15. HEALTH EDUCATION

A. Health Education

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP maintains a health education system that provides programs, services, functions and resources necessary to deliver health education, health promotion and patient education at no cost to its Members.1

PROCEDURES:

A. IEHP delegates the delivery of clinical health education services for Members to the Providers.

B. IEHP provides certain disease or prevention specific health education services for Members. Providers are encouraged to refer Members to IEHP for these programs.

C. Providers are responsible for providing Member-specific clinical health education services to assigned Members with assistance from their IPA as needed. Areas for education include:
   1. Condition-specific health education as needed for diabetes, asthma, and hypertension;
   2. Tobacco use prevention and cessation;
   3. Family planning;
   4. Tuberculosis;
   5. Human immunodeficiency virus (HIV)/ sexually transmitted infection (STI) prevention;
   6. Dental care;
   7. Diet, nutrition, and physical activity;
   8. Perinatal health;
   9. Age-specific anticipatory guidance;
   10. Immunizations;
   11. Substance use disorders; and

D. Providers are responsible for identifying the need for clinical health education services through the following mechanisms or interactions:
   1. Initial Health Assessment/Staying Healthy Assessment - behavioral or clinical questions and observed need;

1 Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.9.
15. HEALTH EDUCATION

A. Health Education

2. Periodic Physical Examinations - behavioral or clinical questions and observed need;
3. Acute illness visits - observed need (e.g., STI counseling/information if treated for STI); and
4. Chronic illness visits - observed need (e.g., dietary/exercise counseling for hypertensive patients).

E. Providers must directly deliver clinical health education services to Members within their scope of practice. Activities can include:
   1. Direct information provided by the Provider (e.g., recommendation of exercise regimen for obese Members);
   2. Supplying brochures or other printed materials to the Member that are pertinent to the need (e.g., the IEHP Immunizations brochure for parents with children); and
   3. Use of educational videotapes in the waiting room or counseling room.

F. Providers are responsible for referring Members for additional necessary health education services that are beyond their scope of practice. Referral options include:
   1. Referral to IEHP Health Education Programs;
   2. Referral to community-based organizations or services; and
   3. Referral to the IPA for medically necessary nutrition education such as Registered Dietitian services. See Policy 14D, “Pre-Service Referral Authorization Process.”

G. IPAs are responsible for assisting their Providers in the delivery of health education services including:
   1. Arranging for medically necessary health education services upon referral from the Provider;
   2. Coordinating and/or referring Members to community-based organizations that provide free or low-cost health education services, utilizing community referral resources such as 2-1-1; and
   3. Providing health education materials including brochures, other written materials and/or videos to the Provider or the Member, including brochures available through IEHP.

H. IEHP provides health education services to Members and Providers through the following mechanisms:
   1. Provision of brochures directly to Provider offices on topics including but not limited to antibiotic use, asthma, immunizations, and diabetes;
   2. Information on community referral resources (e.g. connectie.org and 2-1-1) that list relevant resources in the community;
   3. Provision of brochures to Members on topics including but not limited to Benefits of Joining IEHP, Fever in Children, Parenting, and Contraception.
15. HEALTH EDUCATION

A. Health Education

4. Direct delivery of Health Education Programs to Members to include self-management tools and anticipatory guidance on the following topics:
   
a. Health and Wellness:
      1) Advanced Care Directives
      2) Senior Health
      3) Nutrition
      4) Physical Activity
      5) Heart Health
      6) Depression and Stress
      7) At-Risk Drinking
   
b. Disease Management:
      1) Asthma
      2) Pre-Diabetes
      3) Diabetes
      4) Smoking Cessation
      5) Weight Management
   
c. Perinatal:
      1) Prenatal Education
      2) Breastfeeding Support
      3) Family Planning/STI Prevention
      4) Injury Prevention

   d. Pediatric:
      1) Well-Baby and Immunization
      2) Developmental Screening
      3) Adolescent Health
      4) Healthy Lifestyles

I. IEHP ensures equal access to health care services for limited English proficient Medi-Cal Members. See Policy 9H1, “Cultural and Linguistic Services- Foreign Language Capabilities” for more information.

J. Although not required, Providers may refer Members to the IEHP Health Education Programs

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2 CCI Three-Way Contract September 2019, Section 2.11.
15. HEALTH EDUCATION

A. Health Education

by submitting a Health Education request online through the secure IEHP Provider portal.

K. Members may self-refer to an IEHP Health Education Program by calling IEHP Member Services at (877) 273-IEHP (4347) / TTY (800) 718-4347 or by registering via the online Member portal.

L. IEHP oversees and monitors Providers and IPA compliance with required health education activities through Provider site audits.

M. IEHP monitors Primary Care Provider (PCP) sites to ensure health education materials and resources are ready and available or made available to Members upon request, applicable to the practice and population served and available in threshold languages. Health education services must be documented in the Member’s medical record in accordance with Policy 6A, “Facility Site Review and Medical Record Review Survey Requirements and Monitoring”.

N. IEHP monitors the provision of health education services by IPA through periodic surveys and visits.
15. Health Education

B. Weight Management

APPLIES TO:
A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:
A. The IEHP Weight Management Program is available to Members who are, or at risk for being overweight or obese.
   1. Members under the age of 18 must be accompanied by parent or guardian.
   2. Activities are open to Members seeking weight loss surgery, but participation does not meet utilization management criteria for the authorization of any medical or surgical services.
   3. Activities are not inclusive of a medically supervised weight loss program.

PURPOSE:
A. To promote healthy dietary and physical activity habits for Members interested in preventing health problems related to obesity.

PROCEDURES:
A. Program Registration
   1. IPAs or Providers may submit a Health Education request online through the secure IEHP Provider Portal.
   2. Members may access Weight Management activities themselves by calling Member Services at (877) 273-IEHP (4347) or the online Member Portal at www.iehp.org.
B. Program Description
   1. Eat Healthy, Be Active Community Workshops
      a. Workshops are offered in San Bernardino and Riverside Counties.
      b. Program elements include education regarding nutrition, physical activity, and behavior change.
      c. Workshops are conducted in group settings which include interactive modules, video presentations, and healthy cooking tips.
      d. Members may receive educational tools and incentives at the end of each workshop.
C. IEHP ensures equal access to health care services for limited English proficient Members.¹

¹ Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.11
15. Health Education

B. Weight Management

See Policy 9H1, “Cultural and Linguistic Services - Foreign Language Capabilities” for more information.

D. Evaluation

1. IEHP Health Education Staff monitor processes and facilitation through program site visits.

2. Health Education Manager will conduct random site visits using standardized audit forms.
15. HEALTH EDUCATION

C. IEHP Family Asthma Program

APPLIES TO: [DEC1]

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members who are diagnosed with asthma.

POLICY:

A. The IEHP Family Asthma Program is available to Members, or caregivers of Members, who are diagnosed with asthma as well as their caregivers.

B. Program written materials are available in English and Spanish IEHP threshold languages, which are the only threshold languages designated by the Centers for Medicare and Medicaid Services (CMS) in San Bernardino and Riverside Counties. Language assistance services are provided to Members with limited English proficiency who are not proficient in IEHP threshold languages. Reasonable accommodations are provided to individuals with disabilities and access and/or functional needs.

PURPOSE:

A. To provide self-management tools and intervention strategies to Members diagnosed with asthma.

PROCEDURES:

A. Program Registration

1. Although not required, Providers may submit a Health Education Referral Request online through the secure IEHP Provider Portal.

2. Members may register for the Asthma Program themselves by calling the Member Services Department at (877) 273-IEHP (4347) or online through the IEHP Member Portal at www.iehp.org.

B. Program Description

1. Program topics include:
   a. Asthma Symptoms;
   b. Environmental Triggers;
   c. Interactive demonstration of Peak Flow Meter and Aero Chamber use;
   d. Controller vs Rescue medications; and
   e. Asthma Action Plan.
15. HEALTH EDUCATION

C. IEHP Family Asthma Program

2. Members who attend the Family Asthma Program may receive an educational tool or incentive for their participation.

3. One (1) adult family member or support person may attend with the Member. Support persons do not have to be IEHP Members or have asthma to attend.

C. IEHP ensures equal access to health care services for limited English proficient Medi-Cal Members. See Policy 9H1, “Cultural and Linguistic Services- Foreign Language Capabilities” for more information.

Program classes are instructed by certified educators as determined appropriate by the Health Education Manager.

D. Evaluation

D.E. Evaluation

1. IEHP Health Education Staff monitor program processes and facilitation through program site visits.

2. Health Education Manager will conduct random site visits for quality assurance purposes; assessments will be conducted using standardized audit forms.

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¹ Department of Health Care Services (DHCS) All Plan Letter (APL) 16-006 5(Revised) supersedes policy letters 09-005 and 12-002, “Requirements for use of non-monetary member incentives for incentive programs, focus groups, and member surveys.”

² Coordinated Care Initiative (CCI) Three-Way Contract September 2019 Section 2.11

³ Coordinated Care Initiative (CCI) Three-Way Contract Section 2.11, eff September 1st 2019.
15. HEALTH EDUCATION

C. IEHP Family Asthma Program

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<td>Chief Approval: Signature on file</td>
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<tr>
<td>Chief Title: Chief Medical Officer</td>
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</table>

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15. HEALTH EDUCATION

D. IEHP Diabetes Self-Management Program

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. The IEHP Diabetes Self-Management Program is available to all Members who:
   1. Are not pregnant;
   2. Are at least 14 years of age and over; and
   3. Are diagnosed with diabetes.

PURPOSE:

A. To provide self-management tools and intervention strategies to Members diagnosed with Diabetes.

PROCEDURES:

A. Program Registration
   1. Although not required, Providers may submit a Health Education request online through the secure IEHP Provider Portal.
   2. Members can register for the Diabetes Self-Management Program themselves by calling the Member Services Department at (877) 273-IEHP (4347) or the online Member Portal at www.iehp.org.

B. Program Description
   1. Program curriculum is adapted from the American Diabetes Educator Association (AADE). Program topics include:
      a. Glucose level monitoring;
      b. A1C tracking;
      c. Medication adherence;
      d. Healthy Eating and Meal planning;
      e. Benefits of physical activity.
   2. To promote participation and enhance meaningful engagement, Members who attend the Diabetes Self-Management Program may receive an educational tool or incentive in class sessions.
   3. One (1) adult family member and/or support person may participate in the activities with the Member. Support persons do not have to be IEHP Members or have diabetes to attend.
15. HEALTH EDUCATION

D. IEHP Diabetes Self-Management Program

C. Program classes are instructed by a Diabetes Educator, Registered Nurse, Registered Dietitians, Pharmacists, or other certified Health Educators as deemed appropriate by the Health Education Manager.

D. IEHP ensures that the instructors are using an evidence-based curriculum and activities that adhere to the American Diabetes Association Guidelines (ADA), and American Association of Diabetes Educators (AADE).

E. IEHP ensures equal access to health care services for limited English proficient Members.\(^1\) See Policy 9H1, “Cultural and Linguistic Services- Foreign Language Capabilities” for more information.

F. Evaluation

1. IEHP Health Education Staff monitor program processes and facilitation through program site visits.

2. Health Education Manager will conduct random site visits for quality assurance purposes; assessments will be performed using standardized audit forms.

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INLAND EMPIRE HEALTH PLAN

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<th>Chief Approval: Signature on file</th>
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<tr>
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<td>Revision Date:</td>
<td>January 1, 2021</td>
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</tbody>
</table>

\(^1\) Coordinated Care Initiative (CCI) Three-Way Contract Section 2.11.
15. HEALTH EDUCATION

E. Perinatal Program

APPLIES TO:
A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) Members.

POLICY:
A. The IEHP Perinatal Program is available at no cost to Members who are:
   1. Pregnant at the time of registration; or
   2. Contemplating pregnancy.

PURPOSE:
A. To deliver health education programming which promotes a healthy pregnancy and birth outcome.

PROCEDURES:
A. Program Registration
   1. Although not required, IPAs or Providers may submit a Health Education request online through the secure IEHP Provider Portal.
   2. Members may access perinatal services themselves by calling Member Services at (877) 273-IEHP (4347) or through the online Member Portal at www.iehp.org.
B. Program Description
   1. Start Well/Comienzando Bien Workshop
      a. Workshops are offered in San Bernardino and Riverside Counties.
      b. Program elements will include prenatal/postpartum care, nutrition, injury prevention, well-baby checkups, immunizations, and community resources.
      c. Workshops are conducted in group setting which includes interactive modules, video presentations, and safety demonstrations.
      d. To promote participation and enhance meaningful engagement, Members may receive educational tools and/or incentive items at the end of the workshop.¹
   2. Baby n’ Me Smartphone Application
      a. The application is available for free download from the Apple App Store or Google Play Store in English and Spanish versions.
      b. Application features include tracking tools, interactive media, anticipatory guidance,

¹ Department of Health Care Services (DHCS) All Plan Letter (APL) 16-005 (Revised) Supersedes Policy Letters (PL) 09-005 and 12-002, “Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, and Member Surveys”
15. HEALTH EDUCATION

E. Perinatal Program

evidence-based prevention tips, and resource linkages.

c. Eligible Members must verify their active Member identification numbers and dates of birth to obtain the application. Members must agree to the Terms and Conditions and a Privacy Policy when downloading the digital application on their personal devices.

d. Eligible Members can access all available features of the application without additional costs.

e. Members may participate in optional surveys, text back campaigns, or interactive quizzes. They may receive incentive items for participating.2

3. Loving Support Breastfeeding Helpline Assistance

a. Provide breastfeeding support through Helpline services for Members.

b. Services are provided in a culturally competent manner in threshold languages.

C. Evaluation

1. Workshops and Groups

a. IEHP Health Education Staff monitor processes and facilitation through program site visits.

b. Health Education Manager will conduct random site visits using standardized audit forms.

2. Digital Application

a. Member level reports will be provided by the application developer and will be securely transmitted. Data may be transmitted via Secure File Transfer Protocol (SFTP), secure email, or directly via client configured API.

b. Reports will include end-user data which details how the Member interacts with the features of the application. For Members with certain high-risk pregnancy conditions (e.g. hypertensive disorders, a previous preterm birth, a mood disorder, or a substance use disorder) and who agree to receive contact from an IEHP Team Member, the Health Education Department will provide a monthly report to the Behavioral Health & Care Management Department for telephonic follow up.

INLAND EMPIRE HEALTH PLAN

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<td><strong>Revision Date:</strong></td>
<td>January 1, 2021</td>
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2 DHCS APL 16-005
15. Health Education

F. Diabetes Prevention Program

APPLIES TO:
A. This policy applies to all IEHP DualChoice Cal MediConnect (Medicare-Medicaid) Members.

POLICY:
A. The Diabetes Prevention Program (DPP) is an evidence-based disease prevention program developed by the Centers for Disease Control and Prevention (CDC) and is a Medicare medical benefit covered by IEHP.1

B. Members must meet DPP eligibility criteria developed by the Centers for Medicare and Medicaid Services (CMS) in alignment with the CDC DPP criteria.2

C. IEHP Members may access DPP services at no cost3 and without prior authorization.

PURPOSE:
A. To provide a lifestyle change program to prevent onset of Type 2 Diabetes.4

PROCEDURES:
A. Program Registration
1. Providers may refer IEHP Members to a DPP supplier without prior authorization. Providers can access a list of active DPP suppliers for IEHP, that is maintained by the Health Education Department by going online at www.iehp.org.

2. The benefit may be offered as often as necessary, but the Member’s medical record must indicate that the Member’s medical condition or circumstance warrants repeat or additional participation in the DPP benefit.

B. Program Description:5 The DPP is an interactive program focused on lifestyle changes for Members with prediabetes to prevent or delay the onset of Type 2 Diabetes.

1. Consistent with the CDC curriculum, the DPP is a longitudinal program that consists of at least twenty-two (22) group sessions.

2. Each session is for one (1) hour and topics include:

1 https://www.cdc.gov/diabetes/prevention/lifestyle-program/requirements.html
3 Ibid.
4 Ibid.
5 Ibid.
15. Health Education

F. Diabetes Prevention Program

    a. Self-monitoring diet and physical activity;
    b. Building self-efficacy;
    c. Social support for maintaining lifestyle change; and
    d. Problem-solving strategies for overcoming challenges.

C. IEHP ensures equal access to health care services for limited English proficient IEHP DualChoice Members. See Policy 9H1, “Cultural and Linguistic Services- Foreign Language Capabilities” for more information.

D. Evaluation

    1. IEHP Health Education Department staff will monitor process and facilitation through program site visits.
    2. The Health Education Manager will conduct random site visits using standardized audit forms.
    3. IEHP Health Education Department Staff will perform annual chart audits for select DPP suppliers.
APPLIES TO:
A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:
A. IEHP and its IPAs cover and ensure the provision of an Initial Health Assessment (IHA) for Medicare Members within one hundred twenty (120) calendar days of enrollment with IEHP as part of the Member’s Initial Health Assessment.\(^1\) See Policy 10C, “Initial Health Assessment” for more information.

B. The IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a Primary Care Provider (PCP) to comprehensively assess the Member’s current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies.

PROCEDURES:
A. IEHP PCPs will administer the IHEBA using the “Staying Healthy Assessment” (SHA) form. The SHA consists age-specific questionnaires and are available in English and in all Medi-Cal threshold languages.

B. PCP Responsibilities\(^2\)
   1. PCPs are responsible for assuring the IHEBA is administered as part of the IHA and within the timeframes outlined in this policy. Current Members who have not completed an updated SHA must complete it during the next preventive care office visit (e.g. well-woman exam). Please see Table 1: SHA Periodicity table in this policy.

   2. Existing Members who missed the one hundred twenty (120) calendar day assessment must have the IHEBA administered at their next scheduled non-acute care visit, but no later than their next scheduled health screening exam.

   3. PCPs must ensure the Member completes the appropriate age-specific form and review the completed SHA with the Member. Adult and Senior forms must be completed by the Member in order to preserve confidentiality.

   4. In the case of Members who are unable to complete the SHA form on their own, or prefer assistance, the PCP must provide a staff person to administer the form, read the questions

\(^1\) Department of Health Care Services (DHCS) Policy Letter (PL) 08-003, “Initial Comprehensive Health Assessment”.

\(^2\) DHCS PL 13-001, “Requirements for the Staying Healthy Assessment/Individual Health Education Behavioral Assessment”. 
5. The original completed SHA form must be filed in the Member’s chart as part of the permanent medical record.

6. The PCP must review the completed SHA with the Member, prioritize each Member’s health education needs, and initiate discussion and counseling regarding high-risk behaviors the Member identified in the assessment. Clinic staff members, as appropriate, may assist a PCP in providing counseling and following up if the PCP supervises the clinical staff members and directly addresses medical issues.

7. The PCP must review the SHA with the Member during the years between re-administration of a new SHA assessment. The review should include discussion, appropriate patient counseling, and regular follow-up regarding risk reduction plans.

8. The PCP must sign, print name and date every newly administered SHA to verify it was reviewed with the patient. PCP must complete the “Clinical Use Only” section to indicate topics discussed and assistance provided. Subsequent annual reviews must be signed and dated by PCP in the “SHA Annual Review” section to verify the annual review was conducted with the patient.

9. The assessment form must be re-administered at the appropriate age intervals as designated on the forms.

a. The adult assessment is intended for use by adults 18 to 55 years old. The age at which the PCP should begin administering the senior assessment to a Member should be based on the patient’s health and medical status, and not exclusively on the patient’s age.

Table 1: SHA Periodicity

<table>
<thead>
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<th>Subsequent SHA Administration</th>
<th>SHA Review</th>
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<tr>
<td>DHCS 7089 A</td>
<td>Age Groups 0-6 Months</td>
<td>Within 120 Days of Enrollment</td>
<td>After Entering New Age Group</td>
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<tr>
<td>DHCS 7-12</td>
<td>0-6 Months</td>
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3 DHCS PL 13-001.
4 Ibid.
15. **HEALTH EDUCATION**

G. **Individual Health Education Behavioral Assessment / Staying Healthy Assessment**

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<tr>
<th>7089 B</th>
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<tr>
<td>DHCS 7089 C</td>
<td>1-2 Years</td>
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10. The Member’s refusal to complete the SHA must be documented on the age-appropriate SHA questionnaire by:

   a. Entering the Member’s name (or person completing the form), date of birth, and date of refusal in the header section of the questionnaire;

   b. Checking the box “SHA Declined by Patient;”

   c. Having the PCP sign, print his or her name, and date the “Clinic Use Only” section of the SHA; and

   d. Keeping the SHA refusal in the Member’s medical record.

11. Monitoring of compliance with IHA/IHEBA is performed during the initial and periodic Medical Record Review. Please see Policy 6A, “Facility Site Review and Medical Record Review Survey” for more information.

C. **Tobacco Prevention and Cessation**

1. The SHA includes screening questions regarding Member’s smoking status and/or exposure to tobacco smoke.

   a. Members are to be assessed on their tobacco use status on an annual basis, unless an

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5 DHCS PL 13-001.
6 DHCS All Plan Letter (APL) 16-014 Supersedes PL 14-006, “Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries”.
15. HEALTH EDUCATION

G. Individual Health Education Behavioral Assessment / Staying Healthy Assessment

assessment needs to be re-administered based on the SHA periodicity schedule.

b. PCPs are required to provide interventions, including education or counseling. Additionally, since secondhand smoke can be harmful to children, counseling parents who smoke is also recommended.

c. Providers are to review the questions on tobacco with the Member. This constitutes as individual counseling.

d. Current tobacco use is to be documented in the medical record at every visit for Members of all ages

2. For Tobacco Cessation, IEHP encourages Providers to implement the following interventional approach:

a. Use a validated behavior change model to counsel Members who use tobacco products. Training materials on the following examples may be requested from the Provider Relations Team or accessed online through the non-secure Provider portal:

(1) Use of the “5 A’s” – Ask, Advise, Assess, Assist, and Arrange; and
(2) Use of the “5 R’s” – Relevance, Risks, Rewards, Roadblocks, and Repetition

b. Members are able to receive a minimum of four (4) counseling sessions of at least ten (10) minutes/session. Members may choose individual or group counseling conducted in person or by telephone.

(1) Individual, group, and telephone counseling is offered at no cost to Members who wish to quit smoking, whether or not those Members opt to use tobacco cessation medications.

c. Two (2) quit attempts per year are covered without prior authorization and without any mandatory breaks between quit attempts.

(1) The list of appropriate Current Procedure Terminology (CPT) and International Classification of Diseases (ICD) codes for tobacco may be requested through the Provider Relations Team or accessed online through the non-secure Provider Portal.

d. Members are to be referred to the California Smoker’s Helpline (1-800-NO-BUTTS by phone or www.nobutts.org online) or other comparable quit-line service. Providers are encouraged to use the Helpline’s web referral, or if available in their area, the Helpline’s e-referral system.

e. Providers are strongly encouraged to implement the recommendations from the U.S. Department of Health and Human Services Public Health Service (USPHS) “Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update”. This document is accessible at:
15. HEALTH EDUCATION

G. Individual Health Education Behavioral Assessment / Staying Healthy Assessment


f. Based on the Member’s behavioral risks and willingness to make lifestyle changes, the PCPPCPs should provide tailored health education counseling, intervention, referral, and follow-up. Whenever possible, the PCP and the Member should develop a mutually agreed-upon risk reduction plan.

D. IEHP and IPA Responsibilities

1. IEHP and its IPAs must ensure that all PCPs receive access to the age-appropriate SHA forms.

2. IEHP provides all IPAs and PCPs access to the SHA forms as follows:
   a. Through the annual IEHP Provider Policies and Procedure Manual (See Attachments, “SHA Form – Adult (English & Spanish),” and “SHA Form – Senior (English & Spanish)” in Section 15);
   b. Online through IEHP’s website at www.iehp.org; and
   c. Through the Department of Health Care Services (DHCS) website at https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthyAssessmentQuestionnaires.aspx.

3. IEHP and its IPAs must assist PCPs in providing health education services as indicated by Members on their SHA. This includes authorization of necessary referrals and provision of required education services.

E. SHA Electronic Formats

1. When a Provider or IPA plans to use the SHA in an alternate format (electronic or another paper-based format) they must ensure the following:
   a. All SHA questions for the specific age group are included verbatim;
   b. Referencing the most current version available on the SHA Webpage; and
   c. Informs their contracted health plan at least one (1) month before they plan to implement the SHA in an electronic or alternative format.

F. Alternative IHEBA

1. If Providers plan to use an alternative IHEBA, the tool will be evaluated by IEHP. If IEHP approves the tool, a justification for the use and a copy of the tool will be submitted by IEHP’s Compliance Department to DHCS Medi-Cal Managed Care Division (MMCD) (See Attachment, “Alternative Individual Health Education Behavioral Assessment (IHEBA)” in Section 15). The tool will be comparable to the latest version

7 DHCS PL 13-001.
8 Ibid.
of the SHA including content and specific risk factors, periodicity and schedule for administration, documentation of administration, re-administration, annual review and required follow-up for identified risk factors. The approved alternative IHEBA will be translated into IEHP threshold languages and made available to the PCP. Previously approved alternative IHEBAs will be re-submitted to MMCD for approval every three (3) years.

G. Provider Training

1. IEHP provides all PCPs and IPAs with education and training on the implementation of the “Staying Healthy Assessment” using the standardized SHA Provider Training materials as delineated in Policy 18G, “Provider Resources”. In these training materials IEHP will include:
   a. IHEBA contract and documentation requirements;
   b. Training on how to set timelines for administration, review, and re-administration;
   c. Instructions on how to use the SHA or DHCS-approved alternative assessment; and
   d. Specific information and resources for providing culturally and linguistically appropriate patient health education services/interventions.

2. All PCPs are trained by IEHP Provider Service Representatives regarding patient referral procedures.

3. Additional training is available to Providers on an as needed basis, either via web or face to face by a Provider Services Representative or Quality Management Nurse Educator/Quality Program Nurse. All new PCPs receive SHA training and are informed that the SHA forms are available on IEHPs Provider Portal (See Attachment “Staying Healthy Assessment Instruction Sheet for Provider Office” in Section 15).

4. PCPs are informed of the mandatory SHA training via blast fax which includes: the mandated training deadline date, instructions on how to access the web training and the Proof of Training Form. The Proof of training form must be signed and submitted to IEHP. Additional contact information may be submitted to the IEHP Provider Relations Team should the PCP need additional assistance with the SHA training.

5. IEHPs Provider Services Department tracks all completed SHA trainings by the receipt of the signed Proof of Training Forms. PCPs who have not completed the Proof of Training Form will be contacted by a Provider Services Representative.

6. IEHP provides resources and training to PCPs and subcontractors to ensure the delivery of culturally and linguistically appropriate patient health education services and to ensure that the special needs of vulnerable populations, including SPDs and persons with limited

---

9 DHCS PL 13-001.
15. HEALTH EDUCATION

G. Individual Health Education Behavioral Assessment / Staying Healthy Assessment

English skills, are addressed in the delivery of patient services.\textsuperscript{10}

\textsuperscript{10} DHCS PL 13-001.
## 15. HEALTH EDUCATION

**Attachments**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate Individual Health Education Behavioral Assessment (IHEBA)</td>
<td>15G</td>
</tr>
<tr>
<td>SHA Form – Adult</td>
<td></td>
</tr>
<tr>
<td>a. English</td>
<td>15G</td>
</tr>
<tr>
<td>b. Spanish</td>
<td>15G</td>
</tr>
<tr>
<td>SHA Form – Senior</td>
<td></td>
</tr>
<tr>
<td>a. English</td>
<td>15G</td>
</tr>
<tr>
<td>b. Spanish</td>
<td>15G</td>
</tr>
<tr>
<td>Staying Healthy Assessment (SHA) Instruction Sheet for Provider Office</td>
<td>15G</td>
</tr>
</tbody>
</table>
Alternative Individual Health Education Behavioral Assessment (IHEBA)

Review and Approval Form

Health Plan Name: _______________________________ Date Received: ________________

Health Plan Contact: _____________________________ Phone: ___________ Email: ________________

(Name or Title of Alternative IHEBA) (Date Developed) (Date Updated):

☐ APPROVED AS SUBMITTED* ☐ ADDITIONAL INFORMATION REQUESTED (AIR)

*Approved alternative IHEBA must be resubmitted to MMCD for review and approval every three years (or no later than): ____________________________

Age Groups:

Providers/Provider Groups:

Approved administration, documentation and follow up process:

REVIEWER: HEALTH EDUCATION CONSULTANT III, SPECIALIST

(Name) (Signature) (Date)
# Requirements for Approving an Alternative IHEBA

**Policy Letter 13-001 (Revised)**

Name of the organization/company that developed the Alternative IHEBA? _____________________________________________________

<table>
<thead>
<tr>
<th>A. Content and Risk Factors</th>
<th>Yes</th>
<th>AIR</th>
<th>Additional Information Requested (Explanation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the alternative IHEBA include the content and specific risk factors included in the most current version of the Staying Healthy Assessment (SHA)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Periodicity and Administration Schedule</th>
<th>Yes</th>
<th>AIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the periodicity and schedule for administration of the alternative IHEBA, at a minimum, comparable to the SHA?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Documentation and Verification</th>
<th>Yes</th>
<th>AIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the documentation process for the administration, re-administration, and annual review of the alternative IHEBA included? If so, is it similar (or comparable) to the SHA?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Threshold Language Availability</th>
<th>Yes</th>
<th>AIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will the alternative IHEBA be made available in the threshold languages of its members?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| E. Additional Questions or Comments | |
|-------------------------------------| |
# Staying Healthy Assessment

## Adult

<table>
<thead>
<tr>
<th>Patient’s Name (first &amp; last)</th>
<th>Date of Birth</th>
<th>□ Female □ Male</th>
<th>Today’s Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Person Completing Form (if patient needs help)</th>
<th>□ Family Member □ Friend □ Other (Specify)</th>
<th>Need help with form?</th>
</tr>
</thead>
</table>

Please answer all the questions on this form as best you can. Circle “Skip” if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

**Nutrition**

1. **Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?**
   - Yes
   - No
   - Skip

2. **Do you eat fruits and vegetables every day?**
   - Yes
   - No
   - Skip

3. **Do you limit the amount of fried food or fast food that you eat?**
   - Yes
   - No
   - Skip

4. **Are you easily able to get enough healthy food?**
   - Yes
   - No
   - Skip

5. **Do you drink a soda, juice drink, sports or energy drink most days of the week?**
   - No
   - Yes
   - Skip

6. **Do you often eat too much or too little food?**
   - No
   - Yes
   - Skip

7. **Are you concerned about your weight?**
   - No
   - Yes
   - Skip

8. **Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?**
   - Yes
   - No
   - Skip

**Physical Activity**

9. **Do you feel safe where you live?**
   - Yes
   - No
   - Skip

10. **Have you had any car accidents lately?**
    - No
    - Yes
    - Skip

11. **Have you been hit, slapped, kicked, or physically hurt by someone in the last year?**
    - No
    - Yes
    - Skip

12. **Do you always wear a seat belt when driving or riding in a car?**
    - Yes
    - No
    - Skip

13. **Do you keep a gun in your house or place where you live?**
    - No
    - Yes
    - Skip

14. **Do you brush and floss your teeth daily?**
    - Yes
    - No
    - Skip

15. **Do you often feel sad, hopeless, angry, or worried?**
    - No
    - Yes
    - Skip

16. **Do you often have trouble sleeping?**
    - No
    - Yes
    - Skip

17. **Do you smoke or chew tobacco?**
    - No
    - Yes
    - Skip

18. **Do friends or family members smoke in your house or place where you live?**
    - No
    - Yes
    - Skip

**Dental Health**

**Mental Health**

**Alcohol, Tobacco, Drug Use**
In the past year, have you had:

- **(men)** 5 or more alcohol drinks in one day? [ ] No [ ] Yes [ ] Skip
- **(women)** 4 or more alcohol drinks in one day? [ ] No [ ] Yes [ ] Skip

Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight? [ ] No [ ] Yes [ ] Skip

Do you think you or your partner could be pregnant? [ ] No [ ] Yes [ ] Skip

Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.? [ ] No [ ] Yes [ ] Skip

Have you or your partner(s) had sex without using birth control in the past year? [ ] No [ ] Yes [ ] Skip

Have you or your partner(s) had sex with other people in the past year? [ ] No [ ] Yes [ ] Skip

Have you or your partner(s) had sex without a condom in the past year? [ ] No [ ] Yes [ ] Skip

Have you ever been forced or pressured to have sex? [ ] No [ ] Yes [ ] Skip

Do you have other questions or concerns about your health? [ ] No [ ] Yes [ ] Skip

*If yes, please describe:*

---

**Clinic Use Only**

- Nutrition [ ]
- Physical activity [ ]
- Safety [ ]
- Dental Health [ ]
- Mental Health [ ]
- Alcohol, Tobacco, Drug Use [ ]
- Sexual Issues [ ]

<table>
<thead>
<tr>
<th></th>
<th>Counseled</th>
<th>Referred</th>
<th>Anticipatory Guidance</th>
<th>Follow-up Ordered</th>
<th>Comments:</th>
</tr>
</thead>
</table>

- Patient Declined the SHA

PCP's Signature: [ ]
Print Name: [ ]
Date: [ ]

---

**SHA ANNUAL REVIEW**

PCP's Signature: [ ]
Print Name: [ ]
Date: [ ]

PCP's Signature: [ ]
Print Name: [ ]
Date: [ ]

PCP's Signature: [ ]
Print Name: [ ]
Date: [ ]

PCP's Signature: [ ]
Print Name: [ ]
Date: [ ]
### Evaluación de Salud
*(Staying Healthy Assessment)*

**Adul to (Adult)**

<table>
<thead>
<tr>
<th>Nombre del paciente (nombre y apellido)</th>
<th>Fecha de nacimiento</th>
<th>□ Mujer</th>
<th>□ Hombre</th>
<th>Fecha de hoy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person a que llena el formulario <em>(si el paciente necesita ayuda)</em></td>
<td>□ Familiar □ Amigo □ Otro</td>
<td>□ Sí □ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra “Omitir” si no sabe una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre alguna sección de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.**

**Nutrition**

<table>
<thead>
<tr>
<th>Pregunta</th>
<th>Sí</th>
<th>No</th>
<th>Omitir</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ¿Come frutas y verduras todos los días?</td>
<td>Sí</td>
<td>No</td>
<td>Omitir</td>
</tr>
<tr>
<td>3. ¿Limita la cantidad de alimentos fritos o comida rápida que come?</td>
<td>Sí</td>
<td>No</td>
<td>Omitir</td>
</tr>
<tr>
<td>4. ¿Tiene la posibilidad de comer suficientes alimentos saludables?</td>
<td>Sí</td>
<td>No</td>
<td>Omitir</td>
</tr>
<tr>
<td>5. ¿La mayoría de los días bebe un refresco, jugo, bebida deportiva o bebida energizante?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>6. Por lo general, ¿come demasiado o muy poco?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>7. ¿Le preocupa su peso?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
</tbody>
</table>

**Physical Activity**

<table>
<thead>
<tr>
<th>Pregunta</th>
<th>Sí</th>
<th>No</th>
<th>Omitir</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. ¿Hace ejercicio o realiza actividades, como caminar, jardinería o nadar durante, al menos, ½ hora al día?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. ¿Se siente seguro donde vive?</td>
<td>Sí</td>
<td>No</td>
<td>Omitir</td>
</tr>
</tbody>
</table>

**Safety**

<table>
<thead>
<tr>
<th>Pregunta</th>
<th>Sí</th>
<th>No</th>
<th>Omitir</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. ¿Ha tenido accidentes automovilísticos últimamente?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
</tbody>
</table>

DHCS 7098 H SPANISH (Rev 12/13) SHA (Adult) Page 1 of 3
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Been hit, slapped, kicked, or physically hurt by someone in the last year?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siempre usa cinturón de seguridad cuando conduce o viaja en automóvil?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always wears a seat belt when driving or riding in a car?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Tiene un arma de fuego en su hogar o en el lugar donde vive?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keeps a gun in house or place where she/he lives?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Se cepilla los dientes y los limpia con hilo dental todos los días?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brushes and flosses teeth daily?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Con frecuencia se siente triste, desesperanzado, enojado o preocupado?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often feels sad, hopeless, angry, or worried?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Con frecuencia tiene dificultades para dormir?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often has trouble sleeping?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Fuma o masca tabaco?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smokes or chews tobacco?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Sus amigos o familiares fuman en su hogar o en el lugar donde usted vive?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends/family members smoke in house or place where she/he lives?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>En el último año, ¿ha tomado:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ (hombres) 5 o más bebidas alcohólicas en un solo día?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ (mujeres) 4 o más bebidas alcohólicas en un solo día?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In past year, had (5 for men) or (4 for women) or more alcohol drinks in one day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Consume drogas o medicamentos para ayudarlo a dormir, relaxarse, calmarse, sentirse mejor o perder peso?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cree que usted o su pareja podría estar embarazada?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinks she/he or partner could be pregnant?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cree que usted o su pareja pueden tener una infección de transmisión sexual (sexually transmitted infection, STI), como clamidia, gonorrea, verrugas genitales, etc.?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinks she/he or partner could have an STI?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usted o su(s) pareja(s) tuvieron relaciones sexuales sin utilizar un método anticonceptivo en el último año?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>She/he or partner(s) had sex without using birth control in the past year?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usted o su(s) pareja(s) tuvieron relaciones sexuales con otras personas en el último año?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>She/he or partner(s) had sex with other people in the past year?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin condón en el último año?
She/he or partner(s) had sex without a condom in the past year?

- No
- Sí
- Omitir

¿Alguna vez le forzaron o presionaron para tener relaciones sexuales?
Ever been forced or pressured to have sex?

- No
- Sí
- Omitir

¿Tiene alguna otra pregunta o inquietud sobre su salud?
Any other questions or concerns about health?

- No
- Sí
- Omitir

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only

<table>
<thead>
<tr>
<th></th>
<th>Counseling</th>
<th>Referral</th>
<th>Anticipatory Guidance</th>
<th>Follow-up Ordered</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Dental Health</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol, Tobacco, Drug Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Patient Declined the SHA

PCP's Signature: \[\] Print Name: \[\] Date: 

SHA ANNUAL REVIEW

PCP's Signature: \[\] Print Name: \[\] Date: 

PCP's Signature: \[\] Print Name: \[\] Date: 

PCP's Signature: \[\] Print Name: \[\] Date: 

PCP's Signature: \[\] Print Name: \[\] Date: 

DHCS 7098 H SPANISH (Rev 12/13) SHA (Adult) Page 3 of 3
# Staying Healthy Assessment

## Senior

<table>
<thead>
<tr>
<th>Patient’s Name (first &amp; last)</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Today’s Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Female ☐ Male</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person Completing Form (if patient needs help)</th>
<th>Need help with form?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Family Member ☐ Friend ☐ Other (Specify)</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Please answer all the questions on this form as best you can. Circle “Skip” if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>2  Do you eat fruits and vegetables every day?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>3  Do you limit the amount of fried food or fast food that you eat?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>4  Are you easily able to get enough healthy food?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>5  Do you drink a soda, juice drink, sports or energy drink most days of the week?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>6  Do you often eat too much or too little food?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>7  Do you have difficulty chewing or swallowing?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>8  Are you concerned about your weight?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>9  Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>10 Do you feel safe where you live?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>11 Do you often have trouble keeping track of your medicines?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>12 Are family members or friends worried about your driving?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>13 Have you had any car accidents lately?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>14 Do you sometimes fall and hurt yourself, or is it hard to get up?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>15 Have you been hit, slapped, kicked, or physically hurt by someone in the past year?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>16 Do you keep a gun in your house or place where you live?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>17 Do you brush and floss your teeth daily?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>18 Do you often feel sad, hopeless, angry, or worried?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>19 Do you often have trouble sleeping?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>20 Do you or others think that you are having trouble remembering things?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>21</td>
<td>Do you smoke or chew tobacco?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>22</td>
<td>Do friends or family members smoke in your house or where you live?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>23</td>
<td>In the past year, have you had 4 or more alcohol drinks in one day?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>24</td>
<td>Do you use any drugs or medicines to help you sleep, relax, calm down,</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>feel better, or lose weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Do you think you or your partner could have a sexually transmitted</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Have you or your partner(s) had sex with other people in the past year?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>27</td>
<td>Have you or your partner(s) had sex without a condom in the past year?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>28</td>
<td>Have you ever been forced or pressured to have sex?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>29</td>
<td>Do you have someone to help you make decisions about your health and</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>medical care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Do you need help bathing, eating, walking, dressing, or using the</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>bathroom?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Do you have someone to call when you need help in an emergency?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>32</td>
<td>Do you have other questions or concerns about your health?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If yes, please describe:

---

**Clinic Use Only**

- Nutrition
- Physical activity
- Safety
- Dental Health
- Mental Health
- Alcohol, Tobacco, Drug Use
- Sexual Issues
- Independent Living

<table>
<thead>
<tr>
<th>Clinic Use Only</th>
<th>Counselled</th>
<th>Referred</th>
<th>Anticipatory Guidance</th>
<th>Follow-up Ordered</th>
<th>Comments:</th>
</tr>
</thead>
</table>

- Patient Declined the SHA

PCP's Signature:  
Print Name:  
Date:  

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**SHA ANNUAL REVIEW**

PCP's Signature:  
Print Name:  
Date:  

PCP's Signature:  
Print Name:  
Date:  

PCP's Signature:  
Print Name:  
Date:  

PCP's Signature:  
Print Name:  
Date:  

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DHCS 7098 I (Rev 12/13)  SHA (Senior)  Page 2 of 2
# Evaluación de Salud

**(Staying Healthy Assessment)**

**Personas mayores** *(Senior)*

<table>
<thead>
<tr>
<th>Nombre del paciente (primer nombre y apellido)</th>
<th>Fecha de nacimiento:</th>
<th>□ Mujer</th>
<th>□ Hombre</th>
<th>Fecha de hoy</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Persona que completa el formulario <em>(si el paciente necesita ayuda)</em></th>
<th>□ Familiar</th>
<th>□ Amigo</th>
<th>□ Otro</th>
<th>□ Especifique</th>
<th>¿Necesita ayuda para completar el formulario?</th>
</tr>
</thead>
</table>

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra “Omitir” si no conoce una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre algún punto de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

### Por favor intente responder todas las preguntas de este formulario lo mejor que pueda.

<table>
<thead>
<tr>
<th>Pregunta</th>
<th>Sí</th>
<th>No</th>
<th>Omitir</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>Skip</strong></td>
</tr>
<tr>
<td>2. ¿Come frutas y verduras todos los días?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>Skip</strong></td>
</tr>
<tr>
<td>3. ¿Limita la cantidad de alimentos fritos o comida rápida que come?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>Skip</strong></td>
</tr>
<tr>
<td>4. ¿Tiene la posibilidad de comer suficientes alimentos saludables?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>Skip</strong></td>
</tr>
<tr>
<td>5. ¿La mayoría de los días bebe un refresco, jugo, bebida deportiva o bebida energizante?</td>
<td><strong>No</strong></td>
<td><strong>Yes</strong></td>
<td><strong>Skip</strong></td>
</tr>
<tr>
<td>6. Por lo general, ¿come demasiado o muy poco?</td>
<td><strong>No</strong></td>
<td><strong>Yes</strong></td>
<td><strong>Skip</strong></td>
</tr>
<tr>
<td>7. ¿Tiene dificultades para masticar o tragar?</td>
<td><strong>No</strong></td>
<td><strong>Yes</strong></td>
<td><strong>Skip</strong></td>
</tr>
<tr>
<td>8. ¿Le preocupa su peso?</td>
<td><strong>No</strong></td>
<td><strong>Yes</strong></td>
<td><strong>Skip</strong></td>
</tr>
<tr>
<td>9. ¿Hace ejercicios o realiza actividades, como caminar, jardinería o nadar durante, al menos, ½ hora al día?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>Skip</strong></td>
</tr>
<tr>
<td>10. ¿Se siente seguro donde vive?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>Skip</strong></td>
</tr>
<tr>
<td>11. Por lo general, ¿tiene dificultades para llevar un registro de sus medicamentos?</td>
<td><strong>No</strong></td>
<td><strong>Yes</strong></td>
<td><strong>Skip</strong></td>
</tr>
</tbody>
</table>

**Clinic Use Only:**

- Nutrition
- Physical Activity
- Safety
|   | 12 ¿Sus familiares o amigos se preocupan por la forma en que conduce?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 13 ¿Ha tenido accidentes automovilísticos últimamente?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 14 ¿A veces se cae y se lastima, o le resulta difícil ponerse de pie?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 15 Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 16 ¿Tiene un revólver en su hogar o en el lugar donde vive?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 17 ¿Se cepilla los dientes y los limpia con hilo dental todos los días?  
   | Sí | No | Omitir  
|---|---|---|---|---|---|---|---|
|   | 18 ¿Con frecuencia se siente triste, desesperanzado, enojado o preocupado?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 19 ¿Con frecuencia tiene dificultades para dormir?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 20 ¿Usted u otras personas creen que tiene problemas para recordar cosas?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 21 ¿Fuma o masca tabaco?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 22 ¿Sus amigos o familiares fuman en su hogar o en el lugar donde vive?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 23 En el último año ¿ha tomado 4 o más bebidas alcohólicas en un solo día?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 24 ¿Consume drogas o medicamentos para ayudarlo a dormir, relajarse, calmarse, sentirse mejor o perder peso?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
|   | 25 ¿Cree que usted o su pareja pueden tener una infección de transmisión sexual (sexually transmitted infection, STI), como clamidia, gonorrea, verrugas genitales, etc.?  
   | No | Sí | Omitir  
|---|---|---|---|---|---|---|---|
26. ¿Usted o su(s) pareja(s) tuvieron relaciones sexuales con otras personas en el último año?  
*She/he or partner(s) had sex with other people in the past year?*  
- No  
- Sí  
- Omitir

27. ¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin condón en el último año?  
*She/he or your partner(s) had sex without a condom in the past year?*  
- No  
- Sí  
- Omitir

28. ¿Le han forzado o presionado a tener relaciones sexuales, alguna vez?  
*Ever been forced or pressured to have sex?*  
- No  
- Sí  
- Omitir

29. ¿Cuenta con alguien que lo ayude a tomar decisiones sobre su salud o su atención médica?  
*Has someone to help make decisions about her/his health and medical care?*  
- Sí  
- No  
- Omitir

30. ¿Necesita ayuda para bañarse, comer, caminar, vestirse o ir al baño?  
*Needs help bathing, eating, walking, dressing, or using the bathroom?*  
- No  
- Sí  
- Omitir

31. ¿Tiene a quién llamar cuando necesita ayuda en una emergencia?  
*Has someone to call when she/he needs help in an emergency?*  
- Sí  
- No  
- Omitir

32. ¿Tiene alguna otra pregunta o inquietud sobre su salud?  
*Any other questions or concerns about your health?*  
- No  
- Sí  
- Omitir

**Si la respuesta es afirmativa, por favor describa:**

<table>
<thead>
<tr>
<th>Clinic Use Only</th>
<th>Counselled</th>
<th>Referred</th>
<th>Anticipatory Guidance</th>
<th>Follow-up Ordered</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol, Tobacco, Drug Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent Living</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Declined the SHA**

PCP’s Signature:  
Print Name:  
Date:

**SHA ANNUAL REVIEW**

PCP’s Signature:  
Print Name:  
Date:

PCP’s Signature:  
Print Name:  
Date:

PCP’s Signature:  
Print Name:  
Date:

PCP’s Signature:  
Print Name:  
Date:

DHCS 7098 I SPANISH (Rev 12/13) SHA (Senior) Page 3 of 3
### Staying Healthy Assessment (SHA)

**Instruction Sheet for the Provider Office**

#### SHA Periodicity Table

<table>
<thead>
<tr>
<th>Questionnaire Age Groups</th>
<th>Administer Within 120 Days of Enrollment</th>
<th>Administer / Re-Administer 1st Scheduled Exam (after entering new age group)</th>
<th>Review Every 3-5 Years</th>
<th>Review Annually (Intervening Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 6 Mo</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>7 - 12 Mo</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>1 - 2 Yrs</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>3 - 4 Yrs</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>5 - 8 Yrs</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>9 - 11 Yrs</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>12 - 17 Yrs</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Adult</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Senior</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

#### SHA Completion by Member

- Explain the SHA’s purpose and how it will be used by the PCP.
- Offer SHA translation, interpretation, and accommodation for any disability if needed.
- Assure patient that SHA responses will be kept confidential in patient’s medical record, and that patient’s has the right to skip any question.
- A parent/guardian must complete the SHA for children under 12.
- Self-completion is the preferred method of administering the SHA because it increases the likely hood of obtaining accurate responses to sensitive or embarrassing questions.
- If preferred by the patients or PCP, the PCP or other clinic staff may verbally asked questions and record responses on the questionnaire or electronic format.

#### Patient Refusal to Complete the SHA

- How to document the refusal on the SHA:
  1. Enter the patient’s name and “date of refusal” on first page
  2. Check the box “SHA Declined by Patient” (last page)
  3. PCP must sign, print name and date the back page
- Patients who previously refused/declined to complete the SHA should be encouraged to complete an age appropriate SHA questionnaire each subsequent year during scheduled exams.
- PCP must sign, print name and date an age appropriate SHA each subsequent year verifying the patient’s continued refusal to complete the SHA.

#### SHA Recommendations

**Adolescents (12-17 Years)**

- Annual re-administration is highly recommended for adolescents due to frequently changing behavioral risk factors for this age group.
- Adolescents should begin completing the SHA on their own at the age of 12 (without parent/guardian assistance) or at the earliest age possible. The PCP will determine the most appropriate age, based on discussion with the family and the family’s ethnic/cultural/community background.

**Adults and Seniors**

- The PCP should select the assessment (Adult or Senior) best suited for the patient’s health & medical status, e.g., biological age, existing chronic conditions, mobility limitations, etc.
- Annual re-administration is highly recommended for seniors due to frequently changing risk factors that occur in the senior years.

#### PCP Responsibilities to Provide Assistance and Follow-up

- PCP must review and discuss newly completed SHA with patient. Other clinic staff may assist if under supervision of the PCP, and if medical issues are referred to the PCP.
- If responses indicate risk factor(s) (boxes checked in the middle column), the PCP should prioritize patient’s health education needs and willingness to make life style changes, provide tailored health education counseling, interventions, referral and follow-up.
- Annually, PCP must review & discuss previously completed SHA with patient (intervening years) and provide appropriate counseling and follow-up on patient’s risk reduction plans, as needed.

#### Required PCP Documentation

- PCP must sign, print name and date the newly administered SHA to verify it was reviewed with patient and assistance/follow-up was provided as needed.
- PCP must check appropriate boxes in “Clinical Use Only” section to indicate topics and type of assistance provided to patient (last page).
- For subsequent annual reviews, PCP must sign, print name and date “SHA Annual Review” section (last page) to verify the annual review was conducted and discussed with the patient.
- Signed SHA must be kept in patient’s medical record.

#### Optional Clinic Use Documentation

- Shaded “Clinic Use Only” sections (right column next to questions) and “Comments” section (last page) may be used by PCP/clinic staff for notation of patient discussion and recommendations.