Gold Coast Health Plan℠
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Memorandum

To: Gold Coast Health Plan Skilled Nursing Facility Providers

From: Vicki Wrighster, Senior Director, Provider Network Operations

Re: **Initial Health Appointments, Health Risk Assessment, and IHA Reports and Outreach Logs**

Date: June 27, 2025

We would like to share the following three important updates regarding Gold Coast Health Plan's (GCHP) health services requirements:

1. Initial Health Appointment:

As of Jan. 1, 2023, the Initial Health Appointment (IHA) requirement states that each primary care provider (PCP) must complete and periodically re-administer a comprehensive IHA, in accordance with the state Department of Health Care Services (DHCS) Population Health Management (PHM) Policy Guide, for all newly assigned members **within 120 days** of the member's enrollment. The IHA consists of a history of the member's physical and behavioral health, identification of risks, assessment of need for preventive screens or services and health education, and the diagnosis and plan for any treatment of any diseases. For members less than 18 months of age, the IHA must be completed within 120 calendar days of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures, for members 2 years of age and younger, whichever is sooner. The IHA is not necessary if the member's PCP determines that the member's medical record contains complete information that was updated within the previous 12 months.

The IHA must be provided in a way that is culturally and linguistically appropriate for the member. PCPs shall offer translation, interpretation, and accommodations for any disability, if necessary. PCPs and their staff may contact GCHP's Cultural and Linguistic Department at CulturalLinguistics@goldchp.org for more information.

2. Health Risk Assessment:

An essential component of the IHA, the Health Risk Assessment (HRA), relates to the health and social needs of members, including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH).

An HRA is a patient questionnaire that covers personal and family medical history, lifestyle factors, SDOH, and other relevant health information. The HRA helps health care providers evaluate a patient's overall health status and identify risk factors based on the patient's self-reported responses. Providers who effectively identify and manage risk factors can significantly reduce the number of chronic conditions that develop, which improves patient outcomes and decreases health care costs significantly.

While there is no specific format for the HRA, it must address the following questions / topics as appropriate for age:

- Demographic data
- Self-assessment of health status, frailty and physical functioning
- Biometric assessments
    - Height, weight, body mass index (BMI)
    - Systolic / diastolic blood pressure
    - Blood lipids
    - Blood glucose
- Psychosocial risks
    - Depression / life satisfaction
    - Stress / anger
    - Loneliness / social isolation
    - Pain / fatigue
- Behavioral risks
    - Tobacco / drug use
    - Physical activity
    - Nutrition and dental / oral health
    - Alcohol consumption
    - Sexual history / practices
    - Motor vehicle safety (e.g., booster seat use, seat belt use)
    - Home safety

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH include housing instability, food insecurity, transportation needs, utility needs, interpersonal safety, etc. The Social Needs Screening Tool, created by the American Academy of Family Physicians, is one example of a screening tool that providers can use as a member risk assessment.

For members 65 years of age and older, cognitive health assessments can help identify whether members have signs of Alzheimer's disease or related dementias. Examples of validated screening tools include the General Practitioner Assessment of Cognition, the Mini-Cog, and the Eight-item Informant Interview to Differentiate Aging and Dementia.

Adverse Childhood Experiences (ACEs) are potentially traumatic experiences, such as neglect, experiencing or witnessing violence, having a family member attempt or die by

suicide, household with substance abuse problems, mental health problems and other experiences that occur in childhood that can affect individuals for years and impact their life opportunities. Two examples of validated screening tools are the Adverse Childhood Experience Questionnaire for Adults and the Pediatric ACEs and Related Life Events Screener (PEARLS).

The state Department of Health Care Services (DHCS) removed the Staying Healthy Assessment (SHA) requirement in January 2023. However, we have encouraged continued use of the SHA to meet screening requirements for risk assessments such as sexual health, safety, nutrition, and tobacco / drug / alcohol use. Per DHCS, the SHA will no longer meet the standards for these risk assessments. GCHP is awaiting further guidance to include the implementation date for new approved screening tools, which will be the date that the SHA will no longer be accepted. **GCHP recommends that you begin to pivot away from use of the SHA and utilize individual approved screening tools.**

3. IHA Reports and Outreach Logs:

GCHP's Quality Improvement (QI) Department will continue to distribute monthly IHA outreach lists of newly assigned members to each provider site. These reports are designed and intended to be used for documenting your mandatory IHA outreach attempts. These logs must be completed using the GCHP standardized process for timely IHA outreach log completion and submission.

IHA monthly outreach logs must be submitted to IHA@goldchp.org once completed. GCHP's QI nurses will review all submitted outreach logs for quality assurance and assessment of compliance with IHAs within the 120-day period.

Providers and their staff can e-mail IHA@goldchp.org for:

- Continuing education and training related to the IHA and outreach logs
- Submission of IHA outreach logs
- Updating contact information for recipients of the IHA monthly report

IHA Resources

- IHA Billing Codes
- United States Preventative Services Task Force
- Bright Futures Periodicity Table
- Comprehensive Health Assessment Forms
- Staying Healthy Assessment Questionnaires
- Social Needs Screening Tool

If you have any questions or need further assistance, contact us at QualityImprovement@goldchp.org.

Thank you for your understanding and continued support.