DOB



**SECTION 3 – To be completed by your primary care provider**

PCPs should only fill out this form for SCM enrollees who are enrolled in SJHS ACO. Fill in the Member Results, select a Healthy Behavior statement in discussion with the member, and sign the PCP Attestation.

**Note:** All three parts of Section 3 must be filled in for the attestation to be considered complete. The physical exam must be between July 1, 2024, and June 30, 2025, and must include a current fasting blood glucose and lipid panel in order to fulfill SJHS ACO requirements.

Date of Physical: \_\_\_\_\_ Name of PCP: \_\_\_\_\_

**Member Results**

<b>Blood Pressure</b>	(xxx/xxx mmHg)	Patient diagnosed with hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>BMI</b>	_____Ht. _____Wt. BMI _____ (xx.x)	In the context of all relevant clinical factors, does this BMI indicate need for weight management? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco Use Status</b>	<input type="checkbox"/> Never used tobacco <input type="checkbox"/> Previous tobacco user <input type="checkbox"/> Current tobacco cessation <input type="checkbox"/> Tobacco user	
<b>Cholesterol</b>	Cholesterol known? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient diagnosed with high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If cholesterol known is <b>NO</b> : <input type="checkbox"/> Screening not recommended <input type="checkbox"/> Screening ordered Date ordered: _____	
	If cholesterol known is <b>YES</b> : Total cholesterol: _____ LDL: _____ Date of most recent test: _____ HDL: _____ Triglycerides: _____	
<b>Blood Sugar</b>	Blood sugar known? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient diagnosed with diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If blood sugar known is <b>NO</b> : <input type="checkbox"/> Screening not recommended <input type="checkbox"/> Screening ordered Date ordered: _____	
	If blood sugar known is <b>YES</b> : FBS (xxx mg/dl): _____ Date of most recent test results: _____ A1C (xx.x%): _____	
<b>Influenza Vaccine</b>	Annual Influenza Vaccination? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If Influenza vaccination is <b>NO</b> : <input type="checkbox"/> Vaccination not recommended <input type="checkbox"/> Vaccination recommended	
	If Influenza vaccination is <b>YES</b> : Date of most recent vaccination: ____/____/____	

FIRST NAME, MIDDLE NAME, LAST NAME, DOB



### 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):
  - 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.

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

Submit completed forms via fax to Select Health Network @ 574.283.5950, Attn: SHN Quality Improvement SCM HRA.

**NOTICE REGARDING SAINT JOSEPH HEALTH SYSTEM  
ACCOUNTABLE CARE ORGANIZATION (SJHS ACO) WELLNESS PROGRAM**



**Voluntary Wellness Program**

Saint Joseph Health System Accountable Care Organization (SJHS ACO) includes a voluntary wellness program ("SJHS ACO") available to all School City of Mishawaka employees in the United States. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

**Health Risk Assessment and Biometric Screening**

If you choose to participate in SJHS ACO voluntary wellness program you will be asked to complete a voluntary health risk assessment ("HRA") that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for total and HDL cholesterol, triglycerides and glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations to participate in the Wellness Program.

**Benefits of Participation in SJHS ACO Wellness Program**

In addition to receiving information and coaching that may help you with your health conditions, employees who choose to participate in SJHS ACO wellness program will receive an incentive of a refund in the employee's health plan premium annual contribution. Although you are not required to complete the HRA or participate in the biometric screening in order to participate in the SJHS ACO wellness program, only covered employees and covered spouses who complete the HRA and participate in the biometric screening will receive the health plan premium refund of up to \$300 in 2025.

**Restricted Use of Your Personal and Medical Information**

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health, potential risks, and may also be used to offer you services through SJHS ACO, such as healthy lifestyle coaching.

**Confidentiality, Privacy and Security of Your Personal and Medical Information**

SJHS ACO and Select Health Network, Inc., who administers SJHS ACO, are required by law to maintain the privacy and security of your personally identifiable health information. Although we may use aggregate information--i.e., information that does not identify you or other participants in SJHS ACO--to design a program based on identified health risks in the workplace, we are prohibited from disclosing any personally identifiable information about you except: (1) as necessary to respond to a request from you for a reasonable accommodation; (2) as expressly permitted by law; or (3) as specifically authorized by you. If so, the disclosure is limited to information necessary to process your request and is restricted to personnel whose job responsibilities include handling those requests. Please be assured that your medical information provided in connection with SJHS ACO programs will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to SJHS ACO, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in SJHS ACO wellness program or receiving an incentive. Anyone who receives your information for purposes of providing services to you as part of SJHS ACO will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are individuals (such as health coaches) working on behalf of SJHS ACO who may contact you to discuss your health information and recommend ways to improve your health.

**Retention of Your Personal and Medical Information**

Your HRA and health information will be stored in your electronic medical record at your SJHS ACO Primary Care Provider office. The information will also be stored at Select Health Network and at Auxiant. Information stored electronically will be encrypted during transit and appropriate precautions will be taken to avoid any data breach. In the event a data breach occurs involving information you provide in connection with SJHS ACO, we will notify you immediately.

**Your Rights**

Your participation in SJHS ACO wellness program is purely voluntary, and you have the right to withdraw from participation at any time. Your withdrawal of participation may impact your incentives under the program. The personally identifiable health information collected prior to withdrawal will be retained in accordance with applicable medical recordkeeping and employment laws, and then securely destroyed. You have the right to obtain a copy of the personally identifiable health information that you provide in relation to SJHS ACO and may do so by contacting Select Quality Improvement SCM HRA at 574-283-5959, choose option 5.

You may not be discriminated against in employment because of the medical information you provide as part of participating in SJHS ACO wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Auxiant Member Services at 800-475-2232.