OneCare (HMO SNP)
CalOptima
A Public Agency
Better. Together.

ONECARE MEMBER HEALTH RISK ASSESSMENT

OneCare cares about you and wants to support you and your doctor in keeping you as healthy as possible. You can help us by filling out the following Health Risk Assessment each year you are enrolled in the OneCare program. Your answers will tell us about your health care needs. They will also help your doctor to help you stay healthy. Your information will be kept private and shared only between OneCare and your medical group.

Please print the survey, complete it, and mail it back to us at:

CalOptima OneCare
P.O. Box 11063
Orange CA 92856-9911

Please be sure to make an appointment for your yearly checkup with your doctor.
The information from this survey and from your checkup will help your doctor plan how to best meet your health care needs.

If you have any questions or would like tips on making the most of your doctor visits, please call our Customer Service Department toll-free 7 days a week, 24 hours a day, at **1-877-412-2734**. TTY/TDD users can call toll-free at **1-800-735-2929**.

CalOptima OneCare (HMO SNP) Annual Health Assessment

We want to provide you access to the best care and meet your health needs. If you answer the questions on this survey, we will be able to serve you better. Your answers will be shared with your doctor and will help you get timely health care. We will keep your information private. It is shared only with those treating you or helping you get health care.

Filling out this survey will **not** prevent you from getting health care services. If you need help to fill this survey out, please call **1-877-412-2734,** and we can ask you the questions over the phone. **Please complete and send us your survey as soon as you can.**

Personal Information		
Last Name:	First Name:	Medical Group:
CalOptima ID # (CIN):	Phone (Home):	Phone (Cell):
Address:		Email:
Height:	Weight:	Today's Date:

Instructions:

a. Please read each question and mark the box like this: ☒ for your answer.
b. Some questions ask you to write an answer on the line. Please write your answer on the line next to the question. Thank you!

Health Care Planning

1. **Do you need someone to help you complete this survey?**
   ☐ Yes, my caregiver ☐ Yes, my legal guardian ☐ Yes, family or friend ☐ No
   If yes, why do you need help?
   ☐ Cannot see well ☐ Do not read well ☐ Do not understand some questions
   ☐ Other: why? _____

2. **Do you have someone who makes choices for you, such as a guardian, or are you able to make your own choices?**
   ☐ No, I am able to make my own choices ☐ Yes, I have a legal guardian

3. **Do you have an advance directive for health care?** (This is a document that tells doctors and hospitals what to do in case you are not able to speak for yourself.)
   ☐ No ☐ Living Will ☐ Healthcare Proxy ☐ Durable Power of Attorney ☐ POLST

   If "No," would you like to talk with someone about getting an advance directive?
   ☐ Yes ☐ No

4. **Can we talk to your support person or caregiver about your health if we cannot reach you or if there is an emergency?**
   ☐ Yes ☐ No ☐ I don't have a support person or caregiver
   If "Yes," write the person's name and best phone number to reach them. (We will have you sign a HIPAA consent form for this person.) _____

Current Health Care

5. **When was the last time you saw your doctor (primary care provider)?**
   ☐ Less than 6 months ago ☐ 6 to 12 months ago ☐ More than 1 year ago ☐ Not sure

6. **Have you been told in the last 3 months to get surgery or a procedure and not received it?**
   ☐ Yes ☐ No ☐ Recommended but I refused
   Name of recommended procedure or surgery: _____

7. **Have you lost weight in the last 3 months without trying to lose weight?**
   ☐ Yes; ☐ Less than 10 pounds ☐ 10 to 20 pounds ☐ More than 20 pounds
   ☐ No
   ☐ Not sure

8. **What health conditions do you have? (Check box or write answer.)**
   ☐ Asthma
   ☐ COPD or Chronic Bronchitis
   ☐ Depression, Anxiety, Bipolar, PTSD
   ☐ Diabetes
   ☐ Heart Failure
   ☐ High blood pressure
   ☐ High cholesterol
   ☐ Other: _____
   ☐ Other: _____
   ☐ Other: _____

9. **Have you taken classes or had education to help you manage any of the health conditions in question 8**?
   ☐ Yes; for which condition(s)? _____
   ☐ No

10. **Would you like to get education or help to manage any of the health conditions in question 8?**
    ☐ Yes; for which condition(s)? _____
    ☐ No

11. Are you getting care from a specialist now? Specialists are doctors such as surgeons, heart doctors, skin doctors, mental health professionals, and other doctors who are experts in one area of health care.
☐ Yes ☐ No Name of Specialist: _____

12. When was the last time you saw your specialist?
☐ Less than 6 months ago ☐ 6 to 12 months ago ☐ More than 1 year ago ☐ Not sure

13. Are you pregnant now? ☐ Yes ☐ No
If yes, what is your due date? _____
Are you getting prenatal care now?
☐ Yes ☐ No

14. Are you on dialysis? ☐ Yes ☐ No
If "Yes," how many times per week do you go? _____

15. How many prescription medicines do you take? ☐ 0 to 5 ☐ 6 or more

16. Have you had any problem filling your prescriptions?
☐ Yes; what medicine(s)? _____ ☐ No ☐ Do not currently take any medicines

17. Do you have any health conditions that you want checked out?
☐ Yes; what? _____ ☐ No
If "Yes," is the problem getting worse? ☐ Yes ☐ No

18. In the last 12 months, how often did your doctor (primary care provider) seem to know the important information about the care you received from other doctors?
☐ Never
☐ Sometimes
☐ Usually
☐ Always

Past Health History

19. In the last 12 months, how many times have you fallen?
☐ None ☐ 1 time ☐ 2 times or more

20. In the last 12 months, how many times you been a patient in a hospital where you stayed overnight?
☐ None ☐ 1 time ☐ 2 times or more

21. In the last 6 months, how many times did you go to the emergency room (hospital)?
☐ None ☐ 1 time ☐ 2 times or more

22. In the last 12 months, how many times have you been in a skilled nursing facility?
☐ None ☐ 1 time ☐ 2 times or more

23. Have you had the following health screenings?

- ☐ Flu shot or flu mist in the last year
- ☐ Pneumonia shot in the last 5 years
- ☐ Shot for shingles (h-zoster)
- ☐ Colorectal screen
- ☐ Mammogram in the last 2 years (female only)
- ☐ Pap smear in the last 3 to 5 years (female only)
- ☐ Bone Density Test (osteoporosis test)

24. If you have diabetes, did you have an A1c (blood sugar test), kidney function test and retinal exam (special eye exam) in the last 12 months?

☐ Yes ☐ No ☐ I do not have diabetes

Daily Functioning

25. In general, would you say your health is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

26. Do you do any physical activity for at least 20 minutes each day for 3 days per week (including walking)?

☐ Yes ☐ No

27. On a typical day, which of the following is true for you? Check all that are true.

- ☐ I eat a healthy diet.
- ☐ I have a poor appetite.
- ☐ I have a hard time chewing food or swallowing.

28. In the last 2 weeks, how much of the time did your physical health or emotional problems make it hard for you to work a job?

☐ Do not work ☐ All of the time ☐ Most of the time ☐ Half of the time
☐ Some of the time ☐ None

29. Do you need help from another person with any of these actions? (Check all that apply.)

- ☐ Bathing or taking a shower
- ☐ Changing bandages
- ☐ Climbing stairs
- ☐ Eating
- ☐ Getting dressed
- ☐ Grooming (brushing teeth, shaving)
- ☐ Making meals or cooking
- ☐ Moving out of a bed or a chair
- ☐ Shopping and getting food
- ☐ Special diet
- ☐ Taking medication
- ☐ Transportation
- ☐ Using the toilet
- ☐ Walking
- ☐ Washing dishes or laundry
- ☐ Writing checks or finances
- ☐ No help is needed

30. Can you get around your home by yourself?

☐ Yes, with wheelchair or scooter ☐ Yes, with cane or walker ☐ Yes, without help ☐ No

31. Does your health prevent you from leaving your home?
☐ Yes ☐ No

32. When your pain is the worst, how would you rate your pain on a scale of 0 to 10? (0=no pain and 10=very severe pain)
☐ 0 ☐ 1 to 3 ☐ 4 to 6 ☐ 7 to 10

33. In the last 2 weeks have you had little interest or pleasure in doing things?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

34. In the last 2 weeks have you felt down, sad or hopeless?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

35. In the last 2 weeks have you been feeling nervous, anxious or on edge?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

36. In the last 2 weeks have you been bothered by not being able to stop or control worrying?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Services Received

37. Are you getting wound care now?
☐ Yes; for what? _____ ☐ No

38. Do you have any wounds, sores or skin breakdown that you are <u>not</u> getting treatment for?
☐ Yes ☐ No
If "Yes," please describe: _____

39. Do you use any of these? (Check all that you use now.)

☐ Braces or artificial limbs
☐ Catheter (urinary)
☐ CPAP or BiPAP
☐ Diabetes supplies (glucose meter, etc.)
☐ Diapers or incontinence supplies
☐ Guide dog
☐ Hearing aids
☐ Hospital bed
☐ Hoyer lift
☐ Infusions (such as IV medication)
☐ Motorized scooter
☐ Ostomy bags or supplies
☐ Oxygen
☐ Respirator or ventilator
☐ Slide board
☐ Trach or suction supplies
☐ Tube feeding supplies
☐ Walker or cane
☐ Wheelchair

If you are not using any, do you need any of these aids? ☐ Yes ☐ No
If "Yes," please list: _____

40. Are you getting any of the following services now? (Check all that you use now.)

- ☐ Transportation help
- ☐ Community Based Adult Services (CBAS)
- ☐ County Alcohol or Drug Outpatient Program
- ☐ County Mental Health Case Management Services
- ☐ Food assistance programs (Meals on Wheels, CalFresh, food banks)
- ☐ Help paying utility bills
- ☐ Home Health Nurse
- ☐ Hospice or Palliative Care Program
- ☐ In-Home Operations (IHO)
- ☐ In-Home Supportive Services (IHSS)
- ☐ Multipurpose Senior Service Program (MSSP)
- ☐ Personal Care Services
- ☐ Physical, Occupational, Speech Therapy at Home
- ☐ Regional Center of Orange County (RCOC)
- ☐ Social Worker
- ☐ Veteran's Administration (VA)
- ☐ Other Community Resource(s): _____

Do you need any of these services that you are not getting now? ☐ Yes ☐ No
If "Yes," which one(s)? _____

Social History

41. What language do you prefer to speak?

☐ English ☐ Spanish ☐ Vietnamese
☐ Korean ☐ Farsi ☐ Other: _____

42. What language do you prefer to get written health information in?

☐ English ☐ Spanish ☐ Vietnamese
☐ Korean ☐ Farsi ☐ Other: _____

43. What format do you want to get health information in?

- ☐ Written (print)
- ☐ Written — large print
- ☐ Braille
- ☐ Audio or CD

44. What is your current living arrangement?

- ☐ Live alone
- ☐ Live with spouse or significant other
- ☐ Live with children
- ☐ Live with other relatives or friends
- ☐ Live with paid caregiver
- ☐ Homeless
- ☐ Board and Care Facility
- ☐ Assisted Living Facility
- ☐ Nursing Home
- ☐ Residential Treatment Center
- ☐ Sober Living House
- ☐ Other: _____

Health Risk Assessment

45. Do you have a person who helps you with your daily needs?
☐ No ☐ Yes; who?
If "No," do you want to be assessed for a person to help you? ☐ Yes ☐ No

46. How often do you have problems learning about your health condition or medicines because the written information is hard to read?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

47. Do you smoke or use tobacco now? ☐ Yes ☐ No
If "Yes," do you want help to quit? ☐ Yes ☐ No

48. How often do you have a drink that has alcohol?
☐ Never ☐ Monthly or less ☐ 2–4 times per month ☐ 2–3 times per week
☐ 4 or more times per week

49. How many drinks do you have on a typical day when you are drinking?
☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10+

50. How often do you have 5 or more drinks on one occasion?
☐ Never ☐ Monthly or less ☐ Monthly ☐ Weekly ☐ Daily or almost daily

51. How many times in the past year have you used an illegal drug or used a prescription medicine for non-medical reasons? ☐ Never ☐ 1 time ☐ More than 1 time

52. Have you ever been hurt, threatened or made to feel afraid by a partner or someone you know?
☐ Yes ☐ No
If "Yes," when? _____ If "Yes," who? _____

53. Do you have problems with your memory?
☐ Yes ☐ No

54. Do other people believe you may have problems with your memory?
☐ Yes ☐ No

55. Do you have any cultural and religious beliefs that may affect your treatment choices?
☐ Yes ☐ No
If "Yes," what? _____

Thank you for taking your time to complete this survey. Please fold and return it in the envelope sent with this survey. We look forward to serving you! If you have any questions about your doctor or health care, please call OneCare Customer Service at 1-877-412-2734, 24 hours a day, 7 days a week. TDD/TTY users can call 1-800-735-2929.