

Los Angeles County Staying Healthy Assessment (SHA) Training

Information for Medi-Cal providers in Los Angeles County on completing the Staying Healthy Assessment for patients

Developed by Medi-Cal Managed Care Health Plans





Agenda

- 1) IHEBA/SHA Overview, Goals & Benefits
- 2) SHA Completion & Documentation Process
- 3) SHA Resources
- 4) Electronic SHA & Alternative Assessment
Tools





Definitions

DHCS: Department of Health Care Services

IHA: Initial Health Assessment (DHCS Policy Letter 08-003) includes an IHEBA

IHEBA: Individual Health Education Behavioral Assessment is a generic term for the SHA or DHCS approved alternative assessment tool. IHEBA is a required part of the IHA

SHA: Staying Healthy Assessment is the DHCS's sponsored and approved IHEBA



Introduction

DHCS requires providers to administer an IHEBA to all Medical Managed Care patients as part of their Initial Health Assessment (IHA) and well care visits.

The IHA, at a minimum, shall include:

- a physical and mental health history
- identification of high risk behaviors
- assessment of need for preventive screenings or services and health education
- diagnosis and plan for treatment of any diseases

The IHA must be conducted in a culturally and linguistically appropriate manner for all patients, including those with disabilities.





Introduction Continued

New Staying Healthy Assessment (SHA) forms must be implemented by April 1, 2014

Providers are encouraged to begin using the SHA now





Individual Health Education Behavioral Assessment Goals

- Identify and track patient high-risk behaviors
- Prioritize patient health education needs related to lifestyle, behavior, environment, and cultural and linguistic needs
- Initiate discussion and counseling regarding high-risk behaviors
- Provide tailored health education





Benefits to Providers and Patients

- Builds trust between provider and patient
- Improves patient-provider relationship and patient satisfaction
- Allows for more personalized care plans
- Streamlines HEDIS documentation for providers, ensures members get preventive health services
- Allows provider to document patient counseling



SHA Periodicity Table

Questionnaire	Administer	Administer/Re-administer		Review
Age Groups	Within 120 Days of Enrollment	1 st Scheduled Exam (<i>after entering new age group</i>)	Every 3-5 years	Annually (<i>Interval Years</i>)
0-6 mo.	✓			
7-12 mo.	✓	✓		
1-2 yrs.	✓	✓		✓
3-4 yrs.	✓	✓		✓
5-8 yrs.	✓	✓		✓
9-11 yrs.	✓	✓		✓
12-17 yrs.	✓	✓		✓
Adult	✓		✓	✓
Senior	✓		✓	✓





SHA Recommendations

12–17 years old age group:

- Encourage patients to complete the SHA without a parent/guardian
- Annual re-administration is recommended

Adults and Seniors age group:

- After 55 years of age, use Adult or Senior SHA that is best suited for patient
- Annual re-administration is recommended for seniors





SHA Completion

Assisting the patient in SHA completion:

- Explain the SHA's purpose and how it will be used
- Assure that SHA responses are confidential and will be kept in patient's medical record
- Encourage the patient to self-complete the SHA

Optional:

- SHA questions may be asked verbally and responses recorded directly in patient's electronic medical record





SHA Refusal

- Patients have the right to refuse, decline or skip any or all parts of the SHA
- Encourage patient to complete an age appropriate SHA every subsequent year during a scheduled exam





SHA Provider Review

Reviewing the completed SHA with the patient:

- Determine extent of risk factors on patient's health
- Prioritize risk factors to discuss
- Provide tailored health education counseling, intervention, referral, follow up, and risk reduction plan





SHA Provider Review

Alcohol use question:

- The alcohol screening question is based on USPSTF recommendations
- #19 on the Adult SHA
- #23 on the Senior SHA





SHA Provider Review

New Screening, Brief Intervention and Referral for Treatment (SBIRT) benefit:

- If “yes” to alcohol question, offer an expanded screening questionnaire (such as the AUDIT or AUDIT-C) and if indicated, one to three 15-minute brief interventions
- These screening questionnaires identify patients with potential alcohol use disorders who need referral for further evaluation and treatment



SHA Provider Review

Screening, Brief Intervention and Referral for Treatment (SBIRT):

- Providers offering SBIRT are required to take special training. A list of training resources is available – contact your health plan for more information
- The alcohol SBIRT benefit went into effect January 1, 2014



SHA Documentation

The provider must:

- Sign, print his/her name, and date
- Document specific behavioral–risk topics and patient counseling, referral, anticipatory guidance, and follow–up provided
- Keep signed SHA in patient’s medical record
- Document SHA reviews and SHA refusals





SHA Refusal Documentation

- Document refusal on the SHA and keep in the patient's medical record
- Check box “Patient Declined the SHA”
- Provider must sign, print name, and date the back page of form





Document HEDIS Measures

The SHA is an additional document to provide evidence of certain Healthcare Effectiveness Data and Information Set (HEDIS) measures that require patient counseling, referral, the provision of anticipatory guidance, and follow-up, as appropriate.

Age 0–15 months

- Well child visits ages 0–15 months – Health Education/Anticipatory Guidance

Age 3–17 years

- Weight assessment and counseling for nutrition and physical activity

Age 12–21 years

- Adolescent well care – Health Education/Anticipatory Guidance
- Chlamydia screening
- HPV vaccination
- Prenatal care if pregnant (applies at any age)





Document HEDIS Measures

Adults

- Chlamydia screening
- Prenatal care if pregnant
 - Notify Health Plan of all pregnancies by using the pregnancy notification form (as appropriate)
 - Postpartum care (if appropriate)

Seniors

- Care for older adults
- Functional status screening
- Advance directive



Staying Healthy Assessment

(Staying Healthy Assessment)

12 - 17 Years (12 - 17 Years)

Name (first & last) <i>Jane Doe</i>	Date of Birth <i>04-01-99</i>	<input checked="" type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date <i>9-10-13</i>	Grade in School: <i>9</i>
Person Completing Form <i>Self</i>	<input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Other (Specify)	School Attendance Regular? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

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

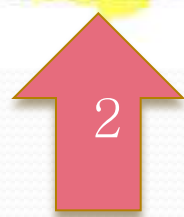
Need Interpreter?
 Yes No

				Clinic Use Only:	
				Nutrition	
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu? <i>(Drinks/eats 3 servings of calcium-rich foods daily)</i>	<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Skip	
2	Do you eat fruits and vegetables at least 2 times per day? <i>(Eats fruits and vegetables at least 2 times per day?)</i>	<input type="radio"/> Yes	<input checked="" type="radio"/> No	<input type="radio"/> Skip	
3	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week? <i>(Eats high fat foods more than once per week?)</i>	<input type="radio"/> No	<input checked="" type="radio"/> Yes	<input type="radio"/> Skip	
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink? <i>(Drinks more than 12 oz. per day of juice/sports/energy drink, or sweetened coffee drink?)</i>	<input type="radio"/> No	<input checked="" type="radio"/> Yes	<input type="radio"/> Skip	
5	Do you exercise or play sports most days of the week? <i>(Exercises or plays sports most days of the week?)</i>	<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Skip	Physical Activity




30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip
32	The last time you had sex, did you use birth control?	Yes	No	Skip
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip
35	Do you have concerns about liking someone of the same sex?	No	Yes	Skip
36	Do you have any other questions or concerns about your health?	No	Yes	Skip

If yes, please describe:



1

3

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input checked="" type="checkbox"/> Nutrition	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div style="text-align: center;">  <p>4</p> </div>
<input checked="" type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/> Safety	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/> Alcohol, Tobacco, Drug Use	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
					<input type="checkbox"/> Patient Declined the SHA

2

PCP's Signature: *John Smith* Print Name: *Dr. John Smith* Date: *9-10-13*

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PCP's Signature: Print Name: Date:

PCP's Signature: Print Name: Date:

PCP's Signature: Print Name: Date:

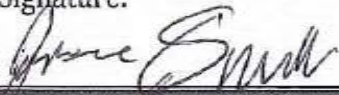
PCP's Signature: Print Name: Date:

1

3

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input checked="" type="checkbox"/> Nutrition	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined the SHA
<input checked="" type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/> Safety	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/> Alcohol, Tobacco, Drug Use	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

PCP's Signature:



Print Name:


Dr. John Smith

Date:

9-10-13

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PCP's Signature:



Print Name:

John Smith

Date:

9-21-14

PCP's Signature:

Print Name:

Date:

PCP's Signature:

Print Name:

Date:

PCP's Signature:

Print Name:

Date:



SHA Resources

All SHA forms are available for download and printing on the DHCS site at:

www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

Available languages:

Arabic*	Khmer*
Armenian	Korean
Chinese	Russian
English	Spanish
Farsi*	Tagalog
Hmong	Vietnamese

* These languages are not currently available on the DHCS website, but can be obtained by contacting your health plan.





SHA Electronic Format

- Notify health plan at least two months before start
- Electronic formats: add SHA questions into an electronic medical record, scan the SHA questionnaire into EMR, or use the SHA in another alternative electronic or paper-based format
- Electronic provider signature needed
- Must include all updated and unaltered SHA questions
- Your health plan will review the electronic format to ensure it meets all requirements prior to implementation



Alternative Assessment Tool

- Use of the SHA tool is strongly recommended
 - Alternatives are permitted but require pre-approval by DHCS
 - Submit request for approval to use alternative assessment tool through your health plan
- Any alternative assessments must be translated to the threshold languages of the health plan's members and meet all the same standards as the SHA
- The American Academy of Pediatrics *Bright Futures* assessment has been pre-approved by DHCS as an alternative IHEBA. It can be used as long as certain conditions are met. Contact your health plan for more information



SHA Additional Resources

- SHA Provider Office Instruction Sheet
- SHA Behavioral Risk Topics
- SHA Pediatric Questions by Age Groups
- SHA Adult Questions by Age Groups

All SHA additional resources are available through the DHCS website.

www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx





Health Plan Resources

Medi-Cal Managed Care Health Plans in Los Angeles County offer:

- SHA Forms & Education
- Interpreting Services
- Health Education Materials
- Health Education Services
- Nurse Advice Line





Contact Information

Anthem Blue Cross

- **Phone: (866) 465-2272**

Care1st Health Plan

- **Email: HealthEducation@care1st.com**
- **Phone: (323) 889-6638 x3282**

Health Net

- **Phone: (800) 804-6074**

L.A. Care Health Plan

- **Email: HealthEducation@lacare.org**
- **Phone: (855) 856-6943**

Molina Healthcare

- **For more information or resources regarding the SHA, please contact your Molina Provider Services Representatives**





Thank You!

