

Policy Title:	Health Risk Assessment (HRA)		
Department:	Clinical Quality Improvement		
Policy Number:	CQI-7		
Issue Day:	Effective Date: 10/16/13		
Next Review Date:	Revision Dates: 12/2/21 11/19/14, 04/01/15, 11/15/19, 11/15/20		
		Approved By:	
			12/2/20
		Julianne Eckert, RN BSN - Director of Clinical Quality Improvement	Date
REFERENCE:	MMCM Chapter 4, Benefits and Beneficiary Protections. Section 110.6 – Ensuring Coordination of Care (Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)		

Purpose: To ensure proper assessment and reporting on member’s risk levels and monitoring timeliness. To define guidance in which Clover Health attempts to conduct Health Risk Assessments (HRA) of all new enrollees and upon an annual basis.

Scope: Medicare Advantage

Policy:

Clover Health will make best effort attempts to conduct an initial health risk assessment (HRA) on all new members within 90 days of their effective date of enrollment and follow up on unsuccessful attempt to contact a member. Additionally, Clover Health will make best effort attempts to conduct an HRA annually (within 90 days of the member's re-enrollment date) and will follow up on unsuccessful attempts to contact a member.

The HRA assesses member demographics, behavioral risks, ability to perform activities of daily living, ability to perform instrumental activities of daily living, identification of chronic diseases, injury risks, modifiable risk factors, and urgent health needs of an individual.

The HRA is appropriately tailored to and takes into account the communication needs of: underserved populations, persons with limited English proficiency, and persons with health literacy needs.

The HRA can be completed by the member via internet, phone or paper-based linguistically and culturally appropriate HRA tool. Clover Health associates (or designated vendor) may at times assist the member in completing the HRA upon member request including providing access to accommodations for individuals with physical, sensory and cognitive limitations (Goetzel-Taylor et al., 2011)

The HRA provides an assessment of the major health and functional challenges presented by members and allows Clover Health and its network of providers to assist with coordination of care. This survey will also be utilized to evaluate progress/deterioration of the health status of members over time.

Definitions:

Best Effort Attempt: A best effort attempt is defined as two outreach attempts which can be a combination of mailed paper form, telephonic, email or SMS text messaging which provides notification to the enrollee of Clover Health's attempt to complete an HRA.

Health Risk Assessment (HRA): The Health Risk Assessment is an evaluation tool that collects self-reported information about the member's health status across a variety of dimensions, can be administered independently by the beneficiary (or designated caregiver, as necessary) or administered by a health professional and takes no longer than 20 minutes to complete.

Procedure:

HRA Assessment Process:

1) HRA Collection:

- a) Clover Health will conduct initial HRA assessment attempt via phone, mail, email or text message within two weeks of the members enrollment date. Clover will use a combination of mail, email, text messaging and will be documented. mailing the HRA assessment and instructions within two weeks of the member's enrollment date/re-enrollment date via the mailed New Member Welcome Kit. The eligible members to receive an HRA are based on enrollment file received from CMS.
 - i) HRA responses received by mail, phone or online submission will be considered complete. HRA is timestamped and entered electronically upon receipt which will indicate date received at plan and data is entered electronically into Salesforce and attached to the member's profile.
 - ii) Partially completed HRAs will be considered "submitted" with infilled fields treated as "Silent"
 - iii) The HRA electronic file is stored within Salesforce.
- b) If no response is received from the first outreach attempt to member within 60 days from original timestamp date of mailing, Clover Health will conduct a second outreach attempt by either mail, phone, email, or text.
 - i) If a response is still NOT received within 30 days of second outreach attempt, the process ends. Clover has the discretion to determine if any additional outreach attempts are made beyond a best effort attempt.
- c) Member has the ability to call Clover Customer Service and ask for assistance in completing the HRA.
- d) If the member is not contacted after best effort attempt, the member's electronic HRA file in Salesforce will indicate "not completed" and the process will be closed.

2) HRA Results:

- Based on HRA results, members will be eligible for applicable coordination of care programs identified through the HRA in the following types of areas:
 - Medications
 - Falls
 - High Utilizers
 - PCP steerage
 - Depression
 - Clinical Home Programs
 - Health conditions

3) HRA Assessment Tool and Program Effectiveness:

- a) At least annually, the HRA tool will be reviewed and updated to reflect guidance and ensure the tool and process aligns with emerging science related to health promotion and disease prevention.
- b) The HRA program will be evaluated at regular intervals to determine its effectiveness and guide program modification need to ensure adherence to evidence-based medicine and alignment with Clover's population.
- c) Reports are generated and presented quarterly or more frequently to the Quality Improvement Committee.

- i) Reports may include:
 - i. Percent of members who completed the HRA
 - ii. Percent of HRAs that were completed within the pre-established time frames.
 - iii. Number of referrals generated off the HRA

Attachment A: Health Risk Assessment

References:

- 1) Goetzel, RZ; Staley, P; Ogden, L; Stange, P; Fox, J; Spangler, J; Tabrizi, M; Beckowski, M; Kowlessar, N; Glasgow, RE, Taylor, MV. A framework for patient-centered health risk assessments – providing health promotion and disease prevention services to Medicare beneficiaries. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2011. Available at: <http://www.cdc.gov/policy/opth/hra/>.

Related Policies:

Attachments:

Attachment A

2021 Health Assessment Survey	
We want to help you be as healthy as you can be with healthcare tailored to you. Fill out the form below to submit your request electronically. Print out this form to submit by mail.	
If you would like help in submitting this information, please call member services at 1-888-778-1478 (TTY 711) 8 am–8 pm local time, 7 days a week.*	
*Between April 1st and September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.	
Name (First Name, Last Name)	<i>Free Text</i>
CPID	<i>Free Text</i>
DOB	<i>Free Text</i>
Today's Date	<i>Free Text</i>
Mobile Phone	<i>Free Text</i>
Email Address	<i>Free Text</i>
What is the best way to reach you? (Email, phone, text, mail, other)	Email Phone Text Mail Other
What is the best time of day to reach you?	Morning (8 am–Noon) Afternoon (Noon–4 pm) Evening (4–8 pm)
Emergency Contact Name	<i>Free Text</i>
Emergency Contact Phone Number	<i>Free Text</i>
Emergency Contact Relationship	<i>Free Text</i>

What problems, if any, do you have with staying healthy now?	<ul style="list-style-type: none"> Not having a good support system Not being able to access or obtain my medical care (prescriptions, copays, etc.) Not being able to afford my housing, or utility bills Not having transportation Not having the equipment I need to be safe (walker, commode chair, grab bars, etc.) Other
Where do you currently live?	<ul style="list-style-type: none"> Private house Private apartment Assisted living facility Senior housing No housing / homeless Other
Who do you live with?	<ul style="list-style-type: none"> I live alone Spouse or partner Other family Friend(s) Hired caregiver(s)
In general, how would you describe your health?	<ul style="list-style-type: none"> Excellent Very good Good Fair Poor
Do you currently smoke or have you smoked in the past?	<ul style="list-style-type: none"> Current smoker Former smoker Never smoked
Approximately how often do you exercise?	<ul style="list-style-type: none"> Never Once a month Once a week More than once a week
How often do you have a drink containing alcohol?	<ul style="list-style-type: none"> Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week
Are you unable to take part in activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? If so, how much are you limited?	<ul style="list-style-type: none"> Yes, very limited Yes, somewhat limited No, not limited at all
Do you use any of the following to help you walk or get around?	<ul style="list-style-type: none"> Crutches Walker Cane Wheelchair Scooter Other None of the above
How many times have you fallen in the last year?	<i>Free Text</i>

Do you need help from another person to do any of the following activities?	<ul style="list-style-type: none"> Feed yourself Use the toilet Put on or take off your clothes Walk within your home Take your medications Take a bath or shower Get out of your bed and into a chair Pick up groceries, prescriptions, etc. None of the above
Little interest or pleasure in doing things in past 2 weeks?	<ul style="list-style-type: none"> Not at all Several days More than half the days Nearly every day
Feeling down, depressed, or hopeless in past 2 weeks?	<ul style="list-style-type: none"> Not at all Several days More than half the days Nearly every day
How often in the past 4 weeks have you had trouble thinking or remembering?	<ul style="list-style-type: none"> Never Seldom Sometimes Often Always
During the past 4 weeks, how often was someone available to help you if you needed help? For example, if you were sick and had to stay in bed, needed someone to talk to, and/or needed help with daily chores.	<ul style="list-style-type: none"> Never Seldom Sometimes Often Always
In the past year, have you been treated for any of the following conditions?	<ul style="list-style-type: none"> High blood pressure (hypertension) Kidney disease High cholesterol Stroke Diabetes Arthritis Heart disease (heart attack, congestive heart failure/CHF, angina) Chronic pain Irregular heart rhythm (atrial fibrillation) Cancer Lung disease (COPD, emphysema, asthma) Dementia Depression or anxiety
How many different doctors have you seen in the past year?	<i>Free Text</i>
How many times have you been to the emergency room or hospital in the past year?	<i>Free Text</i>
How many different medications do you currently take on a daily basis?	<i>Free Text</i>
Are you interested in receiving your medications by mail?	<ul style="list-style-type: none"> Yes No I already receive medications by mail
How often are you able to take your medications as prescribed by your doctor?	<ul style="list-style-type: none"> I always take them as prescribed. I sometimes take them as prescribed. I rarely take them as prescribed. I do not have to take prescribed medications.

How confident are you that you can control and manage most of your health problems?	Very confident Somewhat confident Not very confident I do not have any health problems.
Who is your primary care provider, or PCP (the main doctor who coordinates your care)?	<i>Free Text</i>
Would you like help finding a primary care physician (a main doctor who coordinates your care)?	Yes No
Did someone help you complete this form?	Yes, completed with help of friend, family, or caregiver No, completed by myself
What problems, if any, do you have with staying healthy now?	Not having a good support system Not being able to access or obtain my medical care (prescriptions, copays, etc.) Not being able to afford my housing, or utility bills Not having transportation Not having the equipment I need to be safe (walker, commode chair, grab bars, etc.) Other
Where do you currently live?	Private house Private apartment Assisted living facility Senior housing No housing / homeless Other
Who do you live with?	I live alone Spouse or partner Other family Friend(s) Hired caregiver(s)
In general, how would you describe your health?	Excellent Very good Good Fair Poor
Do you currently smoke or have you smoked in the past?	Current smoker Former smoker Never smoked
Approximately how often do you exercise?	Never Once a month Once a week More than once a week
How often do you have a drink containing alcohol?	Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week
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Do you use any of the following to help you walk or get around?	Crutches Walker Cane Wheelchair Scooter Other None of the above
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How many times have you been to the emergency room or hospital in the past year?	<i>Free Text</i>
How many different medications do you currently take on a daily basis?	<i>Free Text</i>

Are you interested in receiving your medications by mail?	Yes No I already receive medications by mail
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New, Revised or Reviewed/ No Changes	Previous Policy Name, If Applicable/Description of Changes	Department Lead Approval (Name)	Date Department Lead Approved	Date Policy Committee Approved
Revision	Move to Clover template, updated to current process and tool.	Julianne Eckert	11/11/19	11/15/19
Review	Annual Review	Julianne Eckert	11/15/20	12/2/20