

## MT HELP Program Health Assessment Risk Scoring Model

Question (indicate if branching)	Scoring	Branching element if yes																
Do you have a person you think of as your personal doctor or health care provider? <ul style="list-style-type: none"> <li><input type="radio"/> Yes               <ul style="list-style-type: none"> <li><input type="radio"/> What is their Name:</li> <li><input type="radio"/> Phone Number:</li> </ul> </li> <li><input type="radio"/> No</li> </ul>	Not scored If no – assign to an HC to call to assist	Branching element if yes																
How do you prefer to get health and wellness information? <ul style="list-style-type: none"> <li><input type="radio"/> Postal mail</li> <li><input type="radio"/> E-mail</li> <li><input type="radio"/> Text message</li> <li><input type="radio"/> In person</li> <li><input type="radio"/> Internet</li> <li><input type="radio"/> Social media</li> </ul>	Not scored																	
Would you say that in general your health is —? <ul style="list-style-type: none"> <li><input type="radio"/> Excellent</li> <li><input type="radio"/> Very good</li> <li><input type="radio"/> Good</li> <li><input type="radio"/> Fair</li> <li><input type="radio"/> Poor</li> </ul>	Fair – 2 pts Poor – 2 pts																	
<b>Chronic Conditions</b> Has a doctor, nurse, or other health professional EVER told you that you had any of the following? <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 10%; text-align: center;">Not Sure</th> </tr> </thead> <tbody> <tr> <td>Hypertension/High blood pressure</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>High Cholesterol</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Pre-diabetes /high blood sugar</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	Not Sure	Hypertension/High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre-diabetes /high blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 pt for each yes answer except for Heart attack, stroke or angina or coronary heart disease – those count for 2 points  Refer to appropriate DPHHS program	
	Yes	No	Not Sure															
Hypertension/High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
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Gestational diabetes (having diabetes during pregnancy) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Diabetes (do not include if only when you were pregnant) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Heart attack or myocardial infarction <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Angina or coronary heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Arthritis, Rheumatoid arthritis, Gout, Lupus, or Fibromyalgia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
<b>Cancer Screening</b> If aged 50 years or older: A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. When did you last have this test using a home kit? <ul style="list-style-type: none"> <li><input type="radio"/> Within the past year</li> <li><input type="radio"/> 1-2 years ago</li> <li><input type="radio"/> 2-3 years ago</li> <li><input type="radio"/> More than 3 years ago</li> <li><input type="radio"/> Never had a blood stool test</li> </ul>	Not scored	set it up so that it is a branching question if yes is answered to 50 years or older
Colonoscopy is an exam in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. You are usually given medication through a needle in your arm to make you sleepy and told to have someone else drive you home after the test. When was the last time you had a colonoscopy? <ul style="list-style-type: none"> <li><input type="radio"/> Within the past year</li> </ul>	If the answer is one of the following score 1 pt: <ul style="list-style-type: none"> <li><input type="radio"/> More than 10 years ago</li> <li><input type="radio"/> <b>Never had a colonoscopy</b></li> </ul>	set it up so that it is a branching question if the following are the answers to the above: <ul style="list-style-type: none"> <li><input type="radio"/> 1-2 years ago</li> <li><input type="radio"/> 2-3 years ago</li> <li><input type="radio"/> More than 3 years ago</li> <li><input type="radio"/> <b>Never had a</b></li> </ul>

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<ul style="list-style-type: none"> <li>○ 1-2 years ago</li> <li>○ 2-9 years ago</li> <li>○ More than 10 years ago</li> <li>○ Never had a colonoscopy</li> </ul>		<b>blood stool test</b>																				
<p>Women only If aged 40 – 49 years: When did you have your last mammogram?</p> <ul style="list-style-type: none"> <li>○ Within the past year</li> <li>○ 1-2 years ago</li> <li>○ More than 2 years ago</li> <li>○ Never had a mammogram</li> </ul>	Not scored	Could set it up so that it is a branching question if female and yes is answered to 40 – 49 years																				
<p>Women only If aged 50 years or older: When did you have your last mammogram?</p> <ul style="list-style-type: none"> <li>○ Within the past year</li> <li>○ 1-2 years ago</li> <li>○ More than 2 years ago</li> <li>○ Never had a mammogram</li> </ul>	1 pt for more than 2 years ago or never	Could set it up so that it is a branching question if female and yes is answered to 40 years or older																				
<p>Women only If 21 – 64 years: When did you have your last Pap smear?</p> <ul style="list-style-type: none"> <li>○ Within the past year</li> <li>○ 1-2 years ago</li> <li>○ More than 3 years ago</li> <li>○ Never had a Pap smear</li> </ul>	1 pt for more than 3 years ago or never																					
<p>How would you describe your use of these tobacco products?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 15%;">Never Used</th> <th style="width: 15%;">Formerly Used</th> <th style="width: 15%;">Use at times</th> <th style="width: 15%;">Use regularly</th> </tr> </thead> <tbody> <tr> <td>Cigarettes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Cigars</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Pipes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Never Used	Formerly Used	Use at times	Use regularly	Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cigars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pipes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>2 pts for “regularly”</p> <p>1 pt for “use at times”</p>	
	Never Used	Formerly Used	Use at times	Use regularly																		
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		
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Smokeless tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Electronic vapor products (e-cigarettes, e-cigars, e-hookahs, vape pens)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If currently using any tobacco products: How many times have you tried to quit in the past? <ul style="list-style-type: none"> <li><input type="radio"/> Never tried</li> <li><input type="radio"/> 1 time</li> <li><input type="radio"/> 2 times</li> <li><input type="radio"/> 3 times or more</li> </ul>	Not scored – HC to refer to DPHHS Quit Line				Branching question from positive answer above	
How often are you exposed to second-hand smoke at home or at work? <ul style="list-style-type: none"> <li><input type="radio"/> Seldom or never</li> <li><input type="radio"/> Occasionally</li> <li><input type="radio"/> Daily</li> </ul>	1 pt for daily					
<b>Alcohol Section</b>						
<b>Male section</b>						
How often do you have a drink containing alcohol? <ul style="list-style-type: none"> <li><input type="radio"/> Never (skip to next section)</li> <li><input type="radio"/> Monthly or less</li> <li><input type="radio"/> 2–4 times a month</li> <li><input type="radio"/> 2–3 times per week</li> <li><input type="radio"/> 4 or more times a week</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> 2–3 times per week – 1 pt</li> <li><input type="radio"/> 4 or more times a week – 2 pts</li> </ul>					
How many drinks containing alcohol do you have on a typical day when you are drinking? <ul style="list-style-type: none"> <li><input type="radio"/> 1 or 2</li> </ul>	3 or 4 – 1 pt 5 or 6 – 2 pts 7 to 9 – 3 pts				Branching question	

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<ul style="list-style-type: none"> <li><input type="radio"/> 3 or 4</li> <li><input type="radio"/> 5 or 6</li> <li><input type="radio"/> 7 to 9</li> <li><input type="radio"/> 10 or more</li> </ul>	10 or more – 4 pts	
<p>How often do you have 5 or more drinks on one occasion?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Never</li> <li><input type="radio"/> Less than monthly</li> <li><input type="radio"/> Monthly</li> <li><input type="radio"/> Weekly</li> <li><input type="radio"/> Daily or almost daily</li> </ul>	<p>Less than monthly – 1 pt          Monthly – 2 pts          Weekly – 3 pts          Daily or almost daily – 4 pts</p>	Branching question
<b>Total Alcohol Score</b>	<p>Total score = overall risk score          4 – 6 = 3 pts,          7 – 8 = 4 pts          9-10 = 5 pts,          HC should refer to BH with member’s permission</p>	
<b>Female Section</b>		
<p>How often do you have a drink containing alcohol?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Never (skip to next section)</li> <li><input type="radio"/> Monthly or less</li> <li><input type="radio"/> 2–4 times a month</li> <li><input type="radio"/> 2–3 times per week</li> <li><input type="radio"/> 4 or more times a week</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> 2–4 times a month – 1 pts</li> <li><input type="radio"/> 2–3 times per week – 2 pts</li> <li><input type="radio"/> 4 or more times a week – 3 pts</li> </ul>	
<p>How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <ul style="list-style-type: none"> <li><input type="radio"/> 1 or 2</li> <li><input type="radio"/> 3 or 4</li> <li><input type="radio"/> 5 or 6</li> <li><input type="radio"/> 7 to 9</li> <li><input type="radio"/> 10 or more</li> </ul>	<p>3 or 4 – 2 pt          5 or 6 – 3 pts          7 to 9 – 4 pts          10 or more – 5 pts</p>	Branching question

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<p>How often do you have 5 or more drinks on one occasion?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Never</li> <li><input type="radio"/> Less than monthly</li> <li><input type="radio"/> Monthly</li> <li><input type="radio"/> Weekly</li> <li><input type="radio"/> Daily or almost daily</li> </ul>	<p>Monthly – 1 pt Weekly – 2 pts Daily or almost daily – 3 pts</p>	<p>Branching question</p>															
<p><b>Total Score for Alcohol Use</b></p>	<p>Total score = overall risk score 3 – 6 = 3 pts, 7 – 8 = 4 pts, 9- 11 = 5 pts HC should refer to BH with member’s permission . 4 pts or greater</p>																
<p><b>Emotional Health</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Over the past 2 weeks, how often have you been bothered by any of the following problems?</th> <th style="text-align: center;">Not at all</th> <th style="text-align: center;">Several days</th> <th style="text-align: center;">More than half the days</th> <th style="text-align: center;">Nearly every day</th> </tr> </thead> <tbody> <tr> <td>Little interest or pleasure in doing things</td> <td style="text-align: center;">0</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>Feeling down, depressed or hopeless</td> <td style="text-align: center;">0</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> </tbody> </table>	Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	Little interest or pleasure in doing things	0	1	2	3	Feeling down, depressed or hopeless	0	1	2	3	<p>Several days – 1 pt More than half – 2pts Everyday – 3 pts</p>	<p>HC should refer to BH with member’s permission</p>
Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day													
Little interest or pleasure in doing things	0	1	2	3													
Feeling down, depressed or hopeless	0	1	2	3													
<p><b>Total score for emotional health</b></p>	<p>Total 1 – 2 points = 1 point Total 3 – 4 points = 2 points Total 5 – 6 points = 3 points</p>																
<p><b>Diet and Exercise</b> About how much do you weigh without shoes?</p>	<p>Not scored</p>	<p>Text field – if we can calculate BMI that would be great!</p>															

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_____ pounds		
About how tall are you without shoes? _____ feet and _____ inches	Not scored	Text field – if we can calculate BMI that would be great!
Total BMI (either calculated by Aerial or HC)	>30 – 2 pts >40 – 3 pts HC should refer member to DM for weight loss program if BMI > 30 and/or if member is interested at > 25	Text field – if we can auto calculate BMI that would be great!
How would you describe your eating habits? According to Dietary Guidelines for Americans a healthy well-balanced diet is mostly vegetables, fruit, whole grains, low-fat milk products, and lean proteins such as fish, chicken, and beans. And it is low in salt, solid fats, and added sugar. <input type="radio"/> Healthy and well-balanced (go to next section) <input type="radio"/> Need some improvement <input type="radio"/> Need lots of improvement <input type="radio"/> Not sure	Needs some improvement – 1 pt Needs lots of improvement – 2 pts	
What are the reasons that make it difficult to maintain well-balanced eating habits? Mark all that apply <input type="radio"/> No time to cook healthier meals <input type="radio"/> Higher costs of healthier meals <input type="radio"/> Not sure exactly what healthy meals are <input type="radio"/> Healthier meals are not readily available <input type="radio"/> I do not enjoy healthier meals <input type="radio"/> Other	Not scored	Branching from above
Besides at work, how often are you able to engage in physical activity (like brisk walking, cycling, or sports)? <input type="radio"/> Rarely <input type="radio"/> Few times per week <input type="radio"/> Most days <input type="radio"/> I have physical activity scheduled into my daily routine.	<input type="radio"/> Rarely - 2 pts <input type="radio"/> Few times per week - 1 pt	
Are you interested in increasing your physical activity? <input type="radio"/> Yes	Not scored	

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<input type="radio"/> No		
<p>What are the reasons you don't get more physical activity?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Not enough time</li> <li><input type="radio"/> Inconvenient</li> <li><input type="radio"/> Physical disability</li> <li><input type="radio"/> Injury or pain</li> <li><input type="radio"/> Lack of motivation</li> <li><input type="radio"/> Don't like exercise</li> <li><input type="radio"/> Exercise enough already</li> </ul> <p>Other</p>	<p>Physical disability – 2 pts Injury or pain – 2 pts</p> <p>The remainder are 1 pt (excluding exercise enough already)</p>	<p>Was this intended to branch from a No response from previous question? Text field for "other" response</p>
<p><b>Sexual Health</b></p> <p>Have you been sexually active over the last year?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Yes</li> <li><input type="radio"/> No (skip to end)</li> </ul>		
<p>Do you use protection to decrease the risk of sexually transmitted diseases when you have sex?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Yes, all the time</li> <li><input type="radio"/> Sometimes</li> <li><input type="radio"/> No, never</li> <li><input type="radio"/> No, I only have one sexual partner</li> </ul>	<p>Sometimes – 1 pt No, never – 2 pts</p>	<p>Branching from yes response above</p>
<p>Would you like to have a baby in the next year?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Yes</li> <li><input type="radio"/> No</li> <li><input type="radio"/> I'm unsure or OK either way</li> </ul>	<p>Not scored</p>	
<p>If no: What type of birth control (contraception) are you currently using? Mark all that apply</p> <ul style="list-style-type: none"> <li><input type="radio"/> Tubes tied (or female sterilization)</li> <li><input type="radio"/> Vasectomy (or male sterilization)</li> <li><input type="radio"/> Birth control pills, any kind</li> <li><input type="radio"/> Condoms</li> <li><input type="radio"/> Contraceptive implant (for example, Implanon)</li> </ul>	<p>Any of the below:</p> <ul style="list-style-type: none"> <li><input type="radio"/> Condoms</li> <li><input type="radio"/> Foam, jelly, or cream</li> <li><input type="radio"/> Emergency contraceptive (morning after pill)</li> <li><input type="radio"/> Other method</li> <li><input type="radio"/> nothing</li> </ul>	<p>Branching from No or unsure response above</p>

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<ul style="list-style-type: none"> <li>○ Shots (for example, Depo)</li> <li>○ Contraceptive ring (for example, Nuvaring)</li> <li>○ Contraceptive patch (for example, Ortho Evra)</li> <li>○ Diaphragm, cervical cap, or sponge</li> <li>○ Foam, jelly, or cream</li> <li>○ IUD (for example, Mirena)</li> <li>○ Emergency contraceptive (morning after pill)</li> <li>○ Other method</li> <li>○ Nothing</li> </ul>	<p>– 2 pts</p>	
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Total Score	Stratification Level	Action
Less than 7	Low	Refer to appropriate DPHHS program, mail materials*
7 – 12 points	Moderate	Refer to DM/Wellness Program or BH CM for further assessment*
13 or greater points	High	Refer to CM Program (either PH or BH) for further assessment*

Positive answers as indicated above result in a referral to the indicated program regardless of risk stratification level