

Healthy Directions PCP Packet!

Hamilton County's alternative to an on-site health screening.

Complete these steps to earn your incentive in February 2017.

- A** Complete and sign the Registration & Consent Form
- B** Complete and sign the Authorization for use and disclosure of protected health information form
- C** Schedule an annual preventive physical with your doctor
- Your physical must occur between Jan. 1, 2016 – Dec. 31, 2016. Take your Healthy Directions packet with you to your appointment and have your doctor complete and sign the Biometric Measures & Physical Confirmation. It is the participant's responsibility to return the form as part of the completed packet by Jan.6, 2017. (See Step D below.)
 - Have you already received your annual preventive physical within the above timeframe? Take your Healthy Directions packet to your physician's office to have the Biometric Measures & Physical Confirmation Form completed.
 - If you do not have a doctor, you can select a doctor within the Humana benefit plan network. If you need assistance in finding a physician, please go to www.humana.com.
- D** Complete Your Online Health Risk Assessment between 9/1/2016-12/31/2016. You can complete the assessment by using the link below:
- <https://wellsuite.com/trihealthcorphealth/trihealthphs/default.aspx?grid=9d7f9b26851a>
- E** Submit your completed packet by 1/6/2017
- Submit completed packet in its entirety in one of three ways:
 - ❖ Scan and email to hamiltoncounty@trihealth.com
 - ❖ Secure fax 513 852 8595
 - ❖ Mail to Healthy Directions, 11129 Kenwood Road, Cincinnati, OH 45242
 - Keep a copy of all forms for your files. We will notify you when your packet has been processed. Allow 7-10 business days.



Questions about the process?

Please contact hamiltoncounty@trihealth.com or call 513 977 2170

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Healthy Directions Registration & Consent

A

PLEASE PRINT CLEARLY

Complete the information below to register for participation in Healthy Directions. ***Your signature is required at the bottom of the form** to confirm you have read and understand what is involved in participating in Healthy Directions.

Employer: Hamilton County

First Name: _____ Last Name: _____

Date of Birth: __/__/____ Select One: Male Female

Home Address: _____ City: _____

State: _____ Zip Code: _____ Preferred Phone: ____-____-_____

Preferred Email: _____

Healthy Directions Program Participation Acknowledgement

My participation in the TriHealth Healthy Directions program is voluntary. I understand that initiating a follow-up examination to confirm results of any physical screening and obtaining professional medical assistance is my responsibility alone and not that of my health plan, employer Hamilton County or Bethesda Healthcare, Inc. /TriHealth, Inc.

Bethesda Healthcare, Inc. /TriHealth, Inc. will disclose to my (or my spouse's) employer that I had a physical and underwent laboratory testing. Bethesda Healthcare, Inc. /TriHealth, Inc. will make this disclosure in order for my employer to determine eligibility for any available incentive.

My employer will not have access to any of my specific medical information provided through the Healthy Directions Program.

My employer and/or health plan - will have access only to aggregate data to assess population trends. ("Aggregate data" does not personally identify me but combines my individually identifiable medical information with those of other participants in Healthy Directions for review.) Through my participation in the Healthy Directions program, I consent to all of the following:

- Receipt of aggregate data as described in the previous paragraph by my health plan/employer.
- Receipt of such aggregate data by my health plan/employer - wellness advisor, Bethesda Healthcare, Inc. /TriHealth, Inc.
- Disclosure of my personally identifiable biometric data/report by Bethesda Healthcare Inc. / TriHealth, Inc. to the third-party data analytic vendor specified by my health plan/employer- in order for such vendor to determine my eligibility for the incentive and/or for data aggregation as described above in this form.

I affirm that I have read, understand and agree to the terms set forth above, and I wish to participate in the Healthy Directions Program on the terms specified.



* Signature of Participant (Required)

*Date

Healthy Directions Authorization of Use and Disclosure of Protected Health Information



PLEASE PRINT CLEARLY

*Your signature is required at the bottom of the form to confirm you have read and understand what is involved in participating in Healthy Directions.

Participant's Name	Employer: Hamilton County
Date of Birth	Preferred Phone Number
Preferred E-mail address	

1. Provider Making the Use or Disclosure: I authorize Bethesda Healthcare, Inc. and TriHealth, Inc. (referred to hereinafter collectively as "TriHealth") to use and/or disclose my individually identifiable health information as described below.

2. Recipient of the Information: I authorize, Bethesda Healthcare Inc, /TriHealth and the third party data analytics vendor specified by my employer to receive and use the information described below.

3. Type of Information to be Released: I want the following information to be used and disclosed pursuant to this Authorization –

- Medical information that I provide directly to TriHealth, including biometric data.

4. Your Refusal to Sign this Authorization: TriHealth may not condition treatment or health plan enrollment or eligibility for benefits on whether or not you sign this Authorization. If you refuse to sign this Authorization TriHealth will not withhold treatment from you nor will your health insurer condition health plan enrollment or eligibility for benefits.

5. Purpose for the Use or Disclosure: The purpose for the use or disclosure is for my voluntary participation in TriHealth's Healthy Directions Program and in order for TriHealth and/or your employer to make individualized money incentive determinations, e.g., to determine "WellBucks" to award me. In addition, TriHealth and/or the third party data analytics vendor specified by my employer will use the information identified above to create and report aggregate (i.e. my data combined with those of other participants that does not personally identify me) information back to my employer or the employer's wellness program advisor individually identifiable medical information created or received by TriHealth in connection with the Healthy Directions Program will be shared with my employer.

6. Oral Communications: I understand that this Authorization allows TriHealth (and its employees) to discuss my individually identifiable health information described herein with the third party data analytic vendor specified by your employer.

7. Re-disclosure: I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the patient to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Ohio law. Ohio law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

8. Revocation: I understand that I may revoke this Authorization at any time by notifying TriHealth in writing by sending a letter to the address of Bethesda Healthcare, Inc., 11129 Kenwood Road, Cincinnati, Ohio, 45242, addressed to the Coordinator of the Healthy Directions Program I understand that if I revoke this Authorization, it will not affect any actions that TriHealth took before it received my revocation letter.

9. Expiration: This Authorization will expire one year after the date below.



* Signature of Participant (Required)

*Date

Biometric Measures & Physical Confirmation

Take this form with you to your scheduled annual physical to be **completed and signed by your Primary Care Physician**. It is the participant's responsibility to submit the Biometric Measures & Physical Confirmation form as part of the complete packet to be returned to Healthy Directions as outlined below.

Employer Name: Hamilton County

Participant Name: _____ Date of Birth: _____

Preferred Phone: _____ - _____ - _____ Preferred Email: _____

PHYSICAL CONFIRMATION

Type of Service Provided: **Complete Annual Preventive Physical** Date of Service: ____/____/____

***Signature of health care provider (required)**

Date Signed

- All testing must have been completed between 1/1/2016- 12/31/2016.
- Primary care physician needs to complete all information with an * in front of it. Return signed form to participant.

* Does your patient have a history of coronary artery disease (MI, CABG, PTCA)? YES NO

* Does your patient have a history of diabetes? YES NO

* If no, does your patient have pre-diabetes? YES NO

* Does your patient exercise weekly? If so, how often? _____ days/week _____ minutes/day

BIOMETRIC MEASURES	VALUE	TEST DATE (Month/Day/Year)
*Total Cholesterol		
*Triglyceride Level		
*Glucose (fasting)		
*HDL Cholesterol		
*LDL Cholesterol		
Hemoglobin A1c (if physician recommended)		
*Systolic Blood Pressure		
*Diastolic Blood Pressure		
*Height (in feet, inches)		
*Weight (in pounds)		
*Abdominal Circumference (in inches)		

Participant must submit completed packet by 1/6/2017.

Choose one:

- Scan and email to hamiltoncounty@trihealth.com
- Send to the secure fax 513 852 8595
- Mail to Healthy Directions, 11129 Kenwood Road, Cincinnati, OH 45242

Questions? Please contact hamiltoncounty@trihealth.com or call **513 977 2170**

The Online Health Risk Assessment



1. Click this link to access the online HRA:
<https://wellsuite.com/trihealthcorphealth/trihealthphs/default.aspx?grid=9d7f9b26851a>
2. You have between September 1, 2016- December 31, 2016 to complete your online Health Risk Assessment.
3. Please enter your USER ID and PASSWORD as follows:

USER ID is a combination of:

- The first four letters of your first name – _ _ _ _
- The first four letters of your last name -- _ _ _ _
- Your birth month and day – _ _ _ _

EXAMPLE:

John Smith, Date of Birth: Feb 3, 1954 would be JOHNSMIT0203

MY USER ID: _ _ _ _ _ _ _ _ _ _

PASSWORD: last 4 digits of your social security number

Once logged into the system, you will be asked to enter **DATE OF BIRTH**, **HEIGHT** and **WEIGHT** then click on **NEXT**. You will only be allowed to continue if you choose the **I Agree** button to the Terms of Use.

4. Click in the upper left-hand corner on **PERSONAL WELLNESS PROFILE**.
5. Next click on **START NEW ASSESSMENT** in the Blue Box and complete the questionnaire as accurately as possible and answer all questions. Click **NEXT** to continue to each page.
6. In the **PART 12: HEALTH TEST** section, please use your numbers from your Primary Care Physician visit.
7. Once the questions are completed, click **FINISH** at the bottom of the page.
8. **RENAME THE REPORT:** First Name Last Name and Date: John Smith 01.04.2010. Then click **SAVE & EXIT**.
9. You do not need to submit proof of complete the health risk assessment. Your completion will be reported to TriHealth.

Participant submit completed packet



All information must be completed and received by TriHealth on or before 1/6/2017.

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