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G06Q 20/00; H04L 12/2801; H04L 67/10  
See application file for complete search history.

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HEALTH RISK ASSESSMENT (HRA) FORM	
Name Case Coordinator or Manager: _____ Date of this Assessment: _____	
DEMOGRAPHIC INFORMATION: Case Coordinator or Manager Contact Number: _____ CASE #: _____	
Answers to the Following Questions Are Per Member or Care Giver Interview Responses:	
MEMBER NAME:	LOB: [dropdown]
Health Plan ID#	SNP Plan: [dropdown]
DOB/AGE:	Health Plan: [dropdown]
Sex: [dropdown]	WHO Referred to CM: [dropdown]
PCP NAME:	PCP Number: [dropdown]
Contacted: [dropdown] Date: [dropdown]	Date of Last Office Visit with your PCP: [dropdown]
Marital Status: [dropdown]	Language Spoken Primary: [dropdown] Language Understood Primary: [dropdown] Language Read Primary: [dropdown]
ALLERGIES (if none indicate N/A):	Language Spoken Secondary: [dropdown] Language Understood Secondary: [dropdown] Language Read Secondary: [dropdown]
WHAT IS YOUR ETHNICITY: [dropdown]	What are your living arrangements who do you live with? (If Member is Homeless Refer to Social Worker) (if the answer is HOMELES, address in a care plan and request Social Worker intervention): [dropdown]
CULTURAL LINGUISTIC NEEDS:	[dropdown] [dropdown] [dropdown] Other/Needs: [dropdown]
Emergency Contact Person:	Emergency Contact Number: [dropdown]
PSYCHO-SOCIAL STATUS Per Member Interview Responses (Specify using drop down or free boxes)	
Disease Process:	Disease Process: [dropdown]
Member's view of their own health?	Does member attend activities outside the home? [dropdown]
Member's view of their quality of life?	Name/number of person who manages healthcare for member: [dropdown]
Member's Cognitive status?	Does member have good psycho-social support system? [dropdown]
PHQ-2 QUESTIONS: Over the last 2 weeks, have you often been bothered by: (YES to either question, flu with PHQ-9)	2. Feeling down, depressed, or hopeless? [dropdown]
PHQ9 Completed [dropdown] Date: [dropdown]	Date Sent To PCP: [dropdown] (if Blank = N/A)
Lifestyle and Life Planning Per Member Interview Responses (Specify using drop down or free boxes):	
Does the member have any life planning documents in place?	If life planning is in place, indicate which type of process member has in place [dropdown] Request a copy of document for member's file from member [dropdown]
What is the member's code status?	Does the member use alcohol? [dropdown] Does the member use tobacco? [dropdown]
Does the member use Marijuana?	Does the member use any other non-prescribed narcotics? [dropdown] Is member sexually active? [dropdown]
CLINICAL CONDITIONS Per Member Interview Responses Does the Member Have now or a history of ANY of the following? (Specify using drop down or free boxes): Any RED YES answer = 1 point each:	
Disease Process:	Disease Process: [dropdown] Disease Process: [dropdown]

FIG. 2A

Asthma?	<input type="checkbox"/>	Schizophrenia?	<input type="checkbox"/>	CANCER?	<input type="checkbox"/>
Emphysema/COPD?	<input type="checkbox"/>	Anxiety?	<input type="checkbox"/>	What kind of Cancer?	<input type="checkbox"/>
SOB?	<input type="checkbox"/>	Alzheimer's or Dementia?	<input type="checkbox"/>	Chronic Kidney Disease?	<input type="checkbox"/>
Pneumonia?	<input type="checkbox"/>	Parkinson's?	<input type="checkbox"/>	End Stage Renal Disease?	<input type="checkbox"/>
Depression?	<input type="checkbox"/>	Arthritis?	<input type="checkbox"/>	Is this member on Dialysis?	<input type="checkbox"/>
MI?	<input type="checkbox"/>	Osteoporosis?	<input type="checkbox"/>	If on Dialysis, where do they go?	<input type="checkbox"/>
Congestive Heart Failure?	<input type="checkbox"/>	Diabetes?	<input type="checkbox"/>	Urinary tract infection?	<input type="checkbox"/>
Irregular HR/Angina?	<input type="checkbox"/>	Neuropathy? Where?	<input type="checkbox"/>	HIV/AIDS?	<input type="checkbox"/>
Hypertension (HTN)?	<input type="checkbox"/>	Amputation of a limb?	<input type="checkbox"/>	Constipation?	<input type="checkbox"/>
Enter last known B/P	<input type="checkbox"/>	Which Limb?	<input type="checkbox"/>	Diarrhea?	<input type="checkbox"/>
Stroke/CVA?	<input type="checkbox"/>	Retinopathy?	<input type="checkbox"/>	Hepatitis?	<input type="checkbox"/>
Coronary Artery Disease (CAD)?	<input type="checkbox"/>	IBS/ULCERATIVE COLITIS/CHRON'S?	<input type="checkbox"/>	Chronic Liver Disease?	<input type="checkbox"/>
Hypertipidemia?	<input type="checkbox"/>	GI Bleed?	<input type="checkbox"/>	Other Issues	<input type="checkbox"/>
Peripheral Artery Disease?	<input type="checkbox"/>	GERD/ Ulcers?	<input type="checkbox"/>	Is the member Obese?	<input type="checkbox"/>
Height: _____ Weight: _____		BMI by Calculator ( <a href="http://www.bmi-calculator.net">www.bmi-calculator.net</a> )		What is the member's current pain level?	<input type="checkbox"/>
Does the member have acute or chronic PAIN?	<input type="checkbox"/>	Where is the PAIN located?		Does member take pain medication on regular basis?	<input type="checkbox"/>
How many medications does the member take daily?	<input type="checkbox"/>	Is member on Anticoagulation Therapy?	<input type="checkbox"/>	Had Tetanus shot in the last 10 years?	<input type="checkbox"/>
Checked for polypharmacy issues:	<input type="checkbox"/>	If so, on an anticoagulation program?	<input type="checkbox"/>	Does member take all medications as ordered by their providers?	<input type="checkbox"/>
Has member had a flu shot in the last year? DATE: _____	<input type="checkbox"/>	Has member had a Pneumovax shot in the last 5 years? DATE: _____	<input type="checkbox"/>	Select (if NO 1 pt)	<input type="checkbox"/>

FIG. 2B

MEDICATIONS (if NONE Check Here ): Medications member is currently taking at home, include vitamins and over the counter drugs:  
Greater than 12 meds chart in notes and notify PharmD/MD:

DRUG NAME	DOSE	How often	DRUG NAME	DOSE	How often

**FUNCTIONAL STATUS -**  
Activities of Daily Living Per Member interview Responses Does The Member Have ANY of the following?  
(Specify using drop down or free boxes: Any RED answer = 1 point each IF not corrected: (Document in Case notes any issues))

Visual impairment?	Yes - corrected w/ <input type="checkbox"/>	Difficulty bathing?	Incontinent of the bowel? <input type="checkbox"/>
A hearing impairment?	<input type="checkbox"/>	Difficulty dressing?	Incontinent of the bladder? <input type="checkbox"/>
Speech impairment? That interferes with their ability to communicate? (1pt - if unable to communicate)	<input type="checkbox"/>	Difficulty transferring from one surface to another?	Difficulty or unable to prepare meals? <input type="checkbox"/>
Any difficulty walking or maintaining their balance?	<input type="checkbox"/>	Difficulty feeding self?	Difficulty or unable to do housekeeping? <input type="checkbox"/>
Any falls in the last 6 months, how many have they had? <input type="checkbox"/>	<input type="checkbox"/>	Feeding tube?	Difficulty shopping or buying food? <input type="checkbox"/>
Device used to ambulate? <input type="checkbox"/>	<input type="checkbox"/>	Feeding tube is it old or new?	Where is the weakness? <input type="checkbox"/>
		Weakness of the extremities that interfere with their self care or mobility?	Assistance or CARE GIVER? <input type="checkbox"/>
		A manual or electric wheelchair or scooter for mobility?	If YES, how often? <input type="checkbox"/>
			is it used for in home mobility or outside? if member uses an electric wheel chair or scooter where did they get it? Select <input type="checkbox"/>
Was Hospice discussed with this member or the caregiver? <input type="checkbox"/>		Was Palliative Care discussed with this member or the caregiver? <input type="checkbox"/>	Was a Palliative Care or Hospice evaluation ordered? <input type="checkbox"/>
Who was Hospice discussed with (name)? <input type="text"/>		Who was Palliative Care discussed with (name)? <input type="text"/>	If ordered, name and telephone number of agency <input type="text"/>

FIG. 2C

<p><b>TRANSPORTATION ISSUES - Per Member Interview Responses (if NONE Check Here [ ]); What resources are anticipated to be needed for this member/patient or caregiver to support the member/patient in the community or to coordinate with Medicaid benefits? Any RED answer = 1 point each if not corrected</b></p> <p>Community Resources(anticipated or needed):</p>		<p><b>ANTICIPATED COMMUNITY RESOURCES</b></p> <p>Does the member have any difficulty getting to and from medical or dental appointments? Who transports the member when needed? Name of person who transports member: Telephone number of person who transports member:</p>	
<p><b>UTILIZATION PATTERNS Per Member Interview Responses "How many Times Has the ...": (Specify using drop down or free boxes); Any RED answer &gt; 0 = 1 point each</b></p> <p>member been to the ER in the last 3 months? [ ]</p> <p>If went to the ER, called PCP before going? [ ]</p> <p># SNF days used in benefit period (if known)? [ ]</p>		<p>been to the Urgent Care in the last 3 months? [ ]</p> <p>Did the member go during PCP Office hours (9am - 5pm)? [ ]</p> <p>Were PCP appointments available? [ ]</p>	
<p><b>ANTICIPATED INTERDISCIPLINARY CARE TEAM/FOLLOW UP NEEDED; Select all that apply</b></p> <p>Participant: [ ]</p> <p>Participant: [ ]</p> <p>Participant: [ ]</p> <p>Other: [ ]</p>			
<p><b>FOLLOW UP APPOINTMENTS CURRENTLY SCHEDULED (if referred upon hospital discharge):</b></p> <p>Provider Type: [ ] Name#: [ ] Date: [ ]</p> <p>Provider Type: [ ] Name#: [ ] Date: [ ]</p> <p>Provider Type: [ ] Name#: [ ] Date: [ ]</p>			
<p><b>MEMBER UNDERSTANDING AND SATISFACTION PROCESSES Per Member Interview Responses:</b></p> <p>Member Satisfaction Survey/EVALUATION OF PROGRAM (TO BE DONE ANNUALLY &amp; WHEN CASE IS CLOSED); CM to send survey [ ]</p> <p>Member or Family/Caregiver understanding of this process and/or program: [ ]</p> <p>Assess for type of participation that can be utilized with the patient and/or the caregiver: [ ]</p>			
<p><b>CASE MANAGEMENT ADMISSION SUMMARY (Initial Charting):</b></p> <p><b>INITIAL NOTES BY CASE MANAGER</b> (Indicate here the items/focus that you and the member/caregiver have agreed to focus on for the initial care plan on this member; this will be the basis for admission to the program; be sure to include medication reviewed with the member/caregiver)</p>			
<p><b>SCORING / MEETS CRITERIA?</b></p>			
<p><b>SNP MEMBERS:</b> Score 0-11 (LOW SNP): place member on Special Needs Program and assign to SNP coordinator once HRA, Care Plan and initial entry completed. Score 12-18 (Medium SNP): place member on Ambulatory Case Management Program (ACM/SNP) Score 19 or higher (HIGH SNP): place member on Comprehensive CM Program (CCM/SNP)</p>		<p><b>NON SNP MEMBERS:</b> Score 0-11 (LOW CM): Does not meet criteria for Case Management - notify referring provider of outcome/decision. Score 12-18 (MEDIUM CM): place member on Ambulatory Case Management Program (ACM) Score 19 or higher (HIGH CM): place member on Comprehensive CM Program (CCM)</p>	
<p>Count the points from this form and give total score here: ENTER SCORE [ ]</p> <p>MEETS CRITERIA FOR: [ ]</p> <p>ACUITY: [ ]</p>			

FIG. 2D