



Initial Health Appointment

Requirements

New members must receive a comprehensive Initial Health Appointment within the first 120 days of enrollment with Contra Costa Health Plan (CCHP).

Initial Health Appointment (IHA) consists of:

- A history of the Member's physical and mental health
- An identification of risks
- An assessment of need for preventive screens or services using the most current US Preventive Services Task Force A&B Recommendations (see link below)
- Health Education
- The diagnosis and plan for treatment of any diseases

All services must be provided in a way that is culturally and linguistically appropriate for the member.



Initial Health Assessment



Exemptions

CCHP will consider providers compliant with member IHAs if **any** of the following exemptions are documented in the patient's medical record.

- All elements of the IHA have been completed within 12 months of the member's effective date of enrollment, and the provider has reviewed/updated the member's medical record.
- If the provider is able to incorporate relevant information from the member's existing medical record and has received a physical exam within 12 months of the member's effective date of enrollment.
- The member loses his or her eligibility prior to the performance of the IHA.
- The member refuses the IHA (The provider should document the refusal in the medical record.)
- Two documented contact attempts in which the member was non-responsive.

Resources



Follow the *U.S. Preventive Services Task Force* (USPSTF) preventive care standards and guidelines during patient visits. These guidelines can be accessed and downloaded at

<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations>



A full list of CCHP's preventive guidelines can be found at our website:

<https://cchealth.org/healthplan/clinical-guidelines.php>

Initial Health Assessment



Best Practices



Schedule appointments with new members and send reminders prior to the appointment. IHAs require extended visits, so schedule these visits with enough time to complete a full assessment and plan of care.

Document all outreach attempts.



Follow up on all identified high-risk behaviors and needed care through health education, referrals, and provision of needed preventive care.

Document all preventive care, physical and behavioral health assessments, health education and counseling, referrals to specialists or community organizations, and follow up care and treatment provided to patients.

