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][2]

PROCEDURES:

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

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 and observed need;
2. Periodic Physical Examinations - behavioral or clinical questions and observed need;

[1] Department of Health Care Services (DHCS) Policy Letter (PL) 02-04, "Health Education"
[2] ~~Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.9~~

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. 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.

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;
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."

E. 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 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, enrolling in health education classes, and educational materials regarding self-management of chronic conditions. ~~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

G. IEHP ensures equal access to health care services for limited English proficient Members.[3,4] See Policy 9H1, "Cultural and Linguistic Services- Foreign Language Capabilities" for more

[3] Title 42, Code of Federal Regulations (CFR) § 422.2268(a)(7)~~CCI Three-Way Contract September 2019, Section 2.11~~

[4] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-002, Health Education and Cultural and Linguistic Group Needs Assessment

information.

H. Although not required, Providers may refer Members to the IEHP Health Education Programs by submitting a Health Education request online through the secure IEHP Provider portal.

I. 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.

J. 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."

15. HEALTH EDUCATION

A. Health Education

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

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. IEHP provides the Weight Management Program to Members who are, or are at risk for being, overweight or obese.

B. IEHP ensures equal access to its health care services and programs for limited English proficient Members.[1] See Policy 9H1, "Cultural and Linguistic Services - Foreign Language Capabilities" for more information.

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 visiting the online Member Portal at www.iehp.org.

B. Program Description

1. 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.
2. Activities are not inclusive of a medically supervised weight loss program.
~~3. Members under the age of 18 must be accompanied by parent or guardian.~~
~~4.~~3. *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,

[1] Title 42, Code of Federal Regulations (CFR) § 422.2268(a)(7)~~Coordinated Care Initiative (CCI) Three Way Contract September 2019, Section 2.11~~

video presentations, and healthy cooking tips.

d. Members may receive educational tools ~~and incentives~~ at the end of each workshop.

D. Evaluation

1. IEHP Health Education Staff monitor the program processes and facilitation through program site visits.
2. The Health Education Manager will conduct random site visits using standardized audit forms.

15. Health Education

B. Weight Management

Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

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.

POLICY:

A. IEHP offers the IEHP Family Asthma Program to Members~~,~~ who are diagnosed with asthma, as well as their caregivers.

B. IEHP ensures equal access to its health care services and programs for limited English proficient Members.[1] See Policy 9H1, "Cultural and Linguistic Services - Foreign Language Capabilities" for more information.

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

[1] Title 42, Code of Federal Regulations (CFR) § 422.2267(a)(2)~~Coordinated Care Initiative (CCI) Three Way Contract September 2019 Section 2.11~~

~~3.~~2. One (1) adult support person may attend with the Member. Support persons do not have to be IEHP Members or have asthma to attend.

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

D. Evaluation

1. IEHP Health Education Staff monitor program processes and facilitation through program site visits.
2. The Health Education Manager will conduct random site visits for quality assurance purposes; assessments will be conducted using standardized audit forms.

15. HEALTH EDUCATION

C. IEHP Family Asthma Program

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

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 21~~14~~ years of age and over; and
   3. Are diagnosed with diabetes.

B. IEHP ensures equal access to its health care services and programs for limited English proficient Members.[1] See Policy 9H1, "Cultural and Linguistic Services - Foreign Language Capabilities" for more information.

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 through 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.

[1] Title 42, Code of Federal Regulations (CFR) § 422.2268(a)(7)~~Coordinated Care Initiative (CCI) Three-Way Contract Section 2.11~~

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.

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. 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

D. IEHP Diabetes Self-Management Program

Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

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. IEHP offers the IEHP Perinatal Program 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. Becoming a Mom 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.

[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"~~

b. Application features include tracking tools, interactive media, anticipatory guidance, 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.

d.

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

~~e.~~ [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 English and Spanish.~~threshold languages.~~

C. Evaluation
1. Workshops and Groups
   a. IEHP Health Education Staff monitor processes and facilitation through program site visits.
   b. The 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 Application Program Interfaces (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.

[2] ~~DHCS APL 16-005~~

15. HEALTH EDUCATION

E. Perinatal Program

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2019
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

15. Health Education

F. Diabetes Prevention Program

APPLIES TO:

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

POLICY:

A. In accordance with Centers for Disease Control and Prevention (CDC) guidelines, IEHP offers the Diabetes Prevention Program (DPP), an interactive program focused on lifestyle changes for Members with prediabetes to prevent or delay the onset of Type 2 Diabetes. Members must meet DPP eligibility criteria developed by the Centers for Medicare and Medicaid Services (CMS) in alignment with the CDC DPP criteria.[1,~~2~~]

B. IEHP Members may access DPP services at no cost and without prior authorization.[3]

C. IEHP ensures equal access to its health care services and programs for Members with limited English ~~proficient~~ proficiency~~IEHP DualChoice Members~~.[4] See Policy 9H1, "Cultural and Linguistic Services- Foreign Language Capabilities" for more information.

DEFINITION:

A. Diabetes Prevention Program (DPP)~~—~~ ~~–~~ ~~–~~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.[5]

PURPOSE:

A. To provide a lifestyle change program to prevent onset of Type 2 Diabetes.[6]

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

[1] Health Plan Management System (HPMS) Memo, ~~-~~ "Medicare Diabetes Prevention Program Expanded Model," November~~,~~ 23, 2016
~~[2] Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.9~~
[3] Medicare Managed Care Manual, "Benefits and Beneficiary Protections," Section 30.3~~Ibid.~~
[4] Title 42, Code of Federal Regulations (CFR) § 422.2268(a)(7)~~CCI Three-Way Contract September 2019, Section 2.11~~
[5] https://www.cdc.gov/diabetes/prevention/lifestyle-program/requirements.html
[6] Ibid.

indicate that the Member's medical condition or circumstance warrants repeat or additional participation in the DPP benefit.

B. Program Description[7]

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:
   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.

D. Evaluation

1. IEHP Health Education Department staff will monitor process and facilitation through program site visits.
2. The Health Education Manager will review quarterly reports.
3. IEHP Health Education Department Staff will perform annual evaluation for select DPP suppliers.

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Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

[7] https://www.cdc.gov/diabetes/prevention/lifestyle-program/requirements.html~~CCI Three-Way Contract September 2019, Section 2.9~~

15. Health Education

F. Diabetes Prevention Program

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. 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.

DEFINITIONS:

A. Initial Health Assessment (IHA) —The IHA is a comprehensive assessment that is completed during the Member's initial encounter(s) with a selected or assigned Primary Care Provider (PCP), appropriate medical specialist, or non-physician medical provider that is documented in the Member's medical record. The IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a 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.[2]

PROCEDURES:

A. IEHP PCPs will administer the IHEBA using the "Staying Healthy Assessment" (SHA) form. The SHA consists of age-specific questionnaires and are available in English and in all designated threshold languages.

B. PCP Responsibilities[3]

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.

[1] Department of Health Care Services (DHCS) Policy Letter (PL) 08-003, "Initial Comprehensive Health Assessment"
[2] Ibid.
[3] DHCS PL 13-001, "Requirements for the Staying Healthy Assessment/Individual Health Education Behavioral Assessment."

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 to the Member, and record the Member's responses.
5. The 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:[4]
    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[5]

	Periodicity	Initial SHA Administration	Subsequent SHA Administration		SHA Review
DHCS Form Numbers	Age Groups	Within 120 Days of Enrollment	After Entering New Age Group	Every 3-5 Years	Annually (intervening years between administration of new

[4] DHCS PL 13-001
[5] ~~Ibid.~~

					assessment)
~~DHCS 7089 A~~	~~0-6 Months~~	~~√~~	~~√~~		
~~DHCS 7089 B~~	~~7-12 Months~~	~~√~~	~~√~~		
~~DHCS 7089 C~~	~~1-2 Years~~	~~√~~	~~√~~		~~√~~
~~DHCS 7089 D~~	~~3-4 Years~~	~~√~~	~~√~~		~~√~~
~~DHCS 7089 E~~	~~5-8 Years~~	~~√~~	~~√~~		~~√~~
~~DHCS 7089 F~~	~~9-11 Years~~	~~√~~	~~√~~		~~√~~
~~DHCS 7089 G~~	~~12-17 Years~~	~~√~~	~~√~~		~~√~~
DHCS 7089 H	Adult	√		√	√
DHCS 7089 I	Senior	√		√	√

10. The Member's refusal to complete the SHA must be documented on the age-appropriate SHA questionnaire by:[6]
    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. See Policy 6A, "Facility Site Review and Medical Record Review Survey" for more information.

[6] ~~DHCS PL 13-001~~

C. Tobacco Prevention and Cessation[7]

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 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 on through the non-secure Provider Pportal:
      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~~may receive a minimum of four (4) counseling sessions of at least ten (10) minutes/session or more, as appropriate. 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

[7] DHCS All Plan Letter (APL) 16-014 Supersedes PL 14-006, "Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries"

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, 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 in designated threshold languages (English, Spanish, Chinese & Vietnamese) 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 http://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[8]

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. Inform~~s~~ their contracted health plan at least one (1) month before they plan to

[8] DHCS PL 13-001

implement the SHA in an electronic or alternative format.

F. Alternative IHEBA[9]

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 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. See Policy 18G, "Provider Resources". Training materials include:[10]
   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.

[9] Ibid.
[10] ~~DHCS PL 13-001~~Ibid.

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 English skills, are addressed in the delivery of patient services.[11]

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

[11] ~~Title 42, Code of Federal Regulations (CFR) § 422.2268(a)(7)~~

15. HEALTH EDUCATION

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
Alternate Individual Health Education Behavioral Assessment (IHEBA)	15G
SHA Form – Adult	
a. English	15G
b. Spanish	15G
c. Chinese	15G
d. Vietnamese	15G
SHA Form – Senior	
a. English	15G
b. Spanish	15G
c. Chinese	15G
d. Vietnamese	15G
Staying Healthy Assessment (SHA) Instruction Sheet for Provider Office	15G

~~SHA Form – Adult~~

~~a. English~~	~~15G~~
~~b. Spanish~~ ~~c. Chinese~~ ~~d. Vietnamese~~	~~15G~~ ~~15G~~ ~~15G~~

~~SHA Form – Senior~~

~~a. English~~	~~15G~~
~~b. Spanish~~ ~~c. Chinese~~ ~~d. Vietnamese~~ ~~Staying Healthy Assessment (SHA) Instruction Sheet for Provider Office~~	~~15G~~ ~~15G~~ ~~15G~~

15. HEALTH EDUCATION

Attachments

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? _____

A.	Content and Risk Factors	Yes	AIR	Additional Information Requested (Explanation)
	Does the alternative IHEBA include the content and specific risk factors included in the most current version of the Staying Healthy Assessment (SHA).?			
B.	**Periodicity and Administration Schedule**	**Yes**	**AIR**	
	Is the periodicity and schedule for administration of the alternative IHEBA, at a minimum, comparable to the SHA?			
C.	**Documentation and Verification**	**Yes**	**AIR**	
	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?			
D.	**Threshold Language Availability**	**Yes**	**AIR**	
	Will the alternative IHEBA be made available in the threshold languages of its members?			
E.	**Additional Questions or Comments**			

Staying Healthy Assessment

Adult

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.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
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	Nutrition
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	Safety
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	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	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?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **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)

Adulto *(Adult)*

Nombre del paciente (nombre y apellido)	Fecha de nacimiento	☐ Mujer ☐ Hombre	Fecha de hoy
Persona que llena el formulario *(si el paciente necesita ayuda)* ☐ Familiar ☐ Amigo ☐ Otro *Especifique*			¿Necesita ayuda para llenar el formulario? ☐ Sí ☐ No

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.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
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*	Nutrition
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*	
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*	Physical Activity
9	¿Se siente seguro donde vive? *Feels safe where she/he lives?*	Sí *Yes*	No	Omitir *Skip*	Safety
10	¿Ha tenido accidentes automovilísticos últimamente? *Had any car accidents lately?*	No	Sí *Yes*	Omitir *Skip*	

11	Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente? *Been hit, slapped, kicked, or physically hurt by someone in the last year?*	No	Sí *Yes*	Omitir *Skip*	
12	¿Siempre usa cinturón de seguridad cuando conduce o viaja en automóvil? *Always wears a seat belt when driving or riding in a car?*	Sí *Yes*	No	Omitir *Skip*	
13	¿Tiene un arma de fuego en su hogar o en el lugar donde vive? *Keeps a gun in house or place where she/he lives?*	No	Sí *Yes*	Omitir *Skip*	
14	¿Se cepilla los dientes y los limpia con hilo dental todos los días? *Brushes and flosses teeth daily?*	Sí *Yes*	No	Omitir *Skip*	Dental Health
15	¿Con frecuencia se siente triste, desesperanzado, enojado o preocupado? *Often feels sad, hopeless, angry, or worried?*	No	Sí *Yes*	Omitir *Skip*	Mental Health
16	¿Con frecuencia tiene dificultades para dormir? *Often has trouble sleeping?*	No	Sí *Yes*	Omitir *Skip*	
17	¿Fuma o masca tabaco? *Smokes or chews tobacco?*	No	Sí *Yes*	Omitir *Skip*	Alcohol, Tobacco, Drug Use
18	¿Sus amigos o familiares fuman en su hogar o en el lugar donde usted vive? *Friends/family members smoke in house or place where she/he lives?*	No	Sí *Yes*	Omitir *Skip*	
19	En el último año ¿ha tomado: ☐ (**hombres**) 5 o más bebidas alcohólicas en un solo día? ☐ (**mujeres**) 4 o más bebidas alcohólicas en un solo día? *In past year, had (5 for men) or (4 for women) or more alcohol drinks in one day?*	No	Sí (Yes)	Omitir *Skip*	
20	¿Consume drogas o medicamentos para ayudarlo a dormir, relajarse, calmarse, sentirse mejor o perder peso? *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	No	Sí *Yes*	Omitir *Skip*	
21	¿Cree que usted o su pareja podría estar embarazada? *Thinks she/he or partner could be pregnant?*	No	Sí *Yes*	Omitir *Skip*	Sexual Issues
22	¿Cree que usted o su pareja pueden tener una infección de transmisión sexual (sexually transmitted infection, STI), como clamidia, gonorrea, verrugas genitales, etc.? *Thinks she/he or partner could have an STI?*	No	Sí *Yes*	Omitir *Skip*	
23	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin utilizar un método anticonceptivo en el último año? *She/he or partner(s) had sex without using birth control in the past year?*	No	Sí *Yes*	Omitir *Skip*	
24	¿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 *Yes*	Omitir *Skip*	

25	¿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 *Yes*	Omitir *Skip*	
26	¿Alguna vez le forzaron o presionaron para tener relaciones sexuales? *Ever been forced or pressured to have sex?*	No	Sí *Yes*	Omitir *Skip*	
27	¿Tiene alguna otra pregunta o inquietud sobre su salud? *Any other questions or concerns about health?*	No	Sí *Yes*	Omitir *Skip*	Other Questions

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **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:

保持健康評估

(Staying Healthy Assessment)

成人 *(Adult)*

病人姓名（名和姓）	出生日期	☐女 ☐男	當日日期：
填表人（*如病人需要協助*）	☐家人 ☐朋友 ☐其他 *請註明：*		需要幫助填寫本表格嗎？ ☐是 ☐否

請儘量回答本表格所有的問題。如果您不知道答案或不想回答，請圈選「跳過」。如果對本表格有任何問題，請一定要問醫生。您的回答將與您的醫療記錄一同受到保護。

需要翻譯員嗎？ ☐是 ☐否

					Clinic Use Only:
1	您有沒有每天喝或吃 3 份高鈣食品，例如牛奶、乳酪、優格乳、豆漿或豆腐？ *Drinks or eats 3 servings of calcium-rich foods daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Nutrition
2	您是否每天吃蔬菜水果？ *Eats fruits and vegetables every day?*	是 *Yes*	否 *No*	跳過 *Skip*	
3	您有沒有節制食用油炸食品或快餐的量？ *Limits the amount of fried food or fast food eaten?*	是 *Yes*	否 *No*	跳過 *Skip*	
4	您是否能輕易得到足夠的健康食物？ *Easily able to get enough healthy food?*	是 *Yes*	否 *No*	跳過 *Skip*	
5	您是否每週多日喝蘇打飲料、果汁飲料、運動或能量飲料？ *Drinks a soda, juice/sports/energy drink most days of the week?*	否 *No*	是 *Yes*	跳過 *Skip*	
6	你經常吃過多或過少的食物嗎？ *Often eats too much or too little food?*	否 *No*	是 *Yes*	跳過 *Skip*	
7	您擔心您的體重嗎？ *Concerned about weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
8	您是否每天做半小時的運動或一些如散步、園藝、游泳等的活動？ *Exercises or spends time doing moderate activities for at least ½ hour a day?*	是 *Yes*	否 *No*	跳過 *Skip*	Physical Activity
9	您覺得您住的地方安全嗎？ *Feels safe where she/he lives?*	是 *Yes*	否 *No*	跳過 *Skip*	Safety
10	您最近有沒有出車禍？ *Had any car accidents lately?*	否 *No*	是 *Yes*	跳過 *Skip*	
11	在過去一年中您有沒有被打、打耳光、被踢，或被傷害身體？ *Been hit, slapped, kicked, or physically hurt by someone in the last year?*	否 *No*	是 *Yes*	跳過 *Skip*	

12	您開車或乘車時是否總是繫安全帶？ *Always wears a seat belt when driving or riding in a car?*	是 *Yes*	否 *No*	跳過 *Skip*	
13	您是否在家裡或住處存放槍枝？ *Keeps a gun in house or place where she/he lives?*	否 *No*	是 *Yes*	跳過 *Skip*	
14	您每天都有刷牙和使用牙線嗎？ *Brushes and flosses teeth daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Dental Health
15	你是否經常感到悲傷，絕望，憤怒，或擔心？ *Often feels sad, hopeless, angry, or worried?*	否 *No*	是 *Yes*	跳過 *Skip*	Mental Health
16	您是否經常有睡眠問題？ *Often has trouble sleeping?*	否 *No*	是 *Yes*	跳過 *Skip*	
17	你是否抽煙或嚼煙？ *Smokes or chews tobacco?*	否 *No*	是 *Yes*	跳過 *Skip*	Alcohol, Tobacco, Drug Use
18	是否有朋友或家人在您家或住處抽煙？ *Friends/family members smoke in house or place where she/he lives?*	否 *No*	是 *Yes*	跳過 *Skip*	
19	在過去幾年中，您是否曾： ☐（**男性**）一天內喝 5 或更多杯酒？ ☐（**女性**）一天內喝 4 或更多杯酒？ *In the past year, had (5 for men) or (4 for women) or more alcohol drinks in one day?*	否 *No*	是 *Yes*	跳過 *Skip*	
20	您是否使用任何藥物，幫助您睡眠、放鬆、平靜下來、感覺更好或減肥？ *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
21	您是否認為您或您的伴侶可能懷孕了？ *Thinks she/he or partner could be pregnant?*	否 *No*	是 *Yes*	跳過 *Skip*	Sexual Issues
22	你是否覺得您或您的伴侶可能得了性傳播感染（STI），如衣原體，淋病，生殖器疣等？ *Thinks she/he or partner could have an STI?*	否 *No*	是 *Yes*	跳過 *Skip*	
23	您或您的伴侶在過去一年中性交時沒有使用避孕方法嗎？ *She/he or partner(s) had sex without using birth control in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	

24	您或您的伴侶在過去一年中曾和其他人發生性關係嗎？ *She/he or partner(s) had sex with other people in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
25	您或您的伴侶在過去一年中性交時沒有使用保險套嗎？ *She/he or partner(s) had sex without a condom in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
26	你有沒有曾被強迫或被施加壓力而發生性關係？ *Ever been forced or pressured to have sex?*	否 *No*	是 *Yes*	跳過 *Skip*	
27	您是否有其他關於您健康上的問題或疑慮？ *Any other questions or concerns about health?*	否 *No*	是 *Yes*	跳過 *Skip*	Other Questions

若回答是，請描述：

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **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:

Đánh Giá về Giữ Gìn Sức Khỏe

(Staying Healthy Assessment)

Người Lớn *(Adult)*

Tên Bệnh Nhân (tên & họ)	Ngày Sinh	☐ Nữ ☐ Nam	Hôm Nay là Ngày
Người Hoàn Thành Mẫu Đơn *(nếu bệnh nhân cần trợ giúp)*	☐ Thành Viên Gia Đình ☐ Bạn Bè ☐ Khác *Vui lòng ghi rõ:*		Cần hỗ trợ điền mẫu? ☐ Có ☐ Không

Vui lòng trả lời tất cả các câu hỏi trong mẫu này một cách tốt nhất có thể. Khoanh tròn "Bỏ Qua" nếu quý vị không biết câu trả lời hoặc không muốn trả lời. Hãy đảm bảo rằng quý vị sẽ hỏi bác sỹ nếu có thắc mắc liên quan đến bất kỳ điều gì trong mẫu này. Tất cả câu trả lời của quý vị sẽ được bảo vệ như một phần hồ sơ y tế của quý vị.

Cần Phiên Dịch? ☐ Có ☐ Không

					Clinic Use Only:
					Nutrition
1	Quý vị có uống hoặc ăn 3 phần thực phẩm giàu canxi chẳng hạn như sữa, pho mát, sữa chua, sữa đậu nành hoặc đậu phụ hàng ngày hay không? *Drinks or eats 3 servings of calcium-rich foods daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
2	Quý vị có ăn trái cây và rau hàng ngày không? *Eats fruits and vegetables every day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
3	Quý vị có giới hạn lượng thức ăn chiên hoặc thức ăn nhanh mà quý vị ăn không? *Limits the amount of fried food or fast food taken?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
4	Quý vị có thể dễ dàng ăn đủ thức ăn có lợi cho sức khỏe không? *Easily able to get enough healthy food?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
5	Quý vị có uống nước xô-đa, nước ép trái cây, đồ uống thể thao hoặc nước tăng lực hầu hết các ngày trong tuần không? *Drinks soda, juice/ sports/ energy drinks most days of the week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
6	Quý vị có thường ăn quá nhiều hoặc quá ít thức ăn không? *Often eats too much or too little food?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
7	Quý vị có lo lắng về cân nặng của mình hay không? *Concerned about weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
					Physical Activity
8	Quý vị có tập thể dục hoặc dành ½ tiếng một ngày cho các hoạt động như đi bộ, làm vườn, bơi lội không? *Exercises or spends time doing moderate activities for at least ½ hour a day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
					Safety
9	Quý vị có cảm thấy an toàn ở nơi quý vị sống không? *Feels safe where she/he lives?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	

10	Gần đây quý vị có bị tai nạn ô tô nào hay không? *Had any car accidents lately?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
11	Quý vị có bị người nào đánh, bạt tai, đá hay làm bị thương thân thể trong năm vừa qua không? *Been hit, slapped, kicked, or physically hurt by someone in the last year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
12	Quý vị có luôn thắt dây an toàn khi lái xe hoặc đi trên xe không? *Always wears a seat belt when driving or riding in a car?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
13	Quý vị có cất súng trong nhà hoặc nơi ở của mình không? *Keeps a gun in house or place where she/he lives?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
14	Quý vị có đánh răng hay làm sạch kẽ răng của mình hàng ngày hay không? *Brushes and flosses teeth daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Dental Health
15	Quý vị có thường cảm thấy buồn chán, tuyệt vọng, giận dữ hay lo lắng không? *Often feels sad, hopeless, angry, or worried?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Mental Health
16	Quý vị có thường gặp vấn đề về ngủ không? *Often has trouble sleeping?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
17	Quý vị có hút thuốc hay nhai thuốc lá không? *Smokes or chews tobacco?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Alcohol, Tobacco, Drug Use
18	Bạn bè hoặc thành viên gia đình có hút thuốc trong nhà hoặc nơi ở của quý vị không? *Friends/family members smoke in house or place where she/he lives?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
19	Trong năm vừa qua, quý vị có uống: ☐ (**nam giới)** từ 5 ly rượu bia trở lên trong một ngày hay không? ☐ (**phụ nữ**) từ 4 ly rượu bia trở lên trong một ngày hay không? *Had (5 or more for men) or (4 or more for women) alcohol drinks in one day?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
20	Quý vị có sử dụng bất kỳ thuốc hoặc dược phẩm nào giúp quý vị ngủ, thư giãn, bình tĩnh, cảm thấy khỏe hơn hay giảm cân không? *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
21	Quý vị có nghĩ mình hay bạn tình của mình có thể mang thai không? *Thinks she/he or your partner could be pregnant?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Sexual Issues
22	Quý vị có nghĩ mình hoặc bạn tình của mình có thể mắc bệnh lây nhiễm qua đường tình dục (STI) chẳng hạn như, Chlamydia, Bệnh Lậu, sùi mào gà, v.v… không? *Thinks she/he or partner could have an STI?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

23	Quý vị hoặc (những) bạn tình của mình có quan hệ tình dục mà không sử dụng biện pháp ngừa thai trong năm vừa qua không? *She/he or partner(s) had sex without using birth control in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
24	Quý vị hay (những) bạn tình của mình có quan hệ tình dục với những người khác trong năm vừa qua không? *She/he or partner(s) has sex with other people in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
25	Quý vị hoặc (những) bạn tình của mình có quan hệ tình dục mà không sử dụng bao cao su trong năm vừa qua không? *She/he or partner(s) had sex without a condom in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
26	Quý vị đã bao giờ bị cưỡng ép hoặc bị áp lực phải quan hê tình dục hay chưa? *Ever been forced or pressured to have sex?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
27	Quý vị có thắc mắc hay lo lắng nào khác về sức khỏe của mình không? *Any other questions or concerns about health?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Other Questions

Nếu có, vui lòng mô tả:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **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:

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.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
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	Nutrition
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	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **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)

Personas mayores *(Senior)*

Nombre del paciente (primer nombre y apellido)	Fecha de nacimiento:	☐ Mujer ☐ Hombre	Fecha de hoy
Persona que completa el formulario *(si el paciente necesita ayuda)*	☐ Familiar ☐ Amigo ☐ Otro *Especifique*		¿Necesita ayuda para completar el formulario? ☐ Sí ☐ No

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.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
1	¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *Drinks/eats 3 servings of calcium-rich foods daily?*	Sí *Yes*	No	Omitir *Skip*	Nutrition
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	¿Tiene dificultades para masticar o tragar? *Has difficulty chewing or swallowing?*	No	Sí *Yes*	Omitir *Skip*	
8	¿Le preocupa su peso? *Concerned about weight?*	No	Sí *Yes*	Omitir *Skip*	
9	¿Hace ejercicios 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*	Physical Activity
10	¿Se siente seguro donde vive? *Feels safe where she/he lives?*	Sí *Yes*	No	Omitir *Skip*	Safety
11	Por lo general, ¿tiene dificultades para llevar un registro de sus medicamentos? *Often has trouble keeping track of medicines?*	No	Sí *Yes*	Omitir *Skip*	

12	¿Sus familiares o amigos se preocupan por la forma en que conduce? *Family members/friends worried about her/his driving?*	No	Sí *Yes*	Omitir *Skip*	
13	¿Ha tenido accidentes automovilísticos últimamente? *Had any car accidents lately?*	No	Sí *Yes*	Omitir *Skip*	
14	¿A veces se cae y se lastima, o le resulta difícil ponerse de pie? *Sometimes falls and hurts self, or has difficulty getting up?*	No	Sí *Yes*	Omitir *Skip*	
15	Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente? *Been hit, slapped, kicked, or physically hurt by someone in past year?*	No	Sí *Yes*	Omitir *Skip*	
16	¿Tiene un revólver en su hogar o en el lugar donde vive? *Keeps a gun in house or place where she/he lives?*	No	Sí *Yes*	Omitir *Skip*	
17	¿Se cepilla los dientes y los limpia con hilo dental todos los días? *Brushes and flosses teeth daily?*	Sí *Yes*	No	Omitir *Skip*	Dental Health
18	¿Con frecuencia se siente triste, desesperanzado, enojado o preocupado? *Often feels sad, hopeless, angry, or worried?*	No	Sí *Yes*	Omitir *Skip*	Mental Health
19	¿Con frecuencia tiene dificultades para dormir? *Often has trouble sleeping?*	No	Sí *Yes*	Omitir *Skip*	
20	¿Usted u otras personas creen que tiene problemas para recordar cosas? *Thinks or others think that she/he is having trouble remembering things?*	No	Sí *Yes*	Omitir *Skip*	
21	¿Fuma o masca tabaco? *Smokes or chews tobacco?*	No	Sí *Yes*	Omitir *Skip*	Alcohol, Tobacco, Drug Use
22	¿Sus amigos o familiares fuman en su hogar o en el lugar donde vive? *Friends/family members smoke in house or place where she/he lives?*	No	Sí *Yes*	Omitir *Skip*	
23	En el último año ¿ha tomado 4 o más bebidas alcohólicas en un solo día? *In the past year, had 4 or more alcohol drinks in one day?*	No	Sí *Yes*	Omitir *Skip*	
24	¿Consume drogas o medicamentos para ayudarlo a dormir, relajarse, calmarse, sentirse mejor o perder peso? *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	No	Sí *Yes*	Omitir *Skip*	
25	¿Cree que usted o su pareja pueden tener una infección de transmisión sexual (sexually transmitted infection, STI), como clamidia, gonorrea, verrugas genitales, etc.? *Thinks she/he or partner could have an STI?*	No	Sí *Yes*	Omitir *Skip*	Sexual Issues

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 *Yes*	Omitir *Skip*	
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 *Yes*	Omitir *Skip*	
28	¿Le han forzado o presionado a tener relaciones sexuales, alguna vez? *Ever been forced or pressured to have sex?*	No	Sí *Yes*	Omitir *Skip*	
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 *Yes*	No	Omitir *Skip*	Independent Living
30	¿Necesita ayuda para bañarse, comer, caminar, vestirse o ir al baño? *Needs help bathing, eating, walking, dressing, or using the bathroom?*	No	Sí *Yes*	Omitir *Skip*	
31	¿Tiene a quién llamar cuando necesita ayuda en una emergencia? *Has someone to call when she/he needs help in an emergency?*	Sí *Yes*	No	Omitir *Skip*	
32	¿Tiene alguna otra pregunta o inquietud sobre su salud? *Any other questions or concerns about your health?*	No	Sí *Yes*	Omitir *Skip*	Other Questions

Si la respuesta es afirmativa, por favor describa:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **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:

保持健康評估

(Staying Healthy Assessment)

年長者 *(Senior)*

病人姓名（名和姓）	出生日期	☐ 女 ☐ 男	當日日期：
填表人（*如病人需要協助*）	☐家人☐朋友☐其他 *請註明：*		需要幫助填寫本表格嗎？ ☐是☐否

請儘量回答本表格所有的問題。如果您不知道答案或不想回答，請圈選「跳過」。如果對本表格有任何問題，請一定要問醫生。您的回答將與您的醫療記錄一同受到保護。

需要翻譯員嗎？
☐是☐否

					Clinic Use Only:
					Nutrition
1	您有沒有每天喝或吃 3 份高鈣食品，例如牛奶、乳酪、優格乳、豆漿或豆腐？ *Drinks/eats 3 servings of calcium-rich foods daily?*	是 *Yes*	否 *No*	跳過 *Skip*	
2	您是否每天吃蔬菜水果？ *Eats fruits and vegetables every day?*	是 *Yes*	否 *No*	跳過 *Skip*	
3	您有沒有節制食用油炸食品或快餐的量？ *Limits the amount of fried food or fast food eaten?*	是 *Yes*	否 *No*	跳過 *Skip*	
4	您是否能輕易得到足夠的健康食物？ *Easily able to get enough healthy food?*	是 *Yes*	否 *No*	跳過 *Skip*	
5	您是否每週多日喝蘇打飲料、果汁飲料、運動或能量飲料？ *Drinks a soda, juice/sports/energy drink most days of the week?*	否 *No*	是 *Yes*	跳過 *Skip*	
6	你經常吃過多或過少的食物嗎？ *Often eats too much or too little food?*	否 *No*	是 *Yes*	跳過 *Skip*	
7	你是否咀嚼或吞嚥困難？ *Has difficulty chewing or swallowing?*	否 *No*	是 *Yes*	跳過 *Skip*	
8	您擔心您的體重嗎？ *Concerned about weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
9	您是否每天至少做半小時的運動或一些如散步、園藝、游泳等的活動？ *Exercises or spends time doing moderate activities for at least ½ hour a day?*	是 *Yes*	否 *No*	跳過 *Skip*	Physical Activity
10	您覺得您住的地方安全嗎？ *Feels safe where she/he lives?*	是 *Yes*	否 *No*	跳過 *Skip*	Safety
11	您是否經常無法記得您服用的藥物？ *Often has trouble keeping track of medicines?*	否 *No*	是 *Yes*	跳過 *Skip*	

12	家人或朋友是否擔心您駕駛？ *Family members/friends worried about her/his driving?*	否 *No*	是 *Yes*	跳過 *Skip*	
13	您最近有沒有出車禍？ *Had any car accidents lately?*	否 *No*	是 *Yes*	跳過 *Skip*	
14	您是否有時跌倒而導致受傷，或很難起來？ *Sometimes falls and hurts self, or has difficulty getting up?*	否 *No*	是 *Yes*	跳過 *Skip*	
15	在過去一年中您有沒有被打、打耳光、被踢，或被傷害身體？ *Been hit, slapped, kicked, or physically hurt by someone in past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
16	您是否在家裡或住處存放槍枝？ *Keeps a gun in house or place where she/he lives?*	否 *No*	是 *Yes*	跳過 *Skip*	
17	您每天都有刷牙和使用牙線嗎？ *Brushes and flosses teeth daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Dental Health
18	你是否經常感到悲傷，絕望，憤怒，或擔心？ *Often feels sad, hopeless, angry, or worried?*	否 *No*	是 *Yes*	跳過 *Skip*	Mental Health
19	您是否經常有睡眠問題？ *Often has trouble sleeping?*	否 *No*	是 *Yes*	跳過 *Skip*	
20	您或其他人是否認為您記憶有困難？ *Thinks or others think that she/he is having trouble remembering things?*	否 *No*	是 *Yes*	跳過 *Skip*	
21	你是否抽煙或嚼煙？ *Smokes or chews tobacco?*	否 *No*	是 *Yes*	跳過 *Skip*	Alcohol, Tobacco, Drug Use
22	是否有朋友或家人在您家或住處抽煙？ *Friends/family members smoke in house or place where she/he lives?*	否 *No*	是 *Yes*	跳過 *Skip*	
23	在過去幾年中，您是否曾一天內喝4或更多杯酒？ *In the past year, had 4 or more alcohol drinks in one day?*	否 *No*	是 *Yes*	跳過 *Skip*	
24	您是否使用任何藥物，幫助您睡眠、放鬆、平靜下來、感覺更好或減肥？ *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
25	你是否覺得您或您的伴侶可能得了性傳播感染（STI），如衣原體，淋病，生殖器疣等？ *Thinks she/he or partner could have an STI?*	否 *No*	是 *Yes*	跳過 *Skip*	Sexual Issues

26	您或您的伴侶在過去一年中曾和其他人發生性關係嗎？ *She/he or partner(s) had sex with other people in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
27	您或您的伴侶在過去一年中性交時沒有使用保險套嗎？ *She/he or your partner(s) had sex without a condom in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
28	你有沒有曾被強迫或被施加壓力而發生性關係？ *Ever been forced or pressured to have sex?*	否 *No*	是 *Yes*	跳過 *Skip*	
29	有沒有人幫助您決定您的健康和醫療保健？ *Has someone to help make decisions about her/his health and medical care?*	是 *Yes*	否 *No*	跳過 *Skip*	Independent Living
30	您洗澡、吃飯、走路、穿衣或上廁所是否需要幫助？ *Needs help bathing, eating, walking, dressing, or using the bathroom?*	否 *No*	是 *Yes*	跳過 *Skip*	
31	在緊急情況下您需要幫助時，您有沒有可以打電話的人？ *Has someone to call when she/he needs help in an emergency?*	是 *Yes*	否 *No*	跳過 *Skip*	
32	您是否有任何其他關於您健康上的問題或疑慮？ *Any other questions or concerns about health?*	否 *No*	是 *Yes*	跳過 *Skip*	Other Questions

若回答是，請描述：

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
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Đánh Giá về Giữ Gìn Sức Khỏe

(Staying Healthy Assessment)

Người Cao Tuổi *(Senior)*

Tên Bệnh Nhân (tên & họ)	Ngày Sinh	☐ Nữ ☐ Nam	Hôm Nay là Ngày
Người Hoàn Thành Mẫu Đơn *(nếu bệnh nhân cần trợ giúp)*	☐ Thành Viên Gia Đình ☐ Bạn Bè ☐ Khác *Vui lòng ghi rõ:*		Cần hỗ trợ điền mẫu? ☐ Có ☐ Không

Vui lòng trả lời tất cả các câu hỏi trong mẫu này một cách tốt nhất có thể. Khoanh tròn "Bỏ Qua" nếu quý vị không biết câu trả lời hoặc không muốn trả lời. Hãy đảm bảo rằng quý vị sẽ hỏi bác sỹ nếu có thắc mắc liên quan đến bất kỳ điều gì trong mẫu này. Tất cả câu trả lời của quý vị sẽ được bảo vệ như một phần hồ sơ y tế của quý vị.

Cần Phiên Dịch? ☐ Có ☐ Không

					Clinic Use Only:
					Nutrition
1	Quý vị có uống hoặc ăn 3 phần thực phẩm giàu canxi chẳng hạn như sữa, pho mát, sữa chua, sữa đậu nành hoặc đậu phụ hàng ngày hay không? *Drinks/eats 3 servings of calcium-rich foods daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
2	Quý vị có ăn trái cây và rau hàng ngày không? *Eats fruits and vegetables every day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
3	Quý vị có giới hạn lượng thức ăn chiên hoặc thức ăn nhanh mà quý vị ăn không? *Limits the amount of fried food or fast food eaten?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
4	Quý vị có thể dễ dàng ăn đủ thức ăn có lợi cho sức khỏe không? *Easily able to get enough healthy food?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
5	Quý vị có uống nước xô-đa, nước ép trái cây, đồ uống thể thao hoặc nước tăng lực hầu hết các ngày trong tuần không? *Drinks a soda, juice/sports/ energy drink most day of the week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
6	Quý vị có thường ăn quá nhiều hoặc quá ít thức ăn không? *Often eats too much or too little food?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
7	Quý vị có gặp khó khăn trong việc nhai hay nuốt không? *Has difficulty chewing or swallowing?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
8	Quý vị có lo lắng về cân nặng của mình hay không? *Concerned about weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
					Physical Activity
9	Quý vị có tập thể dục hoặc dành thời gian cho các hoạt động như đi bộ, làm vườn hay bơi lội ít nhất ½ tiếng một ngày không? *Exercises or spends time doing moderate activities for at least ½ hour a day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
					Safety
10	Quý vị có cảm thấy an toàn ở nơi quý vị sống không? *Feels safe where she/he lives?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
11	Quý vị có thường gặp vấn đề trong việc theo dõi dược phẩm của mình không? *Often has trouble keeping track of medicines?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

12	Thành viên gia đình hoặc bạn bè có lo lắng khi quý vị lái xe không? *Family members/friends worried about her/his driving?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
13	Gần đây quý vị có bị tai nạn ô tô nào hay không? *Had any car accidents lately?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
14	Thỉnh thoảng quý vị có bị ngã và tự làm bị thương hoặc thấy khó đứng dậy không? *Sometimes falls and hurts self, or has difficulty getting up?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
15	Quý vị có bị người nào đó đánh, bạt tai, đá hay làm bị thương thân thể trong năm vừa qua không? *Been hit, slapped, kicked, or physically hurt by someone in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
16	Quý vị có cất súng trong nhà hoặc nơi ở của mình không? *Keeps a gun in house/place where she/he lives?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
17	Quý vị có đánh răng hay làm sạch kẽ răng của mình hàng ngày hay không? *Brushes and flosses teeth daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Dental Health
18	Quý vị có thường cảm thấy buồn chán, tuyệt vọng, giận dữ hay lo lắng không? *Often feels sad, hopeless , angry, or worried?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Mental Health
19	Quý vị có thường gặp vấn đề về ngủ không? *Often has trouble sleeping?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
20	Quý vị hay những người khác có nghĩ rằng quý vị đang gặp vấn đề về trí nhớ không? *Thinks or others think that she/he is having trouble remembering things?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
21	Quý vị có hút thuốc hay nhai thuốc lá không? *Smokes or chews tobacco?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Alcohol, Tobacco, Drug Use
22	Bạn bè hoặc thành viên trong gia đình có hút thuốc trong nhà hay nơi ở của quý vị không? *Friends/family members smoke in house or place where she/he lives?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
23	Trong năm vừa qua, quý vị có uống từ 4 ly rượu bia trở lên trong một ngày hay không? *In the past year, had 4 or more alcohol drinks in one day?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
24	Quý vị có sử dụng bất kỳ thuốc hoặc dược phẩm nào giúp quý vị ngủ, thư giãn, bình tĩnh, cảm thấy khỏe hơn hay giảm cân không? *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
25	Quý vị có nghĩ mình hoặc bạn tình của mình có thể mắc bệnh lây nhiễm qua đường tình dục (STI) chẳng hạn như, Chlamydia, Bệnh Lậu, sùi mào gà, v.v… không? *Thinks she/he or partner could have an STI?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Sexual Issues

26	Quý vị hay (những) bạn tình của mình có quan hệ tình dục với những người khác trong năm vừa qua không? *She/he or partner(s) had sex with other people in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
27	Quý vị hoặc (những) bạn tình của mình có quan hệ tình dục mà không sử dụng bao cao su trong năm vừa qua không? *She/he or your partner(s) had sex without a condom in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
28	Quý vị đã bao giờ bị cưỡng ép hoặc bị áp lực phải quan hệ tình dục hay chưa? *Ever been forced or pressured to have sex?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
29	Có ai giúp quý vị đưa ra quyết định về việc chăm sóc sức khỏe và y tế cho quý vị không? *Has someone to help make decisions about her/his health and medical care?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Independent Living
30	Quý vị có cần giúp đỡ khi tắm, ăn, đi bộ, mặc quần áo hay sử dụng phòng tắm không? *Needs help bathing, eating, walking, dressing, or using the bathroom?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
31	Quý vị có người nào đó để gọi khi cần giúp đỡ trong trường hợp khẩn cấp không? *Has someone to call when she/he needs help in an emergency?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
32	Quý vị có thắc mắc hay lo lắng nào khác về sức khỏe của mình không? *Any other questions or concerns about your health?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Other Questions

Nếu có, vui lòng mô tả:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
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STAYING HEALTHY ASSESSMENT (SHA)

Instruction Sheet for the Provider Office

SHA PERIODICITY TABLE

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

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 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.