Watertown Regional Medical Center
Wellness Works
125 Hospital Drive
Watertown, WI 53098
T(920)262.4405
F(920)262.4480

Dear WRMC Insured Associates and Spouses,

As part of the 2014/2015 WRMC Employee Wellness Program you are being asked to schedule an annual exam with your Primary Care Provider. This is a change from previous years. Biometric Screenings will not be performed at the hospital this year. At this appointment your provider should test you on *fasting* laboratory values and vital signs, as well as complete the tobacco use statement on Page 5 of this packet. If you have had a yearly exam with your physician since **January 1st, 2014**, and/or your provider has performed all the appropriate tests over the course of one or multiple visits during that timeframe, as listed on page 5, you will not need to be retested. Simply complete the form on page 5 with your provider and submit it to Wellness Works. If you have not had a yearly exam since **January 1st, 2014** you will need to schedule an appointment and complete this documentation per the following instructions.

In order to complete this packet, please follow these instructions:

1. Prior to your appointment you are required to complete and sign the Consent form on page 3.
2. Please take this entire packet with you to your appointment. At the time of your appointment you and your provider will complete page 5 together.
3. At the completion of your appointment please return page 3 to Wellness Works.
4. If your provider uses WRMC's Electronic Medical Record they will also give you page 5 to return at that time (labs will be entered electronically).

   ***If your provider does not use WRMC's Electronic Medical Record they will need to keep page 5 until labs have been processed. At that time they will need to complete the remaining information and fax or mail the form to Wellness Works as instructed. ***

Results from exams with your provider between January 1st, 2014 and June 1st, 2015 will qualify. You may return your completed documents to Wellness Works any time before the deadline of Monday, June 1st, 2015.

Completion of this process is required for all insured associates and spouses. Please contact your provider soon to schedule your appointment or to complete your documentation. Ultimately**, YOU**, the insured associate or insured spouse, are responsible for ensuring all forms are returned to Wellness Works upon completion. If your provider needs to keep page 4 to complete your results, we recommend you follow up in one week's time to ensure it was completed and faxed to Wellness Works. Fax and mailing information can be found at the top of this page and also on the last page of this document.

Again for 2015, WRMC will contribute towards a Health Reimbursement Arrangement (HRA) for insured associates and insured spouses. Money contributed to the HRA may be applied towards your deductible in the same way as in 2014. Each insured associate and insured spouse will receive a $300 contribution to the HRA for a total contribution of up to $600. HRA funds will be available starting January 1st, 2015. For the 2015 plan year all those who are insured will automatically receive this contribution. **To qualify for the HRA contribution in future years, you must complete the 2014/2015 screening process. Associates and spouses who opt not to participate in this process will not qualify for the 2016 contributions.** Incomplete documentation will disqualify you for the 2016 contributions as well. Further details about the HRA Accounts will be included in upcoming communications and meetings.

Completion of this process prior to the deadlines listed above will be the first step to qualify for the 2016 contribution. Upon completion of this process, each participant will also receive a biometric score based on their individual results. Contributions in future years, **2016 and beyond**, will be based both on your completion of this screening process and also on your individual biometric score. Individuals falling short of the recommended scoring ranges will be offered opportunities to participate in the ONE Wellness or ONE Flex program to improve their outcomes and qualify for the corresponding contributions. More information on the biometric scoring system that will be implemented for 2016 is included on page 2 of this packet.

Thank you in advance for your cooperation with this health promotion effort of UW Health Partners WRMC. If you have any questions please contact Wellness Works Clinic Coordinator, Eric Weiss, at 920.262.4405.

UW Health Partners
Watertown Regional Medical Center

2014-2015 Scoring Scale and Future Contributions

After all results have been submitted, each participant will receive a biometric score based on their individual results. These scores will be available after the June 1st, 2015 deadline. Contributions in 2016 will be based both on your completion of this screening process and also on your individual biometric score. Participants scoring **55/100** or higher and who are also **non-tobacco users** will automatically receive the 2016 contribution. Once submitted your results will be scored as follows:

WRMC Biometric Screening Points Scale						
	Low Risk Range	Points Earned	Moderate Risk Range	Points Earned	High Risk Range	Points Earned
BMI	≤ 24.9	10	25.0 - 29.9	5	≥ 30.0	0
Systolic Blood Pressure	< 120	10	120 - 139	5	≥ 140	0
Diastolic Blood Pressure	< 80	10	80 - 89	5	≥ 90	0
Total Cholesterol	< 200	10	200 - 239	5	≥ 240	0
HDL	≥ 40	10	N/A	0	< 40	0
LDL	< 100	10	100 - 129	5	≥ 130	0
TC/HDL Ratio	0 - 3.5:1	10	N/A	0	> 3.5:1	0
Triglycerides	< 150	10	150 - 500	5	>500	0
Fasting Glucose	<100	20	100 - 130	10	>130	0
Total Possible Points = 100						

Individuals scoring below the cutoff of 55/100 will be offered the opportunity to participate in ONE Wellness or ONE Flex to help improve their health and raise their overall score. Once notified, individuals who enroll one of these transformational programs and are actively meeting program criteria will then qualify for the 2016 contributions.

Individuals who are indicated to be smokers or users of other tobacco products will be required to enroll in and complete a designated tobacco cessation program prior to December 1st, 2015. Proof of program completion will be required for those individuals to qualify for the 2016 contribution. Tobacco users will also be subject to the points scale and requirements indicated above.

For individuals scoring below the designated cutoff or those who are tobacco users, the programs listed above will be provided at no cost to you. If you choose not to utilize the options provided by WRMC you must submit qualifying documentation showing proof of results meeting or exceeding the above criteria prior to December 1st, 2015 to be considered for the 2016 contribution. Individuals who qualify for and are actively participating in one of the designated programs will not need any additional documentation to qualify for the 2016 contribution.

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at 920-262-4405 and we will work with you to develop another way to qualify for the reward.

UW Health Partners
Watertown Regional Medical Center

Reset

HEALTH RISK ASSESSMENT CONSENT / AUTHORIZATION

The purpose of this health-screening program, offered through UW Health Partners Watertown Regional Medical Center, is to gather sufficient information so you can receive an informative confidential Health Risk Report. This report provides you with Protected Health Information (PHI). The report you receive and the medical information gathered by Watertown Regional Medical Center constitutes protected health information as defined by the privacy regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Watertown Regional Medical Center has executed confidentiality agreements and certifications as necessary to comply with the HIPPA laws.

Name of Sponsor Employer: **WATERTOWN REGIONAL MEDICAL CENTER**

SECTION I: TO BE COMPLETED BY UW Health Partners WRMC Associate or Spouse (please print)

Please check one**: Fasting*** ◯, **Non-fasting** ◯ **Fasting means you have only consumed water or black coffee during the past 12 hours.*

Last Four Digits of Your Social Security Number _____
** SSN is kept confidential and is used by Watertown Regional Medical Center for identification purposes only and will not be used on any other forms*

Please Print: _____ _____ _____ **Date of Birth:** MM/DD/YYYY
Use Legal Name **(Last Name)** **(First)** **(MI)**

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Are you: ☐ Male, ☐ Female
Regarding the sponsor employer, are you: ◯ employee, ◯ spouse, ◯ retiree, ◯ retiree's spouse, ◯ other

PLEASE REVIEW: I wish to participate in this screening as part of an employer sponsored wellness program. I understand that I have the responsibility for arranging any follow-up examinations indicated by the confidential report I receive upon completion of this process. I understand I may be contacted by the Medical Director if any of my labs are considered high risk. I consent to the taking of blood from me and the testing of the blood sample for cholesterol and blood sugar values, and the transfer of the blood results to Wellness Works. I understand that my biometric data will not be used for any other purpose other than wellness programming, will only be viewable by those involved in the wellness program delivery, and will not be a part of my employee record. I understand there are possible risks associated with a blood draw including, but not limited to, risk of infections, and discomfort and bruising. I understand that other more remote risks may be involved. I release Watertown Regional Medical Center, the health screener, the sponsor employer, and all other personnel and agencies from any responsibilities other than their own negligence in connection with this program provided all government regulated privacy regulations are followed.

I further agree, understand and acknowledge the following:

- This Consent and Authorization is meant to comply with all state and federal laws regulating the form and content of authorizations for disclosure of medical information, including, but not limited to, the medical privacy provisions of the Health Insurance Portability and Accountability Act ("HIPAA").
- That this Consent and Authorization will stay in effect until revoked or superseded by another agreement.
- That I may revoke this Consent and Authorization at any time in writing unless action has already been taken in reliance on this Consent and Authorization. My rights to revoke may also be limited by any Notice of Privacy Practices provided to me by my health care providers pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations.
- That I may refuse to sign this Consent and Authorization.
- That I have the right to request access to all medical records that are used or disclosed pursuant to this Consent and Authorization.
- That a photocopy of this Consent and Authorization will be as valid as the original.
- That upon my request I may receive a copy of this Consent and Authorization.
- That my results will be shared in my Electronic Medical Record (EMR) for physician reviewing.

Signed: _____ Date: _____
Enter Today's Date

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www.uwhpwatertown.com

Dear Provider,

In an effort to improve awareness of the importance of preventive health practices, UW Health Partners WRMC is asking their insured employees and spouses to verify their annual exam results and preventive screening status. As part of our Employee Wellness Program we need your assistance to verify that he/she: 1) had an annual physical exam between ***January 1st, 2014 and June 1st, 2015,*** or has had all of the tests listed performed by you over the course of multiple visits during that timeframe, and 2) is up-to-date on his/her recommended age- and gender-specific preventative screenings. Please verify the status of these tests by completing the attached form and returning it to the employee or by submitting it directly to UW Health Partners Watertown Regional Medical Center per the instructions on the bottom of the form.

For insured associates and spouses to receive full credit for completion of this process, all attached forms must be completed in their entirety. It is the responsibility of the participant to ensure all forms are returned to Wellness Works upon completion. Documents should be submitted as soon as they are complete. The deadline for submission of all screening documentation is ***Monday, June 1st, 2015***.

Thank you in advance for your cooperation with this health promotion effort of UW Health Partners WRMC. If you have any questions please feel free to contact the Wellness Works Clinic Coordinator, Eric Weiss at 920.262.4405.

UW Health Partners
Watertown Regional Medical Center

2014/2015 UW Health Partners WRMC Preventive Care Verification

Form Company Name: UW Health Partners Watertown Regional Medical Center

(Print) First Name: _____ **Last Name:** _____ **Date of Birth:** MM/DD/YYYY

Sex: ☐ **Male** ☐ **Female**

SECTION II: TO BE COMPLETED BY PRIMARY CARE PROVIDER

My Patient is up to date as of today's date for the following preventative screenings (if applicable)

☐ Annual Physical Exam (Men and Women)
☐ Cervical Cancer Screening - Pap or Screening Test (Women)
☐ Breast Cancer Screening – Mammogram (Women)
☐ Colorectal Cancer Screening – Colonoscopy or Screening Test (Men and Women)

***Laboratory Tests (Men and Women)**
Lipid Panel to include:
***Total Cholesterol*_____ *Triglycerides* _____ *HDL* _____ *LDL* _____ *TC/HDL Ratio*_____**
Fasting Blood Glucose: _____

Vital Signs:

B/P **Ht. (in)** **Wt. (lb)** **BMI**

Tobacco use : Cigarettes: ◯ **Yes** ◯ **No** **Other Tobacco Products:** ◯ **Yes** ◯ **No**

To the Insured:
I certify that the above response in regards to tobacco use is true as of the date indicated below. I promise that if my behavior changes so that this statement becomes incorrect, I will file a new correct statement within five (5) days so that a correct Tobacco Status Statement is on file with WRMC at all times. I understand that permitting a false tobacco status statement to remain on file constitutes a falsification of records and may lead to discipline, including termination of employment.

Signature of Participant: _____ **Date:** _____
Enter Today's Date

To the Provider:
I certify that the above responses by my patient are true as of the date indicated below. I understand that as part of WRMC's Wellness Program any tobacco users will be provided programming to assist with quitting at the organization's expense.

Primary Care Provider's Signature: **Date:** _____
Enter Today's Date

Primary Care Provider's Name (please print): _____

***Important Instructions:**

To Providers Utilizing WRMC's Electronic Medical Record:
Please complete these forms and enter final data into the Electronic Medical Record. At this time leave the ***'Laboratory Tests'*** section on this form blank. Return all completed forms to the patient who will submit them to Wellness Works as instructed below. *Lab results should be entered into the EMR as normal once they've been processed.*

To Providers NOT Utilizing WRMC's Electronic Medical Record:
Please retain this form until the ***'Laboratory Tests'*** have been processed. Once finished, please complete this form, including lab values, and fax it to the number listed below. Upon completion of this appointment the patient should retain the completed ***'Consent/Authorization Form'*** and return it to Wellness Works as verification that they had their appointment with you. Your patient will not however receive credit for this appointment until this form is completed and returned by your office.

Please fax or mail this form no later than June 1st, 2015 to:
Eric Weiss; Wellness Works; Fax: (920)262-4480
Mail: UW Health Partners WRMC, Attn: Eric Weiss/Wellness Works, 125 Hospital Dr., Watertown, WI 53098

Submit **Reset**