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

B. Program written materials are available in English and Spanish, 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 functional needs.

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

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

PROCEDURES:

A. Providers are responsible for providing Member-specific clinical health education services to assigned Members with assistance from their Delegated IPA as needed. Areas for education include:

1. Condition-specific health education as needed for diabetes, asthma, hypertension, etc.;
2. Tobacco use prevention and cessation;
3. Family Planning;
4. Tuberculosis;
5. Human Immunodeficiency Virus (HIV)/ Sexually Transmitted Infections (STIs) Prevention;
6. Dental care;
7. Diet, nutrition, and physical activity;
8. Perinatal;
9. Age-specific anticipatory guidance;
10. Immunizations;
11. Substance Abuse; and
15. HEALTH EDUCATION

A. Health Education

B. 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, observed need;
   2. Periodic Physical Examinations - behavioral or clinical questions, 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).

C. 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. Supply 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.

D. 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 (see below);
   2. Referral to community-based organizations or services; and
   3. Referral through the Delegated IPA for medically necessary nutrition education such as Registered Dietitian services. The referral process should be the same as the specialty referrals process designated by the Delegated IPA.

E. Delegated 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.

F. 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
15. HEALTH EDUCATION

A. Health Education

antibiotics, 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.

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
15. HEALTH EDUCATION

A. Health Education

G. Providers may refer Members to the IEHP Health Education Programs by submitting a Health Education Request online through the IEHP Secure Provider portal.

H. 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.

I. IEHP monitors the provision of health education services by Providers as part of the Provider Facility Site Review and Medical Record Review process. Health education services must be documented in the Member’s chart in accordance with Policy 6A, “Facility Site Review and Medical Record Review Survey Requirements and Monitoring”.

G. IEHP may monitor the provision of health education services by Delegated IPA through periodic surveys and visits.

REFERENCE:

A. Coordinated Care Initiative (CCI) Three-Way Contract, Section 2.9, eff. January 1, 2018.
15. Health Education

B. Weight Management

APPLIES TO:

A. This policy applies to all adult 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 not inclusive of a medically-supervised weight loss program.

B. Program written materials are available in English and Spanish, which are the only threshold languages designated by 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 functional needs.

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. Delegated 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.

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 a large group setting which includes interactive modules, video and cooking demonstrations.
      d. Members may receive educational tools and incentives at the end of each workshop.
15. Health Education

B. Weight Management

C. 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:

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 who are diagnosed with asthma.
B. Program classes are instructed by certified educators as determined appropriate by the Health Education Manager.
C. Program written materials are available in English and Spanish, 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 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.
   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. 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.
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 meet all of the following:
   1. Are not pregnant;
   2. Are 14 years and over; and
   3. Are diagnosed with diabetes.
B. Members under the age of 18 must be accompanied by a parent or guardian.
C. Program classes are instructed by a Diabetes Educator, Registered Nurse, Registered Dietitians, or other certified Health Educators as deemed appropriate by the Health Education Manager.
D. IEHP ensures that the instructor is using an evidence-based curriculum and activities that adhere to the American Diabetes Association Guidelines.
E. Program written materials are available in English and Spanish 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, limited access and/or functional needs.

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.
B. Program Description
   1. Program topics include:
      a. Glucose level monitoring;
15. HEALTH EDUCATION

D. IEHP Diabetes Self-Management Program

b. A1C tracking;
c. Medication Adherence; and
d. Meal planning.

2. 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.

C. 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.
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 to Members who meet the following criteria:
   1. Member is in active status with IEHP at the time of participation; and
   2. Member is pregnant at the time of registration.
B. The IEHP Perinatal Program is available to eligible Members at no cost.

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

PROCEDURES:
A. Program Registration
   1. Delegated 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.
B. Program Description
   1. Healthy Me, Healthy Baby 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 a large group setting which includes interactive modules, video, 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.
   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, evidence-based prevention tips, and resource linkages.
15. HEALTH EDUCATION

E. Perinatal Program

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.

3. Breastfeeding Helpline Assistance

a. Provide Members telephonic breastfeeding support with certified lactation educators, and/or registered nurses.
b. Services are provided in a culturally competent manner in English and Spanish (threshold language).

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, 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 Care Management Department and Behavioral Health Department for telephonic follow up.
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.

B. Members must meet DPP eligibility criteria developed by the Centers for Medicare and Medicaid Services (CMS) in alignment with the CDC DPP criteria and in accordance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 18-018, “Diabetes Prevention Program”.

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

D. Program content (written materials, and in-person sessions or virtual sessions) are available in English and Spanish, 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 available to Members with Limited English Proficiency or who are not proficient in IEHP threshold languages. Reasonable accommodations are provided to individuals with disabilities, limited access and/or functional needs.

PURPOSE:

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

PROCEDURES:

A. Program Registration

1. Providers may refer Members to a DPP supplier without prior authorization. Providers can access a list of active DPP suppliers, that is maintained by the Health Education Department:
   a. By contacting the Health Education Department at 1-866-244-4347; or
   c. 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.

2. Members may be directed by their Provider to active DPP suppliers. Members may access the list of active DPP suppliers:
   a. By calling the IEHP Health Education Department at 1-866-224-4347/TTY 1-800-
15. Health Education

F. Diabetes Prevention Program

718-4347; or

B. Program Description

1. Consistent with the CDC’s approved lifestyle change curriculum that does all of the following, the DPP curriculum consists of group sessions and materials about:
   a. Emphasizes self-monitoring, self-efficacy, and problem solving;
   b. Provides for peer or lifestyle coach feedback;
   c. Includes participant materials to support program goals and requires participant weigh-ins to track and achieve program goals;
   d. Social support for maintaining lifestyle changes; and
   e. Problem solving strategies for overcoming challenges.

2. The DPP is a longitudinal program of at least one year. It consists of at least twenty-two (22) sessions. Each session lasts one (1) hour and occurs at sites throughout IEHP’s service area.

C. 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.
REFERENCES:


15. HEALTH EDUCATION

G. Individual Health Education Behavioral Assessment / Staying Healthy Assessment

APPLIES TO:

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

POLICY:

A. All Members are required to complete an Individual Health Education Behavioral Assessment (IHEBA) within one hundred twenty (120) calendar days of enrollment with IEHP as part of the Member’s Initial Health Assessment. Please see Policy 10C, “Initial Health Assessment” for more information.

B. 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.

C. IHEBAs must be administered at appropriate, defined age intervals.

D. IEHP Primary Care Physicians (PCPs) are responsible for ensuring the completion of the IHEBA.

PROCEDURES:

A. IEHP PCPs will administer the IHEBA using the “Staying Healthy Assessment” (SHA) form as required by the Department of Health Care Services (DHCS). The SHA consists of age-specific questionnaires and are available in English and in all Medi-Cal threshold languages.

B. IEHP provides all IPAs and PCPs access to the SHA forms as follows:
   1. 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);
   2. Online through IEHP’s website at www.iehp.org; and
   3. Through the Department of Health Care Services (DHCS) website at https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthyAssessmentQuestionnaires.aspx

C. PCP Responsibilities
   1. PCPs are responsible for assuring the SHA is administered to new Members within one hundred twenty (120) calendar days of the Member’s enrollment. 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. If it is not possible to administer the IHEBA at the initial health assessment, it must be
15. HEALTH EDUCATION

G. Individual Health Education Behavioral Assessment / Staying Healthy Assessment

administered at the next scheduled, non-acute care visit.

3. The “Staying Healthy Assessment” form is available versions for specific age categories, including Adults and Seniors.

4. PCP office staff must assure that Members receive the assessment form appropriate to their age.

5. The Adult and Senior forms must be completed by the Member in order to preserve confidentiality.

6. In the case of Members who are unable to complete the “Staying Healthy Assessment” form on their own, or prefer assistance, the PCP must provide a staff person to administer the form, read the questions to the Member, and record the Member’s responses.

7. PCPs, or their staff, must review the SHA form after completion, and offer appropriate intervention, including written material, counseling, and/or referral. If the person reviewing the form and providing intervention is not the PCP, the PCP must supervise the staff and directly address medical issues.

8. The original completed SHA form must be filed in the Member’s chart as part of the permanent medical record.

9. The PCP must review the completed SHA with the Member and initiate a discussion with the Member regarding behavioral risks 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.

   a. The PCP must prioritize each Member’s health education needs and initiate discussion and counseling regarding high-risk behaviors.

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

      1) Members are to be assessed on their tobacco use status on an annual basis, unless an assessment needs to be re-administered based on the SHA periodicity schedule.

      2) PCPs are to review the questions on tobacco with the Member. This constitutes as individual counseling.

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

10. For Tobacco Cessation, IEHP encourages PCPs to implement the following interventional approach:

   a. PCPs are encouraged to 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 on through the non-
15. HEALTH EDUCATION

G. Individual Health Education Behavioral Assessment / Staying Healthy Assessment

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: https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html.

f. Based on the Member’s behavioral risks and willingness to make lifestyle changes, PCPs 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.

11. 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.

12. The PCP must sign, print name and date the 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 in the “SHA Annual Review” section to verify the annual review was conducted with the patient.

13. Scoring the Initial Health Assessment (IHA)/IHEBA is performed at each initial and
15. **HEALTH EDUCATION**

G. Individual Health Education Behavioral Assessment / Staying Healthy Assessment

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

a. The adult assessment is intended for use in 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

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<tr>
<th>DHCS Form Numbers</th>
<th>Periodicity</th>
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<th>Subsequent SHA Administration</th>
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<td>0-6 Months</td>
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<td>7-12 Months</td>
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<td>√</td>
<td>√</td>
</tr>
<tr>
<td>DHCS 7089 D</td>
<td>3-4 Years</td>
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<td>√</td>
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<td>DHCS 7089 I</td>
<td>Senior</td>
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</table>

15. 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
G. Individual Health Education Behavioral Assessment / Staying Healthy Assessment

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

D. IEHP and IPA Responsibility

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

2. IEHP and its Delegated 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. 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 IHEBA contract and documentation requirements. It will also include training on how to set timelines for administration, review, and re-administration. PCPs will receive instructions on how to use the SHA or DHCS-approved alternative assessment. Specific information and resources for providing culturally and linguistically appropriate patient health education services/interventions must be provided. In addition to the SHA web training, all PCPs are trained by IEHP Provider Service Representatives regarding patient referral procedures. 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. SHA Instruction Sheet is located at: http://www.dhcs.ca.gov/formsandpubs/forms/Documents/MMCD_SHA/GenDocs/SHAInstructionSheetforProviderOffice.pdf. The training is completed by a Provider Services Representative as part of their initial health plan training within the first ten (10) calendar days the PCP is effective with IEHP.

2. Prior to implementation, 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.

3. 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.

4. 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
15. HEALTH EDUCATION

G. Individual Health Education Behavioral Assessment / Staying Healthy Assessment

English skills, are addressed in the delivery of patient services.

F. SHA Electronic Formats

1. When a Provider/Provider group plans to use the SHA in an alternate format (electronic or another paper-based format), as long as the Provider/Provider group:
   a. Uses all SHA questions for the specific age group;
   b. Uses 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.

G. Alternative IHEBA

1. If IEHP PCPs 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). The tool will be comparable to the latest version 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.

REFERENCES:

A. Department of Health Care Services (DHCS) Policy Letter (PL) 13-001 (Revised), “Requirements for the Staying Healthy Assessment / Individual Health Education Behavioral Assessment”.

B. Department of Health Care Services (DHCS) All Plan Letter (APL) 13-017, “Staying Healthy Assessment / Individual Health Education Behavioral Health Assessment for Enrollees from Low-Income Health Program”.

C. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-014 supersedes 14-006, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries”.


<table>
<thead>
<tr>
<th>INLAND EMPIRE HEALTH PLAN</th>
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<tr>
<td><strong>Chief Approval:</strong> Signature on file</td>
</tr>
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<td><strong>Chief Title:</strong> Chief Medical Officer</td>
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</tbody>
</table>

IEHP Provider Policy and Procedure Manual 01/20 Medicare DualChoice MA_15G Page 6 of 6
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>15G</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>15G</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)
(See next page)

*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 (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>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.
# Staying Healthy Assessment

## Adult

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

<table>
<thead>
<tr>
<th>Person Completing Form <em>(if patient needs help)</em></th>
<th>Female</th>
<th>Male</th>
<th>Other (Specify)</th>
<th>Need help with form?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Member</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Friend</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
<td></td>
<td>Yes</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.

### Nutrition

<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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you eat fruits and vegetables every day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you limit the amount of fried food or fast food that you eat?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Are you easily able to get enough healthy food?</td>
<td></td>
<td></td>
<td></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. Are you concerned about your weight?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
</tbody>
</table>

### Physical Activity

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Do you exercise or spend time doing activities, such as walking, gardening, swimming for 1/2 hour a day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you feel safe where you live?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Have you had any car accidents lately?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>11. Have you been hit, slapped, kicked, or physically hurt by someone in the last year?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>12. Do you always wear a seat belt when driving or riding in a car?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Do you keep a gun in your house or place where you live?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
</tbody>
</table>

### Safety

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Do you brush and floss your teeth daily?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>15. Do you often feel sad, hopeless, angry, or worried?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>16. Do you often have trouble sleeping?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
</tbody>
</table>

### Mental Health

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Do you smoke or chew tobacco?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
</tbody>
</table>

### Alcohol, Tobacco, Drug Use

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Do friends or family members smoke in your house or place where you live?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
</tbody>
</table>
In the past year, have you had:
- (men) 5 or more alcohol drinks in one day? __ __ __
- (women) 4 or more alcohol drinks in one day? __ __ __

Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight? __ __ __

Do you think you or your partner could be pregnant? __ __ __

Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.? __ __ __

Have you or your partner(s) had sex without using birth control in the past year? __ __ __

Have you or your partner(s) had sex with other people in the past year? __ __ __

Have you or your partner(s) had sex without a condom in the past year? __ __ __

Have you ever been forced or pressured to have sex? __ __ __

Do you have other questions or concerns about your health? __ __ __

If yes, please describe:

<table>
<thead>
<tr>
<th>Clinic Use Only</th>
<th>Counseled</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>
</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: ___________________________.

PCP's Signature: ___________________________ Print Name: ___________________________ Date: ___________________________.

Attachment 15 - SHA Form - Adult - English

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

*(Staying Healthy Assessment)*

## Adulto *(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><strong>Persona que llena el formulario (si el paciente necesita ayuda)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Familiar</td>
<td>☐ Amigo</td>
<td>☐ Otro</td>
<td>Especifique</td>
<td></td>
</tr>
<tr>
<td>¿Necesita ayuda para llenar el formulario?</td>
<td></td>
<td></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

1. ¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu?
   - Drinks or eats 3 servings of calcium-rich foods daily?
   - Sí Yes  No  Omitir Skip

2. ¿Come frutas y verduras todos los días?
   - Eats fruits and vegetables every day?
   - Sí Yes  No  Omitir Skip

3. ¿Limita la cantidad de alimentos fritos o comida rápida que come?
   - Limits the amount of fried food or fast food eaten?
   - Sí Yes  No  Omitir Skip

4. ¿Tiene la posibilidad de comer suficientes alimentos saludables?
   - Easily able to get enough healthy food?
   - Sí Yes  No  Omitir (Skip)

5. ¿La mayoría de los días bebe un refresco, jugo, bebida deportiva o bebida energizante?
   - Drinks a soda, juice/sports/energy drink most days of the week?
   - No Sí Yes  Omitir Skip

6. Por lo general, ¿come demasiado o muy poco?
   - Often eats too much or too little food?
   - No Sí Yes  Omitir Skip

7. ¿Le preocupa su peso?
   - Concerned about weight?
   - No Sí Yes  Omitir Skip

### Physical Activity

8. ¿Hace ejercicio o realiza actividades, como caminar, jardinería o nadar durante, al menos, ½ hora al día?
   - Exercises or spends time doing moderate activities for at least ½ hour a day?
   - Sí Yes  No  Omitir Skip

### Safety

9. ¿Se siente seguro donde vive?
   - Feels safe where she/he lives?
   - Sí Yes  No  Omitir Skip

10. ¿Ha tenido accidentes automovilísticos últimamente?
    - Had any car accidents lately?
    - No Sí Yes  Omitir Skip
<table>
<thead>
<tr>
<th></th>
<th>Pregunta</th>
<th>Sí</th>
<th>No</th>
<th>Omitir</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente?</td>
<td>No</td>
<td>Sí</td>
<td>Skip</td>
</tr>
<tr>
<td>12</td>
<td>¿Siempre usa cinturón de seguridad cuando conduce o viaja en automóvil?</td>
<td>Sí</td>
<td>No</td>
<td>Omitir</td>
</tr>
<tr>
<td>13</td>
<td>¿Tiene un arma de fuego en su hogar o en el lugar donde vive?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>14</td>
<td>¿Se cepilla los dientes y los limpia con hilo dental todos los días?</td>
<td>Sí</td>
<td>No</td>
<td>Omitir</td>
</tr>
<tr>
<td>15</td>
<td>¿Con frecuencia se siente triste, desesperanzado, enojado o preocupado?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>16</td>
<td>¿Con frecuencia tiene dificultades para dormir?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>17</td>
<td>¿Fuma o masca tabaco?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>18</td>
<td>¿Sus amigos o familiares fuman en su hogar o en el lugar donde usted vive?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>19</td>
<td>En el último año ¿ha tomado:</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td></td>
<td>□ (hombres) 5 o más bebidas alcohólicas en un solo día?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ (mujeres) 4 o más bebidas alcohólicas en un solo día?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>¿Consume drogas o medicamentos para ayudarlo a dormir, relajarse, calmarse, sentirse mejor o perder peso?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>21</td>
<td>¿Cree que usted o su pareja podría estar embarazada?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>22</td>
<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>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>23</td>
<td>¿Usted o su pareja(s) tuvieron relaciones sexuales sin utilizar un método anticonceptivo en el último año?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>24</td>
<td>¿Usted o su pareja(s) tuvieron relaciones sexuales con otras personas en el último año?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>No.</td>
<td>Question</td>
<td>Spanish</td>
<td>English</td>
<td>Options</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>25</td>
<td>¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin condón en el último año?</td>
<td>Sí/No</td>
<td>She/he or partner(s) had sex without a condom in the past year?</td>
<td>Omitir/Skip</td>
</tr>
<tr>
<td>26</td>
<td>¿Alguna vez le forzaron o presionaron para tener relaciones sexuales?</td>
<td>Sí/No</td>
<td>Ever been forced or pressured to have sex?</td>
<td>Omitir/Skip</td>
</tr>
<tr>
<td>27</td>
<td>¿Tiene alguna otra pregunta o inquietud sobre su salud?</td>
<td>Sí/No</td>
<td>Any other questions or concerns about health?</td>
<td>Omitir/Skip</td>
</tr>
</tbody>
</table>

Si la respuesta es afirmativa, describa, por favor:

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**Clinic Use Only**

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□ Patient Declined the SHA

PCP's Signature:  
Print Name:  
Date:

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**SHA ANNUAL REVIEW**

PCP's Signature:  
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# Staying Healthy Assessment

## Senior

| Patient’s Name (first & last) | Date of Birth | □ Female  
□ Male | Today's Date | Person Completing Form (if patient needs help) | □ Family Member  
□ Friend  
□ Other (Specify) | Need help with form? | □ Yes  
□ No |
|-----------------------------|--------------|-----------|-----------|------------------------------------------|----------------|----------------|-----|

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>
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<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>
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</table>

#### Alcohol, Tobacco, Drug Use

- Do you smoke or chew tobacco? | No | Yes | Skip |
- Do friends or family members smoke in your house or where you live? | No | Yes | Skip |
- In the past year, have you had 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 have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.? | 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 someone to help you make decisions about your health and medical care? | Yes | No | Skip |
- Do you need help bathing, eating, walking, dressing, or using the bathroom? | No | Yes | Skip |
- Do you have someone to call when you need help in an emergency? | Yes | No | Skip |
- Do you have other questions or concerns about your health? | No | Yes | Skip |

*If yes, please describe:*

#### SHA ANNUAL REVIEW

**Clinic Use Only**

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

- Patient Declined the SHA

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>¿Necesita ayuda para completar el formulario?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Especifique</td>
<td>Sí</td>
</tr>
</tbody>
</table>

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**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.**

<table>
<thead>
<tr>
<th>N°</th>
<th>Pregunta</th>
<th>Sí</th>
<th>No</th>
<th>Omitir</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>2</td>
<td>¿Come frutas y verduras todos los días?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>3</td>
<td>¿Limita la cantidad de alimentos fritos o comida rápida que come?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>4</td>
<td>¿Tiene la posibilidad de comer suficientes alimentos saludables?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>5</td>
<td>¿La mayoría de los días bebe un refresco, jugo, bebida deportiva o bebida energizante?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>6</td>
<td>Por lo general, ¿come demasiado o muy poco?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>7</td>
<td>¿Tiene dificultades para masticar o tragar?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>8</td>
<td>¿Le preocupa su peso?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td>9</td>
<td>¿Hace ejercicios o realiza actividades, como caminar, jardinería o nadar durante, al menos, ½ hora al día?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>10</td>
<td>¿Se siente seguro donde vive?</td>
<td>Yes</td>
<td>No</td>
<td>Skip</td>
</tr>
<tr>
<td>11</td>
<td>Por lo general, ¿tiene dificultades para llevar un registro de sus medicamentos?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
</tr>
<tr>
<td></td>
<td>Pregunta</td>
<td>Respuesta</td>
<td>Omitir</td>
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</tr>
<tr>
<td>12</td>
<td>¿Sus familiares o amigos se preocupan por la forma en que conduce?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>13</td>
<td>¿Ha tenido accidentes automovilísticos últimamente?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>14</td>
<td>¿A veces se cae y se lastima, o le resulta difícil ponerse de pie?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>15</td>
<td>Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>16</td>
<td>¿Ha tenido accidentes automovilísticos últimamente?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>17</td>
<td>¿Se cepilla los dientes y los limpia con hilo dental todos los días?</td>
<td>Sí</td>
<td>No</td>
<td>Omitir</td>
</tr>
<tr>
<td>18</td>
<td>¿Con frecuencia se siente triste, desesperanzado, enojado o preocupado?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>19</td>
<td>¿Con frecuencia tiene dificultades para dormir?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>20</td>
<td>¿Usted u otras personas creen que tiene problemas para recordar cosas?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>21</td>
<td>¿Fuma o masca tabaco?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>22</td>
<td>¿Sus amigos o familiares fuman en su hogar o en el lugar donde vive?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>23</td>
<td>En el último año ¿ha tomado 4 o más bebidas alcohólicas en un solo día?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>24</td>
<td>¿Consume drogas o medicamentos para ayudarlo a dormir, relajarse, calmarse, sentirse mejor o perder peso?</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>25</td>
<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>No</td>
<td>Sí</td>
<td>Omitir</td>
</tr>
<tr>
<td>Question</td>
<td>No</td>
<td>Sí</td>
<td>Omitir</td>
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<td>-------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>¿Usted o su pareja(s) tuvieron relaciones sexuales con otras personas en el último año?</td>
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<tr>
<td>She/he or partner(s) had sex with other people in the past year?</td>
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<tr>
<td>¿Usted o su pareja(s) tuvieron relaciones sexuales sin condón en el último año?</td>
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<tr>
<td>She/he or your partner(s) had sex without a condom in the past year?</td>
<td></td>
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<tr>
<td>¿Le han forzado o presionado a tener relaciones sexuales, alguna vez?</td>
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<tr>
<td>Ever been forced or pressured to have sex?</td>
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<tr>
<td>¿Cuenta con alguien que lo ayude a tomar decisiones sobre su salud o su atención médica?</td>
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<tr>
<td>Has someone to help make decisions about her/his health and medical care?</td>
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<tr>
<td>¿Necesita ayuda para bañarse, comer, caminar, vestirse o ir al baño?</td>
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<td>Needs help bathing, eating, walking, dressing, or using the bathroom?</td>
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<tr>
<td>¿Tiene a quién llamar cuando necesita ayuda en una emergencia?</td>
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<td>Has someone to call when she/he needs help in an emergency?</td>
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<tr>
<td>¿Tiene alguna otra pregunta o inquietud sobre su salud?</td>
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<tr>
<td>Any other questions or concerns about your health?</td>
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☐ Patient Declined the SHA

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SHA ANNUAL REVIEW

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PCP’s Signature: ___________________________  Print Name: ___________________________  Date: ___________________________

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