

HEALTH PLAN OF SAN JOAQUIN		
Subject: Initial Health Assessments		
Department: Medical Management – Quality Improvement		Policy #: QI 22
Applies to: Medi-cal		Scope: QI
Effective Date: 2/96	Revised Date: 1-08-09	Approved by: <i>Medical Director</i>

POLICY

The Initial Health Assessment (IHA) is a comprehensive assessment that is completed during the member’s initial encounter(s) with a selected or assigned primary care physician (PCP), appropriate medical specialist, or non-physician medical provider and must be documented in the member’s medical record. The IHA enables the member’s PCP to assess and manage the acute, chronic and preventive health needs of the member. The Health Plan of San Joaquin (HPSJ) is responsible for provider training, informing members and creating written procedures to assure provision of an Initial Health Assessment (IHA) and (Individual Health Education Behavioral Assessment) to each new member; unless a valid reason for exemption exists. Primary care providers are notified of each assigned member’s effective date of enrollment and the need for an IHA and IHEBA. For members under the age of 18 months, an IHA and IHEBA are to be performed within 60 days of enrollment, or within periodicity timelines established by the American Academy of pediatrics for ages two (2) and younger whichever is less. For members 18 months of age and older the IHA and IHEBA is to be within 120 days of enrollment.

PROCEDURE

- A. Enrollment** - Upon HPSJ receipt of member enrollment information, from the enrollment FAME membership file from DHS, the following steps will occur:
1. Prior to contracting, the PCP’s are educated on IHA during a pre-Facility Site Review (FSR) training and are audited for compliance during each FSR. This education includes adequate documentation of the IHA components and timeline requirements of an IHA or the reasons IHAs were not completed. Education to providers includes procedures to assure that visit(s) for the IHA are scheduled and that members are contacted about missed IHA appointments.
 2. Upon contract approval, PCP’s are educated by the Provider Services (PS) Department on how to access eligibility lists via the intranet and requirements to schedule and complete an IHA including the components and timeline requirements of an IHA.
 3. The monthly eligibility lists, including newly enrolled members are made available to PCP’s on the intranet. E-mail reminders are auto-generated to providers when their monthly eligibility listings are available for viewing. The PS Dept faxes monthly eligibility lists to providers who do not have Internet access.
 4. Outreach calls are made to the new members by the MS outreach staff each month.

5. A welcome to HPSJ letter is sent to members on the first of each month along with their HPSJ identification cards (ID) with the name of the PCP recorded on it. Members who have not chosen a PCP will receive a welcome to HPSJ letter with a temporary ID card. These members are instructed to contact HPSJ as soon as possible to select a PCP. Members, who do not select a PCP within 30 days, will have one auto assigned to them. The MS Department will designate a default assignment of a PCP based on demographic and language criteria. The member is notified by mail of the newly assigned PCP and provided with a new ID card.
6. The Marketing Department prepares all membership material and has it ready to mail out in the new membership mailing. When possible, the Marketing Department provides members with material that is easy to understand, is culturally appropriate, and is in the member's identified language. If member material is not available in the appropriate language, the member is instructed to phone the health plan so provisions may be made for a translator. The welcome letter included in the new member mailing encourages members to contact their PCP and make an appointment for an IHA. Also included in the new member mailing is an IHA flyer that encourages members who have not had a physical exam in the past year to schedule an appointment with their PCP for an IHA. The flyer also informs the member of what services will be provided during the visit and what information to have available during the IHA such as immunization records and current medications.

B. Initial Health Assessment Components

1. **Comprehensive History** – Providers will document the history which must be sufficiently comprehensive to assess and diagnose acute and chronic conditions which includes, but is not limited to the following:
 - a. **History of Present Illness**
 - b. **Past Medical History** such as: prior major illnesses and injuries, prior operations, prior hospitalizations, current medications, allergies, age appropriate immunization status, age appropriate feeding and dietary status
 - c. **Social History** such as: Marital status and living arrangements, current employment, occupations history, use of alcohol, drugs, and tobacco, level of education, sexual history and any other relevant social factors
2. **Preventive Services**
 - a. **Asymptomatic Healthy Adults** – Providers must adhere to the current edition of the guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF), specifically USPSTF “A” and “B” recommendations for providing preventive screening, testing and counseling services. Status of current recommended services must be documented.
 - b. **Members Under 21 Year of Age** – Providers must provide preventive services for all members less than 21 years of age as specified by the most recent American Academy of Pediatrics (AAP) age specific guidelines and periodicity schedule including immunizations and the provision of required

- l. Safety Prevention
- m. Tobacco Use and Exposure

C. Who Can Perform the IHA

- 1. Member's PCP of Record** – When any person other than the member's PCP performs the IHA, the PCP must ensure that documentation of the IHA is contained in the member's primary medical record, and completed in an accurate and comprehensive manner. PCP's include California licensed physicians qualified to serve as general practitioners, specific board certified or board eligible physicians in; Internal Medicine; Pediatrics; Obstetrics/Gynecology; or Family Practice. Non-Physician Mid-Level Practitioners include Nurse practitioners, certified nurse midwives, physician assistants, and PCPs in training.
- 2. Perinatal Care Providers** – A plan provider who cares for the member during pregnancy may provide the IHA through the initial prenatal visit(s), and must document that the prenatal visit(s) met IHA content and timeline requirements.

D. Timeliness for the Provision of an IHA

- 1. New Plan Members** – All new plan members must have a complete IHA within 60 for ages 18 months or less, or 120 calendar days, for ages >18 months, of enrollment. If the member request or the plan initiates a change in their PCP within the first 60 or 120 days of enrollment and the IHA has not yet been completed, the IHA must be completed by the newly assigned PCP within the established timeline for new members.
- 2. The Effective Date of Enrollment** – is defined as the first of the month following notification from the DHCS that the member is eligible to receive services from the plan and capitation will be paid as long as the member is not on "hold" status.
- 3. For Infants Born to Plan Members** - the effective date of enrollment is the date of birth. Such infants are the responsibility of Health Plan under mother's enrollment and are covered for all medically appropriate plan services from date of birth through the last day of the following month. Thereafter, the infant is identified by his/her own member number.
- 4. In Case of Retroactive Enrollment** – the effective date, for purposes of determining the time-frame for performing the IHA, is the date the plan receives notification of the member's enrollment.

E. Exceptions from IHA Requirements – Exceptions from the timeline requirements described above can occur only in the following situations, and only if documented in the medical record:

- 1. Completed 12 Months Prior to Enrollment** – All elements of the IHA were completed within 12 months prior to the member's effective date of enrollment. If the member's plan PCP did not perform the IHA, the plan PCP must document in

the member's medical record that the findings have been reviewed and updated accordingly.

2. **New Plan Members Who Choose Their Current PCP** – For new Health Plan members who choose their current PCP as their new plan PCP provider, an IHA still needs to be completed within 60 days for ages 18 months or less, and within 120 days for ages over 18 months, of enrollment. The current established PCP may incorporate relevant patient historical information from the member's old chart. However, the PCP must conduct an updated physical exam if the patient has not had a physical exam within 12 months of enrollment.
3. **Member Not Continuously Enrolled** – member is not continuously enrolled in the plan for the required number of days.
4. **Disenrolled Members** – member was disenrolled from the plan before an IHA could be performed.
5. **Members Refusing an IHA** – The member, including emancipated minors or a member's parents or guardian, refusing an IHA. When notified of such, the Health Plan will attempt to offer these members referral or reassignment to another PCP.
6. **Missed Scheduled Appointment** – the member missed a scheduled PCP appointment and two additional documented attempts to reschedule have been unsuccessful. The documentation must include:
 - a. One attempt to contact the member by telephone with the telephone number provided by Health Plan; and
 - b. One attempt to contact the member by letter or postcard sent to the address provided by Health Plan; and
 - c. Health Plan or the PCP has made a good faith effort to update the member's contact information, including updating information received from the Post Office for any change in address and from dialing Directory Assistance for any new telephone number; and
 - d. Attempts to perform the IHA at any subsequent member office visit(s), even if the deadline for IHA completion has elapsed, until the IHA is completed or the member is disenrolled from the plan.

F. Monitoring/Reporting for IHA/IHEBA

1. The HPSJ MIS staff maintains a report program that is run monthly for the Quality Improvement (QI) staff. The report of enrolled members is a listing of members that became eligible two months prior to the report month. For example, a report run for the month of October lists new members that were eligible August 1st. This two-month lag time allows sufficient time for submission of IHA claims and reduces mistaken notification to physicians and members that an IHA/IHEBA has not been received.
2. By the tenth of every month, the QI staff will send letters to the individual PCPs along with listings of members requiring IHAs. The letters serve to remind and to educate the PCPs about the IHA /IHEBA requirement for each new patient and to

outline steps for compliance. Additionally, HPSJ sends a template member letter and member mailing labels to assist the PCP with member outreach.

3. The PCP offices will notify those members who have not had an IHA and will arrange an appointment for them. All attempts to contact the member shall be documented. The provider will return notification of the attempts to the QI department, showing efforts.
4. The QI Department will monitor the number of eligible members receiving their initial health assessments, those physicians whose members receive the IHA/IHEBA and report findings to the Quality Improvement/ Utilization Management Committee on a semi-annual basis.
5. The QI nurses during the facility medical record audit will ensure that the members' completed IHA/IHEBA tool is contained in the member's medical record and available during subsequent preventive health visits. The QI Department also offers provider office training relating to FSR and Medical Record Components, including the IHA and Staying Healthy Assessment Tool.
6. Additionally, through the member complaint and grievance log, the QI Department will monitor for trends and patterns that indicate whether providers or groups of providers are honoring their responsibilities relative to prompt scheduling of initial health assessments as well as following the CHDP required schedule.

The Provider Manual documents the requirements for IHAs/IHEBA including the requirement that IHAs/IHEBA's are completed within 120 days of enrollment.

REFERENCE

- A. Title 22, CCR, Section(s) 53851 and 53910.5, 53902
- B. Medi-Cal Managed Care (MMCD) Policy Letter No. 08-003

Created by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date
02-1-96	04-10-03	S.Steely 2/25/05	SAldred 3/13/06	L.Ortega 08/28/08	L. Ortega 1-8-09 Approved by QIUM Committee