
15. HEALTH EDUCATION

A. Health Education

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

- A. IEHP delegates the delivery of clinical health education services for Members to the PCP and/or IPA.
- B. All health education services are to be offered in a manner that is sensitive to each Member's cultural and linguistic needs. All materials must be available in English and Spanish.
- C. IEHP provides certain disease or prevention specific health education services for Members. PCPs and/or IPAs are encouraged to refer Members to IEHP for these programs.
- D. IEHP oversees and monitors PCP and IPA compliance with required health education activities through PCP site audits and IPA visits.

PROCEDURE:

- A. PCPs are responsible for providing Member specific clinical health education services to assigned Members, with assistance from their IPA as needed. Areas for education include:
- Condition-specific health education as needed for Diabetes, Asthma, Hypertension, etc.
 - Family Planning
 - HIV/STD Prevention
 - Exercise
 - Age-specific Anticipatory Guidance
 - Substance Abuse
 - Tobacco prevention and cessation
 - Injury Prevention
 - Nutrition
 - Tuberculosis
 - Dental
 - Perinatal
 - Immunizations
- B. PCPs are responsible for identifying the need for clinical health education services through the following mechanisms or interactions:
1. Initial Health 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., STD counseling/information if treated or STD); and
 4. Chronic illness visits - observed need (e.g., dietary/exercise counseling for

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hypertensive patients).

- C. PCPs must directly deliver clinical health education services to Members within their scope of practice. Activities can include:
1. Direct information provided by the PCP (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. PCPs 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 Wellness Programs (see below);
 2. Referral to community based organizations or services and
 3. Referral, through the 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 IPA.
- E. IPAs are responsible for assisting PCPs in the delivery of health education services including:
1. Arranging for medically necessary health education services upon referral from the PCP;
 2. Coordinating and/or referring Members to community-based organizations that provide free or low-cost health education services, utilizing the community referral resources such as 2-1-1; and
 3. Providing health education materials including brochures, other written materials and/or videos to the PCP or the Member, including brochures available through IEHP.
- F. IEHP provides health education services to Members, Providers and practitioners through the following mechanisms:
1. Provision of brochures directly to PCP offices (topics include: antibiotics, asthma, immunizations, depression, and diabetes);
 2. Information on community referral resources (e.g. 2-1-1) that lists relevant resources in the community; and
 3. Direct delivery of health education services to Members including:
 - a. Family Asthma Program;
 - b. Diabetes Self-Management Program;

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- c. Weight Loss Program;
 - d. Healthy Heart Program;
 - e. Blood Pressure Management Program
 - f. Stop Smoking Program;
 - g. “Healthy Babies” Pregnancy Program;
 - h. Child Safety Programs (Bicycle Helmets and Car Seats); and
 - i. Living Well With a Disability
- G. The IEHP Family Asthma Program is designed to educate and assist Members in understanding and controlling their asthma. It consists of one, 2 ½ hour group session. The sessions are available for child Members and their caregivers, or adult Members who are diagnosed with asthma. An IEHP Member may participate in the Asthma Program as long as the Member meets the criteria specified in Policy 15D, “IEHP Family Asthma Program.” The sessions are available in English and Spanish.
- H. The IEHP Diabetes Self-Management Program is designed to enable adult Members with diabetes to gain an understanding of the disease process and the daily management of diabetes. It consists of one to five sessions in a group, individual or a combination of these settings. An IEHP Member may participate in the Diabetes Self-Management program as long as the member meets the criteria specified in Policy 15E, “IEHP Diabetes Self-Management Program.” These sessions are available in English and Spanish
- I. The IEHP Weight Loss Program for adult and pediatric Members focuses on how to increase daily exercise activities, nutritional information such as serving sizes, the food guide pyramid, and food label reading, psychosocial issues involved in weight loss, and stress management. An IEHP Member can participate in the Weight Loss Program as long as the Member meets the criteria specified in Policies 15G, “IEHP Adult Weight Loss Program” or 15K “IEHP Pediatric Weight Loss Program.”
- J. The IEHP Healthy Heart Program is an at-home program. Adult Members receive educational materials on ways to decrease coronary risk factors, including lowering blood pressure and blood cholesterol levels, increasing exercise, and achieving a healthy body weight. An IEHP Member may participate in the Healthy Heart Program as long as the Member meets the criteria specified in Policy 15I, “IEHP Healthy Heart Program.”
- K. The IEHP Blood Pressure Management Program is an at-home program available to adult Members who have been diagnosed with “hypertension” by their doctor. Members receive materials and tools to help control their blood pressure, choose healthy foods, and increase physical activities. An IEHP Member may participate in the Blood Pressure Management program as long as the Member meets the criteria specified in Policy 15L, “IEHP Blood Pressure Management Program.”

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- L. The IEHP Stop Smoking Program provides multiple levels of intervention (telephone counseling, and pharmaco-therapy) for Members to assist them in quitting tobacco use. It also offers education and support materials to PCPs to assist their assigned Members to quit. An IEHP Member may participate in the Stop Smoking program as long as the Member meets the criteria specified in Policy 15F, “IEHP Stop Smoking Program.”
- M. The IEHP Healthy Babies Pregnancy Program provides educational materials for pregnant and postpartum Members, including early prenatal care, nutrition, family planning, and immunization. An IEHP Member may participate in the Healthy Babies program as long as the Member meets the criteria specified in Policy 15H, “IEHP ‘Healthy Babies’ Pregnancy Program.”
- N. The IEHP Child Safety Program has two components: a Bicycle Helmet Program and a Car Seat Safety Program. Both programs offer safety equipment (bicycle helmet or infant safety car seat) to help Members ensure the safety of their children. An IEHP Member may participate in the Child Safety program as long as the Member meets the criteria specified in Policy 15B, “IEHP Child Safety Programs.”
- O. The IEHP Living Well with a Disability Program provides information on maintaining a healthy lifestyle for adult Members with disabilities. The program addresses such areas as nutrition, setting goals, developing healthy relationships etc. An IEHP Member may participate in the Living Well with a Disability Program as long as the Member meets the criteria specified by Policy 15M, “IEHP Living Well with a Disability Program.”
- P. PCPs or IPAs may refer Members to the IEHP Wellness Programs by submitting a Health Education Referral Form online at www.iehp.org. Members may self-refer to an IEHP Wellness Program by calling IEHP Member Services at (800) 440-4347/ TTY (909) 890-0731.
- Q. IEHP monitors the provision of health education services by PCPs as part of the PCP facility review process. Health education services must be documented in the Member’s chart in accordance with Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring.”
- R. IEHP may monitor the provision of health education services by IPA periodic surveys and visits.

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B. IEHP Child Safety Programs

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

- A. IEHP provides the IEHP Child Safety Programs for eligible Members to reduce morbidity and mortality rates among infants and young children.
- B. IEHP's Child Safety Program has two components: a Child Car Seat Program and a Bicycle Helmet Program.

PROCEDURE:

- A. Members and their families receive information on the Child Safety program in the following ways:
 - 1. Member post-enrollment kits;
 - 2. Promotion in physician offices;
 - 3. Member Newsletters;
 - 4. Health fairs and community events; and
 - 5. Health Education presentations
- B. IEHP supplies providers with informational materials detailing the Child Car Seat and Bicycle Safety programs, including eligibility information, program description, and enrollment phone numbers.
- C. Car Seat Program:
 - 1. Eligibility (all conditions must be met to receive a free convertible car seat):
 - a. All Members who are pregnant or have given birth within the last 12 months, or a child Member who is under 12 months old;
 - b. Active eligibility status with IEHP for at least 60 consecutive days; and
 - c. Attends a Car Seat Safety Class on proper use and selection of child restraints.
- D. Bicycle Helmet Program:
 - 1. Eligibility: All Members between the ages of 5 and 14 years old, or Members with children between the ages of 5 and 14 years old, and who participate in the Bicycle Safety educational intervention program, are able to receive a free bicycle helmet.

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B. IEHP Child Safety Programs

E. Referral

1. The IPA, providers and IEHP staff may submit a Health Education Referral Form online at www.iehp.org.
2. IEHP Members may self-refer to the program by calling IEHP Member Services at (800) 440-4347.

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C. Cultural and Linguistic Services

1. Foreign Language Capabilities

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members who are Limited English Proficient (LEP).

POLICY:

- A. MMCD/DHCS has currently designated Spanish, and English, as the only threshold languages in San Bernardino and Riverside Counties for Medi-Cal Members.
- B. All IEHP network Providers and practitioners, including network pharmacy and vision practitioners, must provide services to Limited English Proficient (LEP) Members in the Member's primary language. Members cannot be required to provide their own interpreters or pay for them.
- C. Members have the right to request an interpreter at no charge for discussions of medical information.
- D. Providers should not require or suggest the use of family members or friends as interpreters. However, a family member or friend may be used as an interpreter if this is requested by the Member after being informed he/she has the right to use free interpreter services. The use of such an interpreter should not compromise the effectiveness of services or violate the Member's confidentiality. Minors should not be used as interpreters except for extraordinary circumstances, such as medical emergencies.
- E. Providers should document the Member's request for or refusal of interpreter services in their medical record.
- F. Providers may use face-to-face or telephonic interpretation services to meet the language requirement. These interpretation resources are available to Members 24 hours a day/seven days a week.
- G. IEHP and its network of providers and practitioners must provide written materials to Members in designated threshold languages.
- H. All providers and practitioners, including vision practitioners, listed in the IEHP Provider Directory with Spanish-speaking capabilities are required to undergo an annual language competency audit to monitor bilingual Spanish services available to Members.
- I. Members who do not select a PCP at the time of enrollment are assigned to a PCP. Language compatibility is one of the factors in the PCP assignment.
- J. Members have the right to file a complaint or grievance if their linguistic needs are not met.

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C. Cultural and Linguistic Services

1. Foreign Language Capabilities

PROCEDURE:

A. Practitioner Language Capability

1. IEHP lists all foreign language capabilities of Practitioners and/or their staff in the Provider Directory.
2. Any practitioner site indicating capability of a threshold language other than English must have staff who speaks that language available during the office's regular business hours.
3. Practitioner sites indicating capability of a threshold language other than English must provide all recorded messages and signage in the designated language.
4. IEHP verifies the capability of practitioners to provide services in the threshold language at the time of entry into the network.
 - a. In order to be considered a Spanish speaking office, practitioners and/or staff must be able to converse fluently in both English and Spanish, use and pronounce medical and managed care terminology, and be able to assist Members in completing appropriate forms.
 - b. Practitioner sites approved as Spanish-speaking have this information listed in the Provider Directory to assist Members in the selection process.
 - c. IEHP conducts annual audits of practitioner sites and Provider sites listed in the Provider Directory to confirm ongoing threshold language capabilities in accordance with Policy 15C2, "Spanish Language Competency Audits."
5. Members' concerns about the interpretation capabilities in a practitioner's office are followed up by IEHP, and the IEHP practitioner database is corrected as necessary.

B. Interpretation Services

1. Providers and practitioners may not require or suggest that Members provide their own interpreters.
2. For face-to-face interpretation services, practitioners must provide interpreters as needed for Member appointments. IEHP is responsible for the cost of the interpretation services. Sign language interpretation must be in accordance with Policy 9D1, "Providing Interpreters for Members Who Are Deaf or Hard-of-Hearing."

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C. Cultural and Linguistic Services

1. Foreign Language Capabilities

3. When face-to-face interpretation services are required, it is recommended that the Member or practitioner schedule an interpreter at the same time that the medical appointment is being scheduled. Interpreter services are scheduled by calling IEHP Member Services at (800) 440-IEHP (4347). All requests for interpretation services must be scheduled and authorized by IEHP.
4. A notice of at least five working days before a routine medical appointment should be given for the scheduling of an interpreter. IEHP will also make arrangements for emergent or urgent appointments as needed.
5. IEHP has contracted with Pacific Interpreters to provide telephone interpretation services to Members. This company offers interpretation services, 24 hours a day, seven days a week.
6. Members and Providers can call IEHP Member Services to access this telephone interpretation service during business hours. After business hours, Members and Providers can call the 24-Hours Nurse Advice Line at 1-888-244-IEHP (4347) to access interpretation services.
7. Practitioners must document all Member requests for, or refusals of, interpreter services in the Member's medical record.

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C. Cultural and Linguistic Services

2. Spanish Language Competency Audits

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Providers.

POLICY

- A. IEHP verifies the capability of its practitioners to provide services in the threshold languages when practitioners indicate they have this capability at the time of their entry into the IEHP network. Currently, Spanish and English are the only threshold languages in Riverside and San Bernardino Counties as defined by DHCS and MRMIB.
- B. IEHP conducts a language competency audit of all Primary Care Physicians (PCPs), OB/GYN and Vision Practitioners offices that have designated as having the ability to speak Spanish in the initial credentialing process and on an annual basis. These providers are listed in the IEHP Provider Directory as having Spanish speaking capabilities.

PROCEDURE

- A. In order to be considered a Spanish speaking office, practitioners and/or their staff must be able to converse fluently in both English and Spanish, use and pronounce medical and managed care terminology, and be able to assist Members in completing appropriate forms.
- B. On an annual basis IEHP evaluates Spanish-speaking practitioners for language competency.
- C. The technique utilized for assessing targeted language competency within the practitioner site is set up as a monolingual Spanish speaking IEHP staff person calling into the office to verify that someone in the office speaks Spanish. The caller immediately begins speaking Spanish and requests to speak to someone that speaks Spanish. The IEHP staff introduces her/himself as an IEHP employee and begins the audit. The following information is documented from the call:
1. Who in the office speaks Spanish (staff only, doctor only or doctor and staff). IEHP employee verifies with one Spanish speaking employee in each individual doctor's office;
 2. How many people in the office speak Spanish; and
 3. That the use of answering machine or answering service when the office is closed has Spanish options.
- D. Practitioners who do not demonstrate adequate Spanish-speaking capabilities are not listed as a Spanish speaking office in the IEHP Provider Directory and are not assigned

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C. Cultural and Linguistic Services

2. Spanish Language Competency Audits

Members who express a preference for Spanish-speaking PCPs.

- E. Practitioners receive a letter stating the results of the Spanish audit. The office will pass, fail or have a Corrective Action Plan (CAP). CAPs must be submitted within 7 days of receipt of audit results. The written or telephonic CAP must demonstrate how the office is addressing the deficiencies. Failure to supply a CAP may result in Spanish-speaking capability being removed from the provider's information in the IEHP Provider Directory.
- F. CAPs are reviewed and evaluated by IEHP. For rejected CAPs, IEHP includes the specific reasons for rejecting any CAP. If a CAP is approved, IEHP staff will re-audit that location. If the re-audit passes, the provider will keep his/her Spanish-speaking designation in the IEHP Provider Directory.
- G. Until such time as an adequate CAP is received by IEHP the provider will not be listed as a Spanish-speaking provider in the IEHP Provider Directory and Members requesting a Spanish provider will not be assigned.
- H. Audit results are reported to DHCS on an annual basis.
- I. Practitioners directly contracted with IEHP, wishing to appeal the results of the language competency audit must submit the written appeal to IEHP in accordance with Policy 16C, "Provider (IPA, Hospital and Practitioner) Grievance and Appeals Resolution Process."

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- C. Cultural and Linguistic Services
 - 3. Non-Discrimination
-

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

- A. In accordance with Title VI of the Civil Rights Act, all Members must receive access to all covered services without restriction based on race, color, creed, religion, ancestry, age, gender, national origin, marital status, sexual orientation, or physical or mental disability.
- B. IEHP contracted provider organizations must provide covered services to all Members assigned to them, at an appropriate facility, without imposing restrictions as listed above.

PROCEDURES:

- A. IEHP assigns all Members to PCPs, without regard to race, color, creed, religion, ancestry, age, gender, national origin, marital status, sexual orientation, or physical or mental disability.
- B. All IEHP contracted providers and other subcontractors are required to render services to all Members assigned or referred to them. Providers and other subcontractors may not refuse services to any Member based on the criteria listed above.
- C. IEHP Providers and other subcontractors must provide covered services to Members in a uniform manner.
- D. IEHP follows up on all grievances alleging discrimination, and takes appropriate action with all providers, organizations and other subcontractors. All discrimination-related grievances are forwarded to DHCS for review and appropriate action.

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D. IEHP Family Asthma Program

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

- A. IEHP provides the IEHP Family Asthma Program for all Members diagnosed with asthma who are referred, or who self-refer to the program.
- B. Members with asthma may access the Family Asthma Program at no cost without referral or prior authorization.
- C. Program sessions are available in English or Spanish.

PROCEDURE:

A. Program Description

1. The Family Asthma Program:
 - a. Is taught by Respiratory Therapists, Registered Nurses (RN), and/or Health Educators at various locations in Riverside and San Bernardino Counties;
 - b. Consists of one, 2 ½ hour group session; and
 - c. Is available to all Members with asthma. One adult family member or support person can attend for or with the Member with Asthma. Family member or support person does not have to be an IEHP Member or have asthma to attend.
2. IEHP mails reminder letters with a map to Members two weeks prior to the session.
3. IEHP attempts to remind Members by phone, 1-2 days prior to each session.
4. IEHP provides the following items to the program site:
 - a. Program roster;
 - b. Pre-survey;
 - c. Asthma Action Plan and booklets
 - d. Asthma kits; and
 - e. Hypoallergenic mattress and pillow covers.
5. Members attending the Family Asthma Program are requested to complete the Asthma Program Pre-Survey, which provides information on their perceived current asthma status and asthma management skills.

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D. IEHP Family Asthma Program

6. Members with asthma who attend the Family Asthma Program receive an asthma kit including a spacer and peak flow meter, a hypoallergenic mattress and pillow covers, and educational materials.

B. Referral

1. The IPA, providers, IEHP and staff at a designated program site, may refer a Member with asthma to the program.
2. The referring party may submit a Health Education Referral online at www.iehp.org to refer a Member to the program.
3. Members may call IEHP Member Services at (800) 440-4347 to self-refer to the program.

C. Registration

1. On a weekly basis, IEHP contacts and registers those Members who were referred to the Asthma Program. Appropriate Member information is verified and entered into the Health Education database.
2. Members who cannot be reached by phone are mailed a letter informing them to call IEHP if they are interested in registering for the program.

D. Post Program

1. At the end of the session, the attendees complete an evaluation form, providing feedback on class content and instruction. Members complete the Asthma Program Post-Survey, which provides information on their perceived status and asthma management skills.
2. IEHP sends a chart note to the PCPs of those Members who registered for the program regarding the Member's attendance at the program.
3. IEHP administers another post-survey by mail three months after the Member has completed the program. The survey measures the Member's level of knowledge, behavior changes, and self-management skills.

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E. IEHP Diabetes Self-Management Program

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

- A. The IEHP Diabetes Self-Management Program is available to all Members age 18 and over diagnosed with diabetes.
- B. Members may access the Diabetes Self-Management Program at no cost without a referral or prior authorization.
- C. Program sessions and materials are available in English or Spanish.

PROCEDURE:

A. Program Description

1. The Diabetes Program:
 - a. Is taught by Certified Diabetes Educators, Registered Dietitians, or Registered Nurses (RNs) at various locations in Riverside and San Bernardino Counties;
 - b. Consists of one to four sessions either group, individual, or any combination thereof;
 - c. Includes instructions that enable Members with diabetes to gain an understanding of the diabetes disease process, and the daily management of diabetes therapy;
 - d. Is designed to help Members with diabetes minimize hospitalizations and complications due to diabetes; and
 - e. Is available to all Members with diabetes. One adult family member or support person can attend with the Member. Family Member or support person does not have to be an IEHP Member or have diabetes to attend.
2. Each program site offers education intervention consisting of one to four group and/or individual sessions. The Member is given a glucometer or prescribed one at the program if he/she does not already have one.

B. Referral

1. The IPA, providers, IEHP and staff at a designated program site may refer a Member with diabetes to the program.
2. The referring party may submit a Health Education Referral online at www.iehp.org to refer a Member to the program.

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E. IEHP Diabetes Self-Management Program

3. Members may self-refer to the program by calling IEHP Member Services at (800) 440-4347.

C. Registration

1. IEHP contacts and registers those Members who were referred to the Diabetes Self-Management Program. Appropriate Member information is verified and entered into the Health Education database.
2. Members who cannot be reached by phone are mailed a letter informing them to call IEHP if they are interested in registering for the program.
3. A program roster is faxed or emailed to the program site coordinator on an agreed upon date. The program site coordinator is then responsible for scheduling the Members for their individual appointments and/or to remind them of the group classes.

D. Post Program

1. After all the program sessions have been completed, copies of intake information and notes regarding the Member's progress are sent by the program staff to IEHP.
2. A chart note is sent to the Member's PCP indicating the Member's attendance status.

E. Follow-up and Evaluation

1. A follow-up session may be scheduled by the program site at the last session.

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F. IEHP Stop Smoking Program

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

- A. The IEHP Stop Smoking Program is available to all Members who smoke and want to quit.
- B. Members may access the Stop Smoking Program at no cost and without a referral or prior authorization.

PROCEDURE:

A. Program Description

1. Every Member referred to the IEHP Stop Smoking program receives a Program Registration packet containing registration and smoking cessation materials. The packet includes:
 - a. Information on Second-hand Smoke;
 - b. Information on quitting and not starting again;
 - c. Steps to enroll in the program and to receive smoking cessation medications; and
 - d. A Registration Survey/Enrollment Form.
2. The IEHP Stop Smoking Program directs the Members to use the California Smokers' Helpline or enroll in the Chantix Get Quit Support Program.
 - a. Members may call the California Smokers' Helpline at 1-800-NO-BUTTS (800-662-8887). Spanish speakers may call 1-800-45-NO-FUME (1-800-456-6386).
 - 1) Telephone counseling and education is provided.
 - 2) Information is available in English or Spanish.
 - 3) Members receive a certificate of enrollment/completion for pharmacotherapy.
 - b. Members who are prescribed Chantix medication are encouraged to enroll in the Chantix Get Quit Support Plan at 1-877-Chantix (877-242-6849) or online at www.get-quit.com.
 - 1) A step-by-step guide to quitting is designed.
 - 2) The website can be personalized for the Member.

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F. IEHP Stop Smoking Program

- 3) Support is provided for up to a year.
- 4) Member receives a certificate of enrollment for pharmacotherapy.

B. Referral

1. The IPA, providers, IEHP or staff at a designated program site may refer a Member who smokes to the program.
2. The referring party may submit a Health Education Referral online at www.iehp.org.
3. Members may self-refer to the program by calling IEHP Member Services at (800) 440-4347.

C. Registration

1. A Stop Smoking Program Registration Packet is mailed to all Members who are referred to the program.
2. Member must complete and return the Registration Survey/Enrollment Form to be enrolled in the program.
3. Upon return of the Survey, Member information is entered into the Health Education database, registering the Member for the program.

D. Post Program

1. A chart note regarding the Member's program status is sent to the Member's PCP.

E. Post-Survey

1. IEHP administers a post-survey by mail 120 days after the receipt of the Registration Survey/Enrollment Form. The survey process is designed to assess the Member's cessation status, behavior change, and self-management skills.

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15. HEALTH EDUCATION

G. IEHP Adult Weight Loss Program

APPLIES TO:

- A. This policy applies to all adult Medi-Cal Members.

POLICY:

- A. The IEHP Adult Weight Loss Program is available to eligible overweight and obese Members over age 18 who would like to reduce the negative health consequences associated with overweight and obesity.
- B. Overweight for IEHP Members over the age of 18 is defined as having a Body Mass Index of 25 and above.
- C. IEHP assists Members to access weight loss programs that best fit their individual needs. IEHP, however, maintains the right to enroll a Member in an appropriate weight loss program based on eligibility criteria.
- D. Eligible IEHP Members may access the Weight Loss Program at either no cost or for a nominal fee, depending on the program.
- E. Eligible Members will be enrolled in one of the following programs:
 - 1. Weight Watchers;
 - 2. Take Charge; or
 - 3. Family FitZone
- F. IEHP Members may only attend one Weight Loss program at a time.

PROCEDURE:

A. **Weight Watchers**

- 1. Program Description
 - a. Weight Watchers is available throughout Riverside and San Bernardino Counties.
 - b. Weight Watchers materials are available in English and Spanish. Sessions are available in English. Spanish sessions are available in select locations.
 - c. Weight Watchers sessions are once a week for one hour.
 - d. Participants are taught how to make healthy food choices, the importance of a physically active lifestyle, and many other weight loss tips and techniques and group support.
 - e. IEHP recommends Members attend Weight Watchers weekly for at least 15 weeks.

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G. IEHP Adult Weight Loss Program

- f. The IEHP Weight Loss Program with Weight Watchers is a cost-share program. IEHP Members purchase five coupons at a time from IEHP at \$4.00 each coupon. Each coupon is good for one week with Weight Watchers. Members may purchase up to three sets of five coupons good for up to 15 weeks with Weight Watchers.
 - g. IEHP Members who meet program criteria may purchase additional coupons to continue beyond 15 weeks.
 - h. IEHP Members are considered to have completed the program when they have either reached their healthy weight, or have completed at least 15 weeks with Weight Watchers.
 - i. Members who have met the criteria for weight loss and attendance after 15 weeks can purchase 5 more coupons at a time to continue.
 - j. IEHP will not replace lost, stolen or expired coupons.
 - k. IEHP will not reimburse any unused coupons.
2. Eligibility
- a. Overweight or obese IEHP Members 18 or older are eligible for the Weight Watchers program without a physician referral.

B. Take Charge

1. Program Description
- a. The Take Charge Program is available in Riverside and Moreno Valley.
 - b. The Take Charge Program is available in English or Spanish.
 - c. Members attend eight weekly 2-hour sessions.
 - d. The Take Charge Program includes the following educational information:
 - 1) How to increase daily exercise activities;
 - 2) Nutritional information such as serving sizes, the food guide pyramid, and food label reading;
 - 3) Psychosocial issues involved in weight loss; and
 - 4) Stress Management.
2. Eligibility
- a. Overweight or obese IEHP Members 18 years old or older are eligible for the Take Charge program without a physician referral.

C. Family FitZone

1. Program Description

15. HEALTH EDUCATION

G. IEHP Adult Weight Loss Program

- a. Family FitZone is located in Loma Linda inside the LLUMC Drayson Center.
- b. Family FitZone is available in English or Spanish.
- c. IEHP Members age 18 or older attend (7) weekly 1.5- hour sessions. Members have unlimited access to Family FitZone’s Loma Linda facility during the seven week program.
- d. Family FitZone administers pre and post surveys to the Members on site.
- e. Members attending the program learn:
 - 1) General Principles of Nutrition;
 - 2) Increasing Daily Acts of Physical Activity; and
 - 3) “EXERTainment” interactive games to improve fitness level.

E. Referral

1. The IPA, PCP, IEHP, and staff at a designated program site may refer a Member to the Weight Loss Program.
2. The referring party may submit a Health Education Referral online at www.iehp.org to refer a Member to the program.
3. Members may self-refer to the program by calling IEHP Member Services at (800) 440-4347.

F. Registration

1. IEHP attempts to contact and register those Members who were referred to the Weight Loss Program. Members who cannot be reached by phone are mailed a letter informing them to call IEHP if they are interested in registering for the program.
2. During registration, appropriate Member information is verified and a registration survey is completed over the telephone. Members choose the appropriate Weight Loss Program according to location, language, and program preference.

G. Post Program

1. A chart note is sent to the Member’s PCP indicating the Member’s program status.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	September 1, 1999
Chief Title: Chief Medical Officer	Revised date:	January 1, 2012

15. HEALTH EDUCATION

H. IEHP “Healthy Babies” Pregnancy Program

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members who are pregnant, who delivered in the past 6 months, or who are under 6 months of age.

POLICY:

- A. IEHP established the “Healthy Babies” Program to maximize healthy birth outcomes by offering Members education and support materials on issues related to pregnancy and delivery.
- B. All identified pregnant and postpartum Members receive a prenatal and a postpartum packet as part of “Healthy Babies” Program.
- C. Program materials are available in English or Spanish.

PROCEDURE:

- A. IEHP identifies pregnant women from the following sources:
 - 1. Incoming Pregnancy Notification/Outcome Reports;
 - 2. Claims;
 - 3. Other internal sources such as Care Management, Perinatal P4P, or Member Services; and
 - 4. HCO Information provided by the State.
- B. The prenatal magazine, “IEHP Guide to a Healthy Pregnancy”, is mailed to all identified pregnant Members. Topics include:
 - 1. Pre-natal care;
 - 2. Fetal development; and
 - 3. Nutrition and exercise.
- C. IEHP identifies newborns from the following sources:
 - 1. Pregnancy Notification/Outcome Report;
 - 2. Hospital bed days data;
 - 3. IEHP internal sources (Care Management, Perinatal P4P, Member Services); and
 - 4. Claims.
- D. The Postpartum magazine, “IEHP Guide for New Mothers” is mailed to all Members identified as having a newborn baby or to Members under 6 months of age whose mothers request the information. Topics include:
 - 1. Breastfeeding;

15. HEALTH EDUCATION

H. IEHP “Healthy Babies” Pregnancy Program

2. SIDS;
 3. Shaken Baby Syndrome;
 4. Birth Control; and
 5. Baby Blues and postpartum depression.
- E. IEHP practitioners may submit a Health Education Referral online at www.iehp.org.
- F. Members may self-refer by calling IEHP’s Member Services at (800) 440-4347 to register for the program.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 2001
Chief Title: Chief Medical Officer	Revised date:	January 1, 2012

15. HEALTH EDUCATION

I. IEHP Healthy Heart Program

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

- A. The IEHP Healthy Heart Program is available to all IEHP Members over the age of 18 interested in decreasing their risk factors for coronary artery disease.
- B. IEHP Members may access the Healthy Heart Program at no cost and without a referral or prior authorization at no cost.
- C. Program materials are available in English or Spanish.
- D. Program materials are limited to one set per household per year.

PROCEDURE:

- A. Program Description
1. IEHP's Healthy Heart Program is an interactive mailing program that consists of five phases.
 2. The program consists of two life style guides covering the following topics:
 - a. Risk factors of heart disease;
 - b. Cholesterol and fats;
 - c. Eating for a healthy heart;
 - d. Women and heart disease;
 - e. Blood pressure;
 - f. Stress;
 - g. Exercise and fitness; and
 - h. Smoking and heart disease.
 3. Members are registered for the program after they return their "Healthy Heart Enrollment Form" to IEHP.
 4. Members receive the first "Lifestyle Guide" and Risk Factors DVD.
 5. Members who see their PCP and complete the "Health Test Results Form" will receive a Shopping List Pad and a Stater Bros. Gift card.
 6. Members receive the second "Lifestyle Guide" and "End-of-Program Feedback Form."

15. HEALTH EDUCATION

I. IEHP Healthy Heart Program

7. Members who return the End-of-Program Feedback Form to IEHP receive a certificate of completion and an exercise DVD.

B. Referral

1. IPAs, providers, IEHP and staff at a designated program site may refer a Member to the Healthy Heart program.
2. The referring party may submit a Health Education Referral online at www.iehp.org.
3. Members may self-refer to the program by calling IEHP Member Services at (800) 440-4347.

C. Registration

1. When a referral to the program is made through self-referral or PCP referral, IEHP pre-registers the member and mails an Invitation Packet with the Healthy Heart Enrollment form.
2. The Member is registered in the Healthy Heart Program upon IEHP's receipt of the completed "Healthy Heart Enrollment Form".

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Medical Officer	Revised date:	January 1, 2012

15. HEALTH EDUCATION

J. Health Education Behavioral Assessment (HEBA)

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

- A. All Medi-Cal Members are required to complete a Health Education Behavioral Assessment (HEBA) within 120 days of enrollment with IEHP.
- B. Existing Members who missed the 120-day assessment must have the HEBA administered at their next scheduled, non-acute care visit but no later than their next scheduled health screening exam.
- C. HEBA's must be administered at appropriate, defined age intervals.
- D. IEHP PCPs are responsible for ensuring the completion of the HEBA.

PROCEDURE:

- A. IEHP supplies IPAs with the HEBA forms to be completed by each Member.
- B. IPAs must assure that each PCP has the age-appropriate HEBA forms. IPAs must order English and Spanish forms through IEHP and distribute them to the PCP offices upon receipt. PCPs can also request forms in Chinese, Vietnamese, Hmong, Laotian, and Russian through their IPA. The HEBA forms are also posted on the IEHP website www.iehp.org.
- C. PCP Responsibilities
 1. PCPs are responsible for assuring the HEBA is administered to each Member within 120 days of the Member's enrollment. The HEBA may be conducted as part of the Member's initial health assessment, required within 120 days of enrollment. Refer to Policy 10A, "Initial Health Assessment" for more information.
 2. If it is not possible to conduct the HEBA at the initial health assessment, it must be conducted at the next scheduled, non-acute care visit.
 3. The HEBA must be conducted using the "Staying Healthy" assessment form as required by the Department of Health Care Services (DHCS) (see Attachments 15-1a, 15-1b, 15-1c, 15-1d and 15-1e in Section 15, "Attachments").
 4. The "Staying Healthy" assessment form is available in five separate age categories:
 - a. 0-3 years - Infant/Toddler;
 - b. 4-8 years - Child;
 - c. 9-11 years - Pre-Adolescent;

15. HEALTH EDUCATION

J. Health Education Behavioral Assessment (HEBA)

- d. 12-17 years - Adolescent; and
 - e. 18 years and older – Adult.
5. PCP office staff must assure that Members receive the assessment form appropriate to their age.
 6. The assessment forms must be completed by the parent/guardian for Members in the Infant/Toddler, Child and Pre-Adolescent age groups. The Adolescent and Adult forms must be completed by the Member in order to preserve confidentiality.
 7. In the case of Members who are unable to complete the “Staying Healthy” assessment form on their own, the PCP must provide a staff person to administer the form, read the questions to the Member, and record the Member’s responses.
 8. PCPs, or their staff, must review the “Staying Healthy” assessment 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 review the form for appropriateness, and initial upon review.
 9. The original completed HEBA form must be filed in the Member’s chart as part of the permanent medical record.
 10. PCPs must review the completed form and intervention plan with Members annually, at a minimum, when the Members present for a scheduled visit.
 11. The assessment form must be re-administered at the appropriate age intervals as designated on the forms (0-3 years, 4-8 years, 9-11 years, 12-17 years, 18 years and older). This should occur at the Member’s first scheduled health exam after changing into the next age group.
- D. IPA Responsibility
1. IPAs must ensure that all PCPs receive the age-appropriate HEBA forms.
 2. IPAs must assist PCPs in providing health education services as indicated by Members on their HEBA. This includes authorization of necessary referrals and provision of required education services.
- E. Provider Training
1. IEHP provides PCPs and IPAs with education and training on the implementation of the “Staying Healthy” assessment. All providers receive a “Staying Healthy” assessment instruction manual. Training is available to providers on an as needed basis.

15. HEALTH EDUCATION

J. Health Education Behavioral Assessment (HEBA)

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Medical Officer	Revised date:	August 1, 2007

15. HEALTH EDUCATION

K. IEHP Pediatric Weight Loss Program

APPLIES TO:

- A. This policy applies to all pediatric Medi-Cal Members.

POLICY:

- A. The IEHP Pediatric Weight Loss Program is available to overweight and obese Members age 3 through 17 that meet the specific program eligibility.
- B. Eligible IEHP Members may access the Pediatric Weight Loss Program at no cost or with a modest share of cost for some programs. Eligible IEHP Members must have a physician referral.
- C. The Pediatric Weight Loss Program consists of these programs:
1. Chaparral Medical Group;
 2. Family FitZone;
 3. Shapin' Up & Slimmin' Down;
 4. Take Charge; and
 5. Weight Watchers
- D. IEHP Members may only attend one Pediatric Weight Loss program at a time.
- E. Members must have a Body Mass Index (BMI) at or above the 85th percentile for age and gender.
- F. IEHP has separate Weight Loss Programs for its Adult Members who are 18 years of age and older in accordance with Policy 15G, "IEHP Adult Weight Loss Program."

PROCEDURE:

- A. Chaparral Medical Group (Pediatrics)
1. Program Description
 - a. Chaparral Medical Group is available in Fontana.
 - b. Chaparral Medical Group is available in English (a Spanish Interpreter is available if needed).
 - c. At least one parent or guardian is required to attend all sessions with the Member.
 - d. Program for ages 3-7 and 14-17
 - 1) Members attend four individual sessions. Sessions are 45 minutes to 1 hour in duration.

15. HEALTH EDUCATION

K. IEHP Pediatric Weight Loss Program

- 2) Chaparral Medical Group uses a specially designed curriculum for Pediatric Members who are overweight and/or obese. Topics include:
 - a) How to increase daily physical activities;
 - b) Nutritional information such as portion sizes, label reading, and fast food eating; and
 - c) Helping children define why they eat.
 - 3) IEHP Members are considered to have completed the program when they have completed four sessions of the Chaparral Medical Group program.
- e. Program for ages 8-13
- 1) Members attend six 90-minute group sessions, one per week for 6 weeks.
 - 2) Topics include:
 - a) How to increase daily physical activities;
 - b) Nutritional information such as portion sizes, label reading, and fast food eating; and
 - c) Positive self-image.
 - 3) Members are considered to have completed the program when they have completed five sessions.
2. Eligibility
- a. Eligibility for the Chaparral Medical Group program is determined on a case-by-case basis. The following criteria are used to assist in determining the Member's eligibility for the program:
 - 1) A BMI for age and gender at or above the 85th percentile;
 - 2) Member proximity to program location; and
 - 3) Must be between the ages of 3 and 17.
 - b. IEHP reserves the right to ultimately determine a Member's eligibility for Chaparral Medical Group.
- B. Family FitZone
1. Program Description
 - a. Family FitZone features physically interactive and virtual reality games. It is available in Loma Linda.
 - b. Program is available in English or Spanish.

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K. IEHP Pediatric Weight Loss Program

- c. Members attend one 90-minute session per week for a period of 7 weeks.
 - d. Family FitZone uses a specially designed curriculum that consists of a nutrition education component and an exercise component.
 - e. Members have unlimited access to workout at the Family FitZone facility during the 7 week program.
 - f. IEHP Members are considered to have completed the program when they have completed 6 out of 7 sessions of Family FitZone.
 - g. If Members attend 6 out of 7 sessions of Family FitZone, they are eligible to receive a 1-month free membership to Family FitZone.
 - h. Members can receive up to 4 months of free membership to Family FitZone if they meet the minimum workout attendance of 12 times a month during the previous month. Two out of the 12 workouts can be physical activity performed outside of the Family FitZone facility.
 - i. At least one parent or guardian is required to attend all sessions with the Member.
2. Eligibility
- a. The following criteria are used to assist in determining the Member's eligibility for the program:
 - 1) A BMI for age and gender at or above the 85th percentile;
 - 2) Member's proximity to program location; and
 - 3) Member must be between the ages of 5 and 17.
 - b. IEHP reserves the right to ultimately determine a Member's eligibility for the Family FitZone program.
- C. Shapin' Up & Slimmin' Down
1. Program Description
- a. Shapin' Up & Slimmin' Down is available in Ontario.
 - b. Program is available in English and Spanish.
 - c. Participants must be between 7 and 13 years old.
 - d. Members attend 90 minute sessions every week for 7 weeks.
 - e. At least one parent or guardian is required to attend all sessions with the Member.
2. Topics Include:
- a. Concept of "sugar free" drinks;
 - b. Super sizing;

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K. IEHP Pediatric Weight Loss Program

- c. Portion distortion;
 - d. Carbohydrates, proteins and fats;
 - e. Emotional eating;
 - f. Importance of fruits and vegetables.
3. Eligibility
- a. Eligibility for the Shapin' Up & Slimmin' Down Program is determined by the following criteria are used to assist in determining the Member's eligibility for the program:
 - 1) A BMI for age and gender at or above the 85th percentile;
 - 2) Member's proximity to program location; and
 - 3) Must be between ages 7 and 13.
 - b. IEHP reserves the right to ultimately determine a Member's eligibility for the Shapin' Up & Slimmin' Down program.
4. Members are considered to have completed the program when they have completed five sessions.
- D. Take Charge
1. Program Description
- a. The Take Charge Program is available in Riverside and Moreno Valley.
 - b. The Take Charge Program is available in English or Spanish.
 - c. Members attend eight weekly 2-hour sessions.
2. Topics include:
- a. How to increase daily acts of physical activity;
 - b. Nutritional information such as serving sizes, the food guide pyramid, and food label reading;
 - c. Psychosocial issues involved in weight loss; and
 - d. Stress Management.
3. Members are considered to have completed the program when they have completed seven sessions.
4. Eligibility
- a. Eligibility for the Take Charge Program is determined on a case-by-case basis. The following criteria are used to assist in determining the Member's eligibility for the program:
 - 1) IEHP Members must be between the ages of 7-17;

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K. IEHP Pediatric Weight Loss Program

- 2) A BMI for age and gender at or above the 85th percentile; and
 - 3) Member's proximity to program location.
- b. IEHP reserves the right to ultimately determine a Member's eligibility for the Take Charge Program.

E. Weight Watchers

1. Program Description

- a. Weight Watchers meeting locations are available throughout Riverside and San Bernardino Counties.
- b. Weight Watchers written materials are available at the site in English and Spanish. Sessions are generally held in English. Spanish sessions are available in select locations.
- c. Members attend Weight Watchers group meetings once a week for one hour.
- d. Participants are taught how to make healthy food choices, eating sensible portions, the importance of a physically active lifestyle, and many other weight loss tips and techniques within a support group setting.
- e. At least one parent or guardian is required to attend all meetings with the Member.
- f. IEHP recommends Members attend Weight Watchers for at least 15 weeks.
- g. The IEHP Weight Loss Program with Weight Watchers is a cost share program. IEHP Members purchase five coupons at a time from IEHP at \$4.00 each. Each coupon is good for one Weight Watchers meeting per week. Members may purchase up to three sets of five coupons good for up to 15 weeks with Weight Watchers.
- h. IEHP Members who meet program criteria may purchase five additional coupons to continue beyond 15 weeks.
- i. IEHP Members are considered to have completed the program when they have either reached their healthy weight, or have completed at least 15 weeks with Weight Watchers.
- j. IEHP will not replace lost, stolen or expired coupons. IEHP will not reimburse the Member for any unused coupons.

2. Eligibility

- a. The following criteria are used to assist in determining the Member's eligibility for the program:
 - 1) Members must be between the ages of 10-17; and

15. HEALTH EDUCATION

K. IEHP Pediatric Weight Loss Program

2) A BMI for age and gender at or above the 85th percentile.

b. IEHP reserves the right to ultimately determine a Member's eligibility for Weight Watchers.

F. Referral

1. The IPA, PCPs, IEHP, and staff at a designated program site may refer a Member to the Pediatric Weight Loss Program.
2. The referring party may submit a Health Education Referral online at www.iehp.org to refer a Member to the program.
3. Members may self-refer to the program by calling IEHP Member Services at (800) 440-4347. A referral request will be submitted to Member's PCP.

G. Registration

1. IEHP attempts to contact Members' parents or legal guardian to register those Members who were referred to the Weight Loss Program. Members' parents or legal guardian who cannot be reached by phone are mailed a letter informing them to call IEHP if they are interested in registering their child for the program.
2. During registration on the phone, appropriate Member information is verified, a registration survey is completed, and Member eligibility is determined. Depending on eligibility, Members are registered for a Pediatric Weight Loss program.
3. If the Member is not eligible or does not have access to a Pediatric Weight Loss Program, IEHP Health Education Department will refer them back to their PCP for a nutritionist consult with Member's IPA.

H. Post Program

1. A chart note is sent to the Member's PCP indicating the Member's attendance status.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 2002
Chief Title: Chief Medical Officer	Revised date:	January 1, 2012

15. HEALTH EDUCATION

L. IEHP Blood Pressure Management Program

APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

- A. The IEHP Blood Pressure Management Program is available to any IEHP Member over the age of 18 who is diagnosed with hypertension and interested in learning to take control of their blood pressure.
- B. IEHP Members can access the Blood Pressure Management Program at no cost but must have a PCP referral.
- C. Program materials are available in English or Spanish.

PROCEDURE:

- A. Program Description
 - 1. IEHP's Blood Pressure Management Program is an interactive home mailing program that consists of an Invitation Letter and three separate educational packets.
 - 2. Invitation
 - a. The Invitation Letter is mailed to Members referred to the Blood Pressure Management Program, with RSVP to be signed by Member if interested in receiving packets.
 - 3. The topics covered in the three packets are:
 - a. Introduction and Overview of Blood Pressure;
 - b. Food and Physical Activity; and
 - c. Monitoring My Blood Pressure and Stress.
 - 4. Each packet contains:
 - a. A cover letter describing the program and packet contents;
 - b. An informational video on packet topic;
 - c. An informational booklet on packet topic;
 - d. An agreement form;
 - e. A business reply envelope; and
 - f. Tip sheets or tools.
 - 5. All Members referred to the Blood Pressure Management Program receive an Invitation. Members who sign and return the RSVP receive Packet One.

15. HEALTH EDUCATION

L. IEHP Blood Pressure Management Program

6. Members are asked to complete and return follow-up material in each packet to IEHP to receive the next packet.
7. Members who complete and return all follow up material receive a free blood pressure cuff.

B. Referral

1. The IPA and practitioners may refer a Member to the Blood Pressure Management program.
2. The referring party may submit a Health Education Referral online at www.iehp.org to refer a Member to the program.

C. Registration

1. IEHP mails the Invitation Packet with an RSVP to referred Members to enroll them in the program.
2. Members who are interested sign and return the RSVP to IEHP.
3. IEHP staff verifies the Member's address to send the Blood Pressure Management Program materials.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	August 1, 2006
Chief Title: Chief Medical Officer	Revised date:	January 1, 2012

15. HEALTH EDUCATION

M. IEHP Living Well With a Disability Program

APPLIES TO:

- A. This policy applies to all adult IEHP Medi-Cal Members with Disabilities.

POLICY:

- A. IEHP contracts with Independent Living Centers to conduct the Living Well With A Disability (LWD) Program.
- B. The LWD Program is available to all IEHP Members age 18 years and older who have a disability.
- C. Members may access the LWD Program at no cost and without a referral from their physician.
- D. Program sessions and materials are available in English. Other alternative formats such as Braille, large print, and audio are available upon request.

PROCEDURE:

A. Program Description

1. Living Well With A Disability:
 - a. Is taught by facilitators trained in the LWD Program Curriculum;
 - b. Consists of 8-12 hours of group educational sessions;
 - c. Is designed to help Members with disabilities minimize hospitalizations and complications due to their disability; and
 - d. Is available to all adult Members with disabilities. One adult caretaker or support person can attend with the Member. Caretaker/support person does not have to be an IEHP Member or have a disability to attend.
2. The LWD program is held no less than bi-annually.
3. The LWD programs are held in accessible locations in San Bernardino, Victorville and Riverside.
4. A maximum of 20 Members may attend each session.
5. IEHP Members who attend the program receive an IEHP Cookbook and a Chair Dancing exercise video. Daily bus passes are available, as needed.

B. Referral

1. The IPA, providers, IEHP and staff at a designated program site may refer an adult Member with disabilities to the program.
2. The referring party may submit a Health Education Referral Form online at www.iehp.org.

15. HEALTH EDUCATION

M. IEHP Living Well With a Disability Program

3. IEHP Members may self-refer to the program by calling IEHP Member Services at (800) 440-4347.

C. Registration

1. IEHP Members with a disability code are recruited for the LWD program.
2. Invitation letters about the program are sent to IEHP Members identified about 6 to 8 weeks before a class begins.
3. IEHP Members with disabilities call IEHP Member Services to register for the LWD Program.
4. A program roster containing the list of IEHP Members enrolled in the LWD Program is faxed or emailed to the program site coordinator on an agreed upon date.
5. Program site coordinator makes reminder calls to the enrolled Members between one day and one week before the program.

D. Post Program

1. After all the program sessions have been completed, copies of intake information are sent by the program site coordinator to IEHP.
2. A chart note is sent to the Member's PCP indicating the Member's attendance status.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 2011
Chief Title: Chief Medical Officer	Revised date:	January 1, 2012

15. HEALTH EDUCATION

Attachments

<u>ATTACHMENT</u>	<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
15-1	Health Education Behavioral Assessment (HEBA) Form	
	a. Children 0-3 years of age - English & Spanish	15J
	b. Children 4-8 years of age - English & Spanish	15J
	c. Children 9-11 years of age - English & Spanish	15J
	d. Children 12-17 years of age - English & Spanish	15J
	e. Adults 18+ years of age - English & Spanish	15J

**Interventions
Code/Date/Initials**

Does Your Child:					
12.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
13.	Breastfeed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
14.	Drink formula, milk, or eat yogurt at least 2 times each day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
15.	Eat fruits and vegetables every day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
16.	Eat foods that may cause choking such as nuts, popcorn, hotdogs, whole grapes, or hard candy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
17.	Spend time at a house or apartment complex with a swimming pool or hot tub?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
18.	Spend time in a home where a gun is kept?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
19.	Spend time in a home with anyone who smokes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
20.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
21.	Has your child ever witnessed or been a victim of abuse or violence?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
22.	Do you have other questions or concerns about your child's health? (Please identify) _____ _____ _____ _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	

For Clinical Use

Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

Privacy Statement

The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a, Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your health care provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record, and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and regulation including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form may be transferred to state and local governmental and regulating agencies, contracted health plans, and health care providers.

CUESTIONARIO
“MANTENGA A SU NIÑO SALUDABLE”
Niños de 0 a 3 años

Patient Stamp	
Patient Number _____	Plan Name/Number _____
<i>If patient stamp not used, write in Patient and Plan Name/Number</i>	

Nombre y apellido del niño	Fecha de nacimiento	Sexo <input type="checkbox"/> Niño <input type="checkbox"/> Niña	Fecha	For Clinical Use
Nombre de la persona que llena el cuestionario	Parentesco con el niño <input type="checkbox"/> Padre/Madre <input type="checkbox"/> Tutor legal <input type="checkbox"/> Pariente <input type="checkbox"/> Amigo <input type="checkbox"/> Otro			Assistance needed: Reading: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No

El equipo médico de su niño y usted pueden colaborar para tener una buena salud. Por favor, conteste estas preguntas lo mejor que pueda. Si no sabe la respuesta, o no desea contestar, puede marcar (✓) “omita”. Puede hablar con su proveedor de salud acerca de cualquier pregunta. Sus respuestas serán confidenciales, y serán parte del expediente médico de su niño.

<i>Ejemplo de una pregunta y respuesta: ¿Va su niño a la guardería?</i>	<input checked="" type="checkbox"/>	No	Omita	Interventions Code/Date/Initials
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	<u>En su casa: (Does your home have:)</u>			
1.	¿Tiene un detector de humo que funcione? <i>(A working smoke detector?)</i>	Sí	No	Omita
2.	¿El agua que sale de la llave es lo bastante caliente, como para quemar a su niño? <i>(Water that comes from the faucet hot enough to burn your child?)</i>	No	Sí	Omita
3.	Si usted tiene un segundo piso, ¿tiene rejas en las ventanas y en las escaleras? <i>(Window guards and stair gates above the first floor?)</i>	Sí	No	Omita
4.	¿Están los productos de limpieza, medicinas y cerillos o fósforos, en un armario cerrado bajo llave? <i>(Cleaning supplies, medicines, and matches in a locked cabinet?)</i>	Sí	No	Omita
5.	¿Tiene apuntado el número de teléfono del centro para el control del del envenenamiento, cerca del teléfono? <i>(The phone number for the poison control center posted by your telephone?)</i>	Sí	No	Omita
	<u>Usted: (Do you:)</u>			
6.	¿Siempre acuesta a su niño boca arriba, si es menor de 12 meses de edad? <i>(Always put your child to sleep on his/her back, if younger than 12 months of age?)</i>	Sí	No	Omita
7.	¿Alguna vez acuesta a su niño con un biberón con jugo, leche o refresco? <i>(Ever put your child to sleep with a bottle of juice, milk, or soda?)</i>	No	Sí	Omita
8.	¿Se asegura de cepillarle los dientes a su niño, todos los días? <i>(Make sure your child’s teeth are brushed every day?)</i>	Sí	No	Omita
9.	¿Siempre se queda con su niño, cuando está en la bañera? <i>(Always stay with your child when he/she is in the bathtub?)</i>	Sí	No	Omita
10.	¿Siempre pone a su niño en un asiento de seguridad para bebés, en la parte de atrás del carro, y le abrocha el cinturón de seguridad? <i>(Always put your child in a car seat and seat belt in the back seat of a car?)</i>	Sí	No	Omita
11.	¿Siempre camina alrededor de su carro, para asegurarse que no hay niños, antes de manejar en reversa? <i>(Always walk around your car to check for children before backing out?)</i>	Sí	No	Omita

For Clinical Use					
Intervention Codes:	C: Counseling	EM: Educational Materials	R: Referral	F: Follow-up Needed	SPN: See Progress Notes

Interventions
Code/Date/Initials

Su niño: (Does your child:)

12. ¿Recibe atención médica de alguna persona, aparte de un médico, como un acupunturista, un curandero, un yerbatero u otros? (Receive health care from anyone besides a medical doctor [such as an acupuncturist, herbalist, curandero, or other healer]?) No Sí Omita
13. ¿Es alimentado con leche materna? (Breastfeed?) No Sí Omita
14. ¿Toma fórmula, leche o yogur, por lo menos 2 veces cada día? (Drink formula, milk or eat yogurt at least 2 times each day?) Sí No Omita
15. ¿Come frutas y verduras todos los días? (Eat fruits and vegetables every day?) Sí No Omita
16. ¿Come alimentos como nueces, palomitas de maíz, salchichas, uvas enteras o caramelos, que podrían atragantarlo? (Eat foods that may cause choking, such as nuts, popcorn, hotdogs, whole grapes, or hard candy?) No Sí Omita
17. ¿Pasa tiempo en una casa o departamento, donde hay una alberca o jacuzzi? (Spend time at a house or apartment complex with a swimming pool or hot tub?) No Sí Omita
18. ¿Pasa tiempo en una casa, donde hay una pistola? (Spend time in a home where a gun is kept?) No Sí Omita
19. ¿Pasa tiempo en una casa, donde alguien fuma? (Spend time in a home with anyone who smokes?) No Sí Omita
20. ¿Pasa tiempo al aire libre, sin usar loción, sombrero o camisa, para protegerse contra el sol? (Often spend time outdoors without sunscreen or other protection, such as a hat or shirt?) No Sí Omita
21. ¿Ha sido su niño alguna vez testigo o víctima de abuso o violencia física? (Has your child ever witnessed or been a victim of physical abuse or violence?) No Sí Omita
22. **¿Tiene usted alguna pregunta o preocupación relacionada con la salud de su niño?** (Do you have other questions or concerns about your child's health?) No Sí Omita

(Por favor escríbala) (Please identify) _____

For Clinical Use

Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

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Patient Stamp

Patient Number

Plan Name/Number

If patient stamp not used, write in Patient and Plan Name/Number

**“STAYING HEALTHY” ASSESSMENT
Children, 4–8 years of age**

Child’s name (first, last)	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Today’s date	For Clinical Use
Your name	Relationship to child <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other			Assistance needed: Reading: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No

You and your child’s health care team can work together towards better health. Please answer these questions as best you can. You may check (✓) “Skip” if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child’s medical record.

<i>Sample Question and Answer: Does your child play sports?</i>			<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	Interventions Code/Date/Initials
<u>Does Your Home Have:</u>						
1.	A working smoke detector?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
2.	Water that comes from the faucet hot enough to burn your child?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
3.	Window guards above the first floor?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
4.	Cleaning supplies, medicines, and matches in a locked cabinet?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
5.	The phone number for the poison control center posted by your telephone?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
<u>Does Your Child:</u>						
6.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
7.	See the dentist at least once a year?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
8.	Drink milk or eat yogurt or cheese at least 2 times each day?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
9.	Eat fruits and vegetables every day?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
10.	Eat only a limited amount of fried or fast foods?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	

For Clinical Use

Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

**Interventions
Code/Date/Initials**

<u>Does Your Child:</u>			
11.	Play actively 5 days a week?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
12.	Need to lose or gain weight?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
13.	Ever play in the street or unsupervised in the front yard?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
14.	Always use a booster seat and seat belt when riding in a car?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
15.	Always wear a helmet when riding a bike or skateboard?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
16.	Spend time at a house or apartment complex with a swimming pool or hot tub?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
17.	Spend time in a home where a gun is kept?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
18.	Spend time in a home with anyone who smokes?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
19.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
<u>Has Your Child:</u>			
20.	Ever witnessed or been a victim of abuse or violence?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
21.	Had any problems at home or school?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
22.	Do you have other questions or concerns about your child's health? (Please identify) _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	

For Clinical Use

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Privacy Statement

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CUESTIONARIO
“MANTENGA A SU NIÑO SALUDABLE”
Niños de 4 a 8 años

Patient Stamp	
_____	_____
Patient Number	Plan Name/Number
<i>If patient stamp not used, write in Patient and Plan Name/Number</i>	

Nombre y apellido del niño	Fecha de nacimiento	Sexo <input type="checkbox"/> Niño <input type="checkbox"/> Niña	Fecha	For Clinical Use
Nombre de la persona que llena el cuestionario	Parentesco con el niño <input type="checkbox"/> Padre/Madre <input type="checkbox"/> Tutor legal <input type="checkbox"/> Pariente <input type="checkbox"/> Amigo <input type="checkbox"/> Otro			Assistance needed: Reading: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No

El equipo médico de su niño y usted pueden colaborar para tener una buena salud. Por favor, conteste estas preguntas lo mejor que pueda. Si no sabe la respuesta, o no desea contestar, puede marcar (✓) “omita”. Puede hablar con su proveedor de salud acerca de cualquier pregunta. Sus respuestas serán confidenciales, y serán parte del expediente médico de su niño.

Ejemplo de una pregunta y respuesta: <i>¿Practica su niño deportes?</i>	<input checked="" type="checkbox"/>	No	Omita	Interventions Code/Date/Initials
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En su casa: (Does Your Home Have:)

- | | | | |
|---|----|----|-------|
| 1. ¿Tiene un detector de humo que funcione? <i>(A working smoke detector?)</i> | Sí | No | Omita |
| 2. ¿El agua que sale de la llave es lo bastante caliente, como para quemar a su niño? <i>(Water that comes from the faucet hot enough to burn your child?)</i> | No | Sí | Omita |
| 3. Si usted tiene un segundo piso ¿tiene rejas en las ventanas? <i>(Window guards above the first floor?)</i> | Sí | No | Omita |
| 4. ¿Están los productos de limpieza, medicinas y cerillos o fósforos, en un armario cerrado bajo llave? <i>(Cleaning supplies, medicines and matches in a locked cabinet?)</i> | Sí | No | Omita |
| 5. ¿Tiene apuntado el número de teléfono del centro para el control del envenenamiento, cerca del teléfono? <i>(The phone number for the poison control center posted by your telephone?)</i> | Sí | No | Omita |

Su niño (Does Your Child:)

- | | | | |
|--|----|----|-------|
| 6. ¿Recibe atención médica de alguna persona, aparte de un médico, como un acupunturista, un curandero, un yerbatero u otros? <i>(Receive health care from anyone besides a medical doctor [such as an acupuncturist, herbalist, curandero, or other healer]?)</i> | No | Sí | Omita |
| 7. ¿Va al dentista, por lo menos una vez al año? <i>(See the dentist at least once a year?)</i> | Sí | No | Omita |
| 8. ¿Toma leche o yogur, o come queso, por lo menos 2 veces al día? <i>(Drink milk or eat yogurt or cheese at least 2 times each day?)</i> | Sí | No | Omita |
| 9. ¿Come frutas y verduras todos los días? <i>(Eat fruits and vegetables every day?)</i> | Sí | No | Omita |
| 10. ¿Come solamente una cantidad limitada de alimentos fritos o comidas rápidas? <i>(Eat only a limited amount of fried or fast foods?)</i> | Sí | No | Omita |

For Clinical Use

Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

				Interventions Code/Date/Initials
Su niño: (Does Your Child:)				
11.	¿Participa en juegos activos, 5 días a la semana? <i>(Play actively 5 days a week?)</i>	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omita
12.	¿Necesita perder o aumentar de peso? <i>(Need to lose or gain weight?)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omita
13.	¿Algunas veces juega en la calle, o sin supervisión, en el jardín del frente de una casa o departamento? <i>(Ever play in the street or unsupervised in the front yard?)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omita
14.	¿Usa un asiento elevado de seguridad y el cinturón de seguridad, siempre que va en carro? <i>(Always use a booster seat and seat belt when riding in a car?)</i>	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omita
15.	¿Usa un casco protector, siempre que anda en bicicleta o en patineta? <i>(Always wear a helmet when riding a bike or skateboard?)</i>	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omita
16.	¿Pasa tiempo en una casa o departamento, donde hay una alberca o jacuzzi? <i>(Spend time at a house or apartment complex with a swimming pool or hot tub?)</i>	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omita
17.	¿Pasa tiempo en una casa, donde hay una pistola? <i>(Spend time in a home where a gun is kept?)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omita
18.	¿Pasa tiempo en una casa, donde alguien fuma? <i>(Spend time in a home with anyone who smokes?)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omita
19.	¿Pasa tiempo al aire libre, sin usar loción, sombrero o camisa, para protegerse contra el sol? <i>(Often spend time outdoors without sunscreen or other protection such as a hat or shirt?)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omita
Su niño (Has Your Child:)				
20.	¿Ha sido alguna vez testigo o víctima de abuso o violencia física? <i>(Ever witnessed or been a victim of physical abuse or violence?)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omita
21.	¿Ha tenido algún problema en la casa o en la escuela? <i>(Had any problems at home or school?)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omita
22.	<p>¿Tiene usted alguna pregunta o preocupación relacionada con la salud de su niño? <i>(Do you have other questions or concerns about your child's health?)</i></p> <p>(Por favor, escríbala) <i>(Please identify)</i> _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omita

For Clinical Use

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Patient Stamp

Patient Number

Plan Name/Number

If patient stamp not used, write in Patient and Plan Name/Number

**“STAYING HEALTHY” ASSESSMENT
Pre-adolescents, 9–11 years of age**

Child’s name (first, last)	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Today’s date	For Clinical Use
Your name	Relationship to child <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other			Assistance needed: Reading: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No

You and your child’s health care team can work together towards better health. Please answer these questions as best you can. You may check (✓) “Skip” if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child’s medical record.

Annual Review
Date/Initials

Sample Question and Answer: Does your child go to school?

Yes No Skip

Interventions
Code/Date/Initials

Does Your Child:

- | | | | |
|--|------------------------------|------------------------------|-------------------------------|
| 1. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Skip |
| 2. See the dentist at least once a year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Skip |
| 3. Drink milk or eat yogurt or cheese at least 3 times each day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Skip |
| 4. Eat fruits and vegetables every day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Skip |
| 5. Eat only a limited amount of fried or fast foods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Skip |
| 6. Play actively 5 days a week? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Skip |
| 7. Need to lose or gain weight? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Skip |
| 8. Often feel sad or depressed? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Skip |
| 9. Always wear a helmet when riding a bike or skateboard? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Skip |
| 10. Always wear a seatbelt when riding in a car? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Skip |
| 11. Spend time in a home where a gun is kept? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Skip |

For Clinical Use

Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

**Interventions
Code/Date/Initials**

Does Your Child:

12. Spend time with any friends who carry a gun, knife, club, or other weapon? No Yes Skip
13. Spend time in a home with anyone who smokes? No Yes Skip
14. Often spend time outdoors without sunscreen or other protection such as a hat or shirt? No Yes Skip

Has Your Child:

15. Ever smoked cigarettes or chewed tobacco? No Yes Skip
16. Ever had alcohol such as beer, wine, wine coolers, or liquor? No Yes Skip
17. Ever smoked marijuana, sniffed glue, or used street drugs? No Yes Skip
18. Had friends or family members who had a problem with drugs or alcohol? No Yes Skip
19. Started dating or "going with" boyfriends/girlfriends? No Yes Skip
20. Become sexually active? No Yes Skip
21. Ever been molested or sexually abused? No Yes Skip
22. Ever witnessed or been a victim of physical abuse or violence? No Yes Skip
23. Had problems at home or school? No Yes Skip
24. **Do you have other questions or concerns about your child's health?** No Yes Skip

(Please identify) _____

For Clinical Use

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Interventions
Code/Date/Initials

Su niño: (Does Your Child:)

12. ¿Pasa tiempo con amigos, que llevan consigo una pistola, cuchillo, macana u otra arma? *(Spend time with any friends who carry a gun, knife, club, or other weapon?)* No Sí Omita
13. ¿Pasa tiempo en una casa, donde alguien fuma? *(Spend time in a home with anyone who smokes?)* No Sí Omita
14. ¿Pasa tiempo al aire libre, sin usar loción, sombrero o camisa, para contra el sol? *(Often spend time outdoors without sunscreen or other protection such as a hat or shirt?)* No Sí Omita

Su niño: (Has Your Child:)

15. ¿Ha fumado alguna vez cigarrillos, o masticado tabaco? *(Ever smoked cigarettes or chewed tobacco?)* No Sí Omita
16. ¿Ha tomado alguna vez alcohol como cerveza, vino, wine coolers o licor? *(Ever had alcohol such as beer, wine, wine coolers, or liquor?)* No Sí Omita
17. ¿Ha fumado alguna vez marihuana, inhalado pegamento, o usado otras drogas? *(Ever smoked marijuana, sniffed glue, or used street drugs?)* No Sí Omita
18. ¿Ha tenido amigos o familiares, que tuvieron un problema con las drogas o el alcohol? *(Had friends or family members who had a problem with drugs or alcohol?)* No Sí Omita
19. ¿Ha comenzado a tener citas románticas? *(Started dating or "going with" boyfriends/girlfriends?)* No Sí Omita
20. ¿Ha empezado a tener actividad sexual? *(Become sexually active?)* No Sí Omita
21. ¿Ha sido alguna vez abusado sexualmente? *(Ever been molested or sexually abused?)* No Sí Omita
22. ¿Ha sido alguna vez testigo o víctima de abuso o violencia física? *(Ever witnessed or been a victim of physical abuse or violence?)* No Sí Omita
23. ¿Ha tenido algún problema en la casa o en la escuela? *(Had problems at home or school?)* No Sí Omita
24. **¿Tiene usted alguna pregunta o preocupación relacionada con la salud de su niño?** *(Do you have other questions or concerns about your child's health?)* No Sí Omita

(Por favor escribala) *(Please identify)* _____

For Clinical Use

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Your answers to questions about sex and family planning cannot be shared with anyone, including your parents, without your special written permission.

Interventions
Code/Date/Initials

Do you ever:			
16.	Smoke cigarettes or cigars or chew tobacco?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
17.	Drink alcohol such as beer, wine, wine coolers, or liquor?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
18.	Drive a car after drinking or ride in a car driven by someone who has been drinking?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
19.	Use drugs such as marijuana, cocaine, crack, crank, or ecstasy?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
20.	Have you ever had sex? <i>If "yes," continue to next question. If "no," go to question 26.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
21.	Do you think you or your partner could be pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
22.	Have you had sex without using birth control in the last year?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
23.	Do you think you or your partner could have a sexually transmitted disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
24.	Have you or your partner(s) had sex with any other people in the past year?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
25.	Did you or your partner use a condom the last time you had sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
Have you:			
26.	Ever been forced or pressured to have sex?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
27.	Ever been hit, slapped, kicked, or physically hurt by someone?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
28.	Ever carried a gun, knife, club, or other weapon?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
29.	Do you have other questions or concerns about your health? (Please identify) _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	

For Clinical Use

Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

Privacy Statement

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**CUESTIONARIO
“MANTENTE SALUDABLE”
Adolescentes de 12 a 17 años**

Patient Stamp	
Patient Number _____	Plan Name/Number _____
<i>If patient stamp not used, write in Patient and Plan Name/Number</i>	

Nombre y apellido del paciente	Fecha de nacimiento	Sexo <input type="checkbox"/> Hombre <input type="checkbox"/> Mujer	Fecha	For Clinical Use
Nombre de la persona que llena el cuestionario (Si es diferente al paciente)	Parentesco con el adolescente <input type="checkbox"/> Padre/Madre <input type="checkbox"/> Tutor legal <input type="checkbox"/> Pariente <input type="checkbox"/> Amigo <input type="checkbox"/> Otro			Assistance needed: Reading: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No

El equipo médico y tú pueden colaborar para tener una buena salud. Por favor, contesta estas preguntas lo mejor que puedas. Si no sabes la respuesta, o no deseas contestar, puedes marcar (✓) “omite”. Puedes hablar con tu proveedor de salud acerca de cualquier pregunta. Tus respuestas serán confidenciales y serán parte de tu expediente médico.

Ejemplo de una pregunta y respuesta: ¿Practicar deportes?	<input checked="" type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omite	Interventions Code/Date/Initials
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Tú: (Do You:)				
1. ¿Vives con tu familia? (Live at home?)	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omite	
2. ¿Vas a la escuela? (Go to school?)	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omite	
3. ¿Recibes atención médica de alguna persona, aparte de un médico, como un acupunturista, un curandero, un yerbatero, u otros? (Receive health care from anyone besides a medical doctor [such as an acupuncturist, herbalist, curandero, or other healer]?)	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omite	
4. ¿Vas al dentista, por lo menos una vez al año? (See the dentist at least once a year?)	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omite	
5. ¿Tomas leche o yogur, o comes queso, por lo menos 3 veces al día? (Drink milk or eat yogurt or cheese at least 3 times each day?)	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omite	
6. ¿Comes frutas y verduras todos los días? (Eat fruits and vegetables every day?)	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omite	
7. ¿Intentas reducir la cantidad de alimentos fritos o comidas rápidas que comes? (Try to limit the amount of fried or fast foods that you eat?)	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omite	
8. ¿Haces ejercicio, o practicas un deporte activo, 5 días a la semana? (Exercise or play an active sport 5 days a week?)	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omite	
9. ¿Crees que necesitas perder o aumentar de peso? (Think you need to lose or gain weight?)	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omite	
10. ¿Te sientes a menudo triste, deprimido o desesperado? (Often feel sad, down, or hopeless?)	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omite	
11. ¿Usas el cinturón de seguridad, siempre que vas en carro? (Always wear a seat belt when riding in a car?)	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omite	
12. ¿Usas un casco protector, siempre que andas en bicicleta o en patineta? (Always wear a helmet when riding a bike or skateboard?)	<input type="checkbox"/> Sí	<input type="checkbox"/> No	<input type="checkbox"/> Omite	
13. ¿Pasas tiempo en una casa, donde hay una pistola? (Spend time in a home where a gun is kept?)	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omite	
14. ¿Pasas tiempo en una casa, donde alguien fuma? (Spend time in a home with anyone who smokes?)	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omite	
15. ¿Pasas tiempo al aire libre, sin usar loción, sombrero o camisa, para protegerte contra el sol? (Often spend time outdoors without sunscreen or other protection such as a hat or shirt?)	<input type="checkbox"/> No	<input type="checkbox"/> Sí	<input type="checkbox"/> Omite	

For Clinical Use					
Intervention Codes:	C: Counseling	EM: Educational Materials	R: Referral	F: Follow-up Needed	SPN: See Progress Notes

Tus respuestas a las preguntas sobre el sexo y la planificación familiar no se compartirán, ni siquiera con tus padres. Si deseas que ellos se enteren, debes firmar un permiso. *(Your answers to questions about sex and family planning cannot be shared with anyone, including your parents, without your special written permission.)*

For Clinical Use

**Interventions
Code/Date/Initials**

Alguna vez: (Do You Ever:)			
16.	¿Has fumado alguna vez cigarrillos o puros, o masticado tabaco? <i>(Smoke cigarettes or cigars or chew tobacco?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
17.	¿Has tomado alcohol como cerveza, vino, <i>wine coolers</i> o licor? <i>(Drink alcohol such as beer, wine, wine coolers, or liquor?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
18.	¿Has manejado un carro, después de haber tomado bebidas alcohólicas, o estuviste en uno, manejado por alguien que ha estado tomando? <i>(Drive a car after drinking or ride in a car driven by someone who has been drinking?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
19.	¿Has usado drogas como la marihuana, cocaína, <i>crack</i> , <i>crank</i> <i>(Use drugs such as marijuana, cocaine, crack, or ecstasy?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
20.	¿Has tenido relaciones sexuales? (Have you ever had sex?) <i>Si la respuesta es sí, continúa con las siguientes preguntas. Si la respuesta es no, pasa a la pregunta 26: (If "yes," continue to next question. If "no," go to question 26.)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
21.	¿Crees que tú podrías, o que tu pareja podría estar embarazada? <i>(Do you think you or your partner could be pregnant?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
22.	¿Has tenido relaciones sexuales en el último año, sin usar algún método anticonceptivo? <i>(Have you had sex without using birth control in the last year?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
23.	¿Crees que tú podrías, o que tu pareja podría tener una enfermedad transmitida sexualmente? <i>(Do you think you or your partner could have a sexually transmitted disease?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
24.	En el último año, ¿tú o tu pareja han tenido relaciones sexuales con otras personas? <i>(Have you or your partner(s) had sex with any other people in the past year?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
25.	La última vez que tuvieron relaciones sexuales, ¿usaste un condón con tu pareja? <i>(Did you or your partner use a condom the last time you had sex?)</i>	<input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> Omite	
Alguna vez: (Have you:)			
26.	¿Te han forzado o presionado, a tener relaciones sexuales? <i>(Ever been forced or pressured to have sex?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
27.	¿Te han golpeado, abofeteado, pateado o lastimado físicamente? <i>(Ever been hit, slapped, kicked, or physically hurt by someone?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
28.	¿Has llevado contigo una pistola, cuchillo, macana u otra arma? <i>(Ever carried a gun, knife, club, or other weapon?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	
29.	¿Tienes alguna pregunta o preocupación relacionada con tu salud? <i>(Do you have other questions or concerns about your health?)</i> <i>(Por favor, escríbela) (Please identify)</i> _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omite	

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Your answers to questions about alcohol and drug use cannot be released to others without your special written permission.

**Interventions
Code/Date/Initials**

Do You:

- 11. Smoke cigarettes or cigars or use any other kinds of tobacco? No Yes Skip
- 12. Use any drugs or medicines to go to sleep, relax, calm down, feel better, or lose weight? No Yes Skip
- 13. Often have more than 2 drinks containing alcohol in one day? No Yes Skip
- 14. Think you or your partner could be pregnant? No Yes Skip
- 15. Think you or your partner could have a sexually transmitted disease? No Yes Skip

Have You:

- 16. Or your partner(s) had sex without using birth control in the last year? No Yes Skip
- 17. Or your partner(s) had sex with other people in the past year? No Yes Skip
- 18. Or your partner(s) had sex without a condom in the past year? No Yes Skip
- 19. Ever been forced or pressured to have sex? No Yes Skip
- 20. Ever been hit, slapped, kicked, or physically hurt by someone? No Yes Skip
- 21. **Do you have other questions or concerns about your health?** No Yes Skip

(Please identify) _____

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Sus respuestas a las preguntas sobre el uso de alcohol y drogas no se compartirán con otras personas, sin su permiso por escrito. *(Your answers to questions about alcohol and drug use cannot be released to others without your special written permission.)*

For Clinical Use

**Interventions
Code/Date/Initials**

Usted: (Do You:)

- | | |
|---|--|
| 11. ¿Fuma cigarrillos o puros, o usa otra clase de tabaco?
<i>(Smoke cigarettes or cigars or use any other kinds of tobacco?)</i> | <input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omita |
| 12. ¿Toma alguna droga o medicina para dormir, relajarse, calmarse, sentirse mejor o perder peso?
<i>(Use any drugs or medicines to go to sleep, relax, calm down, feel better, or lose weight?)</i> | <input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omita |
| 13. ¿Toma a menudo más de dos bebidas alcohólicas en un día?
<i>(Often have more than 2 drinks containing alcohol in one day?)</i> | <input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omita |
| 14. ¿Cree que usted o su pareja podría estar embarazada?
<i>(Think you or your partner could be pregnant?)</i> | <input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omita |
| 15. ¿Cree que usted o su pareja podría tener una enfermedad transmitida sexualmente?
<i>(Think you or your partner could have a sexually transmitted disease?)</i> | <input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omita |

Usted: (Have You:)

- | | |
|---|--|
| 16. En el último año, ¿usted o su pareja ha tenido relaciones sexuales, sin usar algún método anticonceptivo?
<i>(Or your partner(s) had sex without using birth control in the last year?)</i> | <input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omita |
| 17. En el último año, ¿usted o su pareja ha tenido relaciones sexuales con otras personas?
<i>(Or your partner(s) had sex with other people in the past year?)</i> | <input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omita |
| 18. En el último año, ¿usted o su pareja ha tenido relaciones sexuales, sin usar un condón?
<i>(Or your partner(s) had sex without a condom in the past year?)</i> | <input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omita |
| 19. ¿Alguna vez le han forzado o presionado, a tener relaciones sexuales?
<i>(Ever been forced or pressured to have sex?)</i> | <input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omita |
| 20. ¿Alguna vez le han golpeado, abofeteado, pateado o lastimado físicamente?
<i>(Ever been hit, slapped, kicked, or physically hurt by someone?)</i> | <input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omita |
| 21. ¿Tiene alguna pregunta o preocupación relacionada con su salud?
<i>(Do you have other questions or concerns about your health?)</i>
(Por favor escríbala) <i>(Please identify)</i> _____

_____ | <input type="checkbox"/> No <input type="checkbox"/> Sí <input type="checkbox"/> Omita |

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