

Move Your Life in a Healthy Direction *and realize the rewards!*



Why Take Part in Healthy Directions?

City of El Dorado cares about your health and wants to provide you with resources to help you live better both inside and outside of work. That's why we offer a voluntary wellness program for all employees and spouses covered by the medical plan called **Healthy Directions**, administered by TriHealth.

Program Incentive

Participants in Healthy Directions earn an incentive by taking a few simple steps to better understand their health, including scheduling an annual physical with their primary care physician (PCP). Once all required action steps are completed, participants will receive one of the following incentives: **A discount on health premiums: \$20 per month for single, \$40 per month for family if both employee and their spouse complete the program. Employees not on the health plan will receive a PTO day. Your incentive will be awarded the month following completion.**

Primary Care Physician (PCP)

Establishing a relationship with your primary care physician, someone familiar with your medical history and able to coordinate all aspects of your care, is an essential part of the Healthy Directions program. Together, you and your physician determine how best to improve your overall wellbeing.

Please note that City of El Dorado will not have access to any specific, personal health information through Healthy Directions.

Program Participation

This packet contains complete instructions and the forms needed to help you get started with Healthy Directions. Please read it carefully and complete all steps necessary to earn your incentive.

Questions?

Email: healthydirectionspcp@trihealth.com

Call: 866 256 9007

Action Steps for Participation

- Complete and sign the registration and consent form.
- Have an annual preventive physical with your primary care physician.
- Complete a standard lab-test blood draw that identifies biometric measures such as your cholesterol, glucose and triglyceride levels.
- Receive your incentive the month after you complete the necessary steps.

Enrollment Deadline

Participants in the TriHealth Healthy Directions Wellness Program must complete the necessary steps by **3/31/2017** and submit the completed packet by **4/30/2017**.

Welcome to Healthy Directions!

City of El Dorado's wellness program administered by TriHealth

Steps to Earning Your Incentive

A

Complete and sign the Registration & Consent Form*

* Required to receive your incentive

B

Schedule an annual preventive physical with your doctor

- Your physical must occur between **July 1, 2016- March 31, 2017**. 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 **April 30, 2017**. (See Step C 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 City of El Dorado health benefit plan network. If you need assistance in finding a physician, please go to www.umar.com.

C

Submit your completed packet by 4/30/2017

- Submit completed packet in its entirety in one of three ways:
 - ❖ Scan and email to healthydirectionspcp@trihealth.com
 - ❖ Secure fax 513 852 3166
 - ❖ 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 healthydirectionspcp@trihealth.com or call 866 256 9007.

Healthy Directions Registration & Consent

A

PLEASE PRINT CLEARLY

Complete the information below to register for participation in Healthy Directions. A separate form must be completed if both an employee and spouse choose to participate. ***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: City of El Dorado

First Name: _____ Last Name: _____

Previous/Maiden Name (if changed in last 12 months): _____

Date of Birth: __ / __ / __ __ __

Select One: Male Female

Select One:

Employee: Do you have a spouse on your City of El Dorado medical plan?

If yes, provide name: _____

Spouse of Employee: Provide name of City of El Dorado employee: _____

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 (or spouse's employer/health plan) 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 (or my spouse's) employer to determine eligibility for the incentive.

My (or my spouse's) employer will not have access to any of my specific medical information provided through the Healthy Directions Program.

My employer and/or health plan - or my spouse's employer/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's/employer's or my spouse's employer/health plan.
- Receipt of such aggregate data by my health plan/employer - or my spouse's health plan/employer - wellness advisor, USI Insurance Services LLC and USI Holdings Corporation ("USI").
- 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 -or my spouse's health plan/employer - in order for such vendor to determine my eligibility for medical insurance premium discounts 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

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: City of El Dorado

Participant Name: _____ Date of Birth: _____

Previous/Maiden Name (if changed in last 12 months): _____

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 **7/1/2016- 3/31/2017**.
- 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)		

C Participant submit completed packet by 4/30/2017

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