Initial Health Assessment (IHA)

Network Medical Management

Health Services Department

IHA Overview

- **An IHA consists of a history and physical examination and a health education behavioral assessment that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs.**
- IHA is performed within 90 days of enrollment or within the past 12-months for annual assessments
- PO shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented. (*Documented attempts that demonstrate PCP's unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement*)
- The IHA, at a minimum, must include a physical and mental health history, and completion of the age-appropriate Staying Healthy Assessment (SHA) form with all elements addressed

IHA Requirements

- **The initial and annual complete physical and mental health history exam includes, but is not limited to:**
  - Present and past illness(es) with hospitalizations, operations and medications
  - Physical exam including review of all organ systems including but not limited to:
  - Height and weight
  - Blood pressure
  - General appearance
  - BMI
  - Total serum cholesterol
  - Clinical breast exam
  - Pap smear on all women determined to be sexually active, regular screening may be discontinued after age 65 on those participants who have had regular screening with consistent normal results
  - Tuberculosis Screening: All Members will receive TB testing upon enrollment and annual screening will be part of the annual history and physical (*this can be screening but there needs to be documentation of risks, high, low, etc.*)

American Academy of Pediatrics (AAP) and California Child Health and Disability Prevention (CHDP) Guideline

for age 21 and under

- All gender-specific, age-related screenings are present.
- For members under 21 years of age, the medical record includes a documented age-appropriate assessment per the American Academy of Pediatrics (AAP) and California Child Health and Disability Prevention (CHDP) guidelines and periodicity tables.
- The medical record includes documented blood pressure, height, and weight, as age-applicable.
- Documented referral to the Women, Infants, and Children (WIC) program for pregnant, breastfeeding, or postpartum women or parent/guardian if applicable.
- The IHA was performed within 120 calendar days of enrollment, or for ages 2 or younger, within periodicity timelines established by the AAP, whichever is less.
- Three (3) documented outreach attempts if no IHA appointment scheduled.
- Two (2) outreach attempts (1 verbal and 1 written) for missed appointments
- Member refuses. Must document and encourage member to contact Health Plan for provider re-assignment.
- For members under the age of 18 months, the IHA also must be completed within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages 2 or younger, whichever is less.

USPSTF Guideline

for age 65 and older

- Aortic Aneurysm Screening
- Bone mass measurement
- Breast Cancer Screening (mammograms)
- Cardiovascular Disease Testing/Risk Reduction Visit
- Cervical and Vaginal Cancer Screening
- Colorectal Cancer Screening
- Depression Screening
- Diabetes Screening
- HIV Screening
- Immunizations (per CDC guidelines)
- Trichomonas
- Herpes
- Intimate Partner Violence Screening
- Folic Acid Supplementation
- Screening and Counseling to reduce alcohol misuse
- Screening for lung cancer with low dose computed tomography (LDCT)
- Chlamydia screen for all sexually active females who at high-risk
- Gonorrhea/Syphilis screening/Sexually Transmitted Infections Counseling
- Hepatitis B screening; Hepatitis C screening
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Skin Cancer Behavioral Counseling
- Blood pressure screening: adults
- BRCA risk assessment and genetic counseling/testing
- Breast cancer preventive medications
- Fall prevention: older adults
- Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater
- Mental health and status evaluation
- Social history
- Sexual history
- Use of alcohol, tobacco and drugs
- Diagnosis and plan of care

Staying Healthy Assessment (SHA) Overview

- SHA is the DHCS-sanctioned IHEBA (Individual Health Education Behavioral Assessment) and is a required IHA component:
  - Available in 9 age categories and 12 languages
  - To be updated annually during well visits and as patient enters a new age group
  - Provider must review SHA with patient and provide an intervention for high risk areas
  - Staying Healthy Assessment Questionnaires (ca.gov)

IHA Criteria –ALL MEMBERs

The IHA was performed within 90 days for Covered Members, and within 120 days for Medi-Cal from the date of enrollment
If IHA has not been completed, the medical record reflects attempts to schedule IHA per Health Plan policy
If the IHA has not been completed due to Missed appointments, **the MR reflects documented missed appointments and at least two (2) attempts for follow-up, as appropriate**
If the member refused an IHA, documentation includes evidence of the member refusal within IHA timeframes.
The medical record reflects diagnostic, treatment and follow-up services for **symptomatic findings or risk factors** identified in the IHA within 60 days following discovery. Evidence that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.
The medical record reflects a SHA/IHEBA assessment has been: a) administered and reviewed by the primary care provider during an office visit, b) reviewed at least annually by the primary care provider with Members who present for a scheduled visit, and c) re-administered by the primary care provider at the appropriate age intervals.
The medical record reflects TB assessments for all members
The medical record includes a documented testing for TB in the IHA.(high risk) screening for TB risk factors including a Mantoux skin test on all persons determined at high risk
Initial and annual assessment of tobacco use for each adolescent and adult member
The medical record reflects that the HPV immunization was offered to age appropriate - Male & Female. (9-26).
Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
The medical record reflects a dental screening /oral assessment and dental referral starting at age 3 or earlier, if warranted
Evidence that member and family education, including healthy lifestyle changes when warranted is provided
Coordination of carved out and linked services, and referral to appropriate community resources and other agencies are found in medical records
The medical record includes identification, treatment and follow-up on obese members
The medical record includes documented age-appropriate immunizations

IHA Criteria –Age 0-21 yrs

For Members under 21 Years of Age the medical record reflects completion of an age appropriate IHA according to the most recent edition of the American Academy of Pediatrics (AAP) age specific guidelines and periodicity schedule. The IHA must also include an age specific assessment and services required by the Child Health and Disability Prevention Program (CHDP).
The medical record includes documented lab testing/Screening: (b) Required screening procedures. Unless medically contraindicated or deemed inappropriate by the health assessment provider, or refused by the person, health assessments shall include the following procedures: (1) Health and developmental history. (2) Unclothed physical examination including assessment of physical growth. (3) Assessment of nutritional status. (4) Inspection of ears, nose, mouth, throat, teeth and gums. (5) Vision screening. (6) Hearing screening. (7) Tuberculin testing and laboratory tests appropriate to age and sex, including tests for anemia, diabetes and urinary tract infections...
The medical record includes documented **lab testing for anemia at 12 months**
The medical record includes **documented lab testing for diabetes for age 5 years and over who are at risk**
The medical record includes a documented testing for lead poisoning in IHA (if appropriate). (Lead level checks at ages 12 mos. or 24 mos.) Lead level range-above 15 should be referred to Los Angeles Lead Program
The medical record includes documented testing for Sickle Cell (SCA) trait in the IHA (if appropriate)
The medical record includes documented **lab testing for anemia at 12 months**
The medical record includes **documented lab testing for diabetes for age 5 years and over who are at risk**
The medical record includes a documented testing for lead poisoning in IHA (if appropriate). (Lead level checks at ages 12 mos. or 24 mos.) Lead level range-above 15 should be referred to Los Angeles Lead Program

IHA Criteria –ADULT & FEMALE

ADULT MEMBERS
For **Asymptotic Adults**, the medical record reflects completion of an age appropriate IHA according to the most current edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) as documented by a history & physical & review of organ systems
The medical record includes colon and rectal cancer screening for **adults 50 years to 75 years old**
Performance of the initial complete history and physical exam for adults includes, but is not limited to: **a) blood pressure,** **b) height and weight,**
24. Performance of the initial complete history and physical exam for adults includes, but is not limited to: **c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over**

FEMALE MEMBERS
The medical record includes a documented **clinical breast examination over the age 40 years of age**
The medical record includes a **documented Mammogram at age 50 to 74 years.**
The medical record includes **documented Osteoporosis screening for females 65 years and older**
Chlamydia screen for Sexually active women, including pregnant persons. The USPSTF recommends screening for chlamydia in **all sexually active women 24 years or younger** and in **women 25 years or older who are at increased risk for infection.**
Screening for cervical cancer in women age 21 to 65 years with cytology (Pap smear) every 3 years (or arrangements made for performance) on all women determined to be sexually active The USPSTF recommends screening for **cervical cancer every 3 years with cervical cytology alone** in women aged 21 to 29 years. The USPSTF recommends **screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting)** for women aged 30 to 65 years.
Documented referral to the Women, Infants, and Children (WIC) program for: (i) pregnant, (ii) breastfeeding, or (iii) postpartum women or (iv) parent/guardian of children or children under the age of five (5).