INITIAL HEALTH APPOINTMENT TOOLKIT FOR PROVIDERS & STAFF: PATHWAY TO SUCCESS

Using a structured, evidence-based approach, transform the IHA from a passive requirement to an active, member-centric experience that establishes trust and promotes long-term engagement with your patients.

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Final Compliance Attestation Footer

Document Integrity Warning: *Regulatory compliance for Medi-Cal Managed Care and Medicare Advantage programs is subject to rapid modification by state and federal entities. This document was last verified for baseline accuracy in* ***June 2026****. Users must cross-reference this version number against current DHCS and CMS active transmittals to ensure validity prior to clinical deployment..*

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Quality & Population Health Management


Preventive Care & Screenings
Patient Relationship
Electronic Health Record (EHR)
Diagnosis & Treatment
Medication Management
Health Education & Counseling Fitness
Referral to Specialists
Vaccination & Immunization
Lifestyle Management (Nutrition)
Patient Portal
Continuous Care & Follow-up

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Disclaimer

The information provided in this guidebook is intended for informational and educational purposes only. While every effort has been made to ensure the accuracy and completeness of these guidelines, the ultimate responsibility for clinical compliance, documentation accuracy, and adherence to all state and federal regulations remains with the provider and their clinical staff.

Providers are encouraged to regularly consult the latest Department of Health Care Services (DHCS) updates, Medi-Cal Managed Care Plan contracts, and professional coding standards to ensure full compliance with evolving Initial Health Appointment (IHA) and CalAIM requirements. Use of this toolkit does not guarantee specific audit outcomes or reimbursement.

Overview

Welcome to the Initial Health Appointment (IHA) Toolkit, a comprehensive resource designed to support providers, care teams, and administrative staff in delivering timely, high quality, and person-centered care to Medi-Cal and Medicare Advantage members. Why should you prioritize the IHA? Because when every new member is healthy, heard, and well-cared for from day one, you are building a foundation of trust that keeps our community out of the emergency room and on the path to wellness.

San Francisco Health Plan has developed this resource to help you standardize and optimize Initial Health Appointment (IHA) compliance. Utilizing a "Pathway to Success" model, this toolkit gives you the tools you need to support your practice in delivering high-value patient outcomes. Its goal is to transform the IHA from a "passive requirement" into an "active, member-centric experience" designed to build long-term trust with patients.

This central hub simplifies regulatory requirements by providing clear guidelines, practice-ready tools, billing references, and outreach standards.

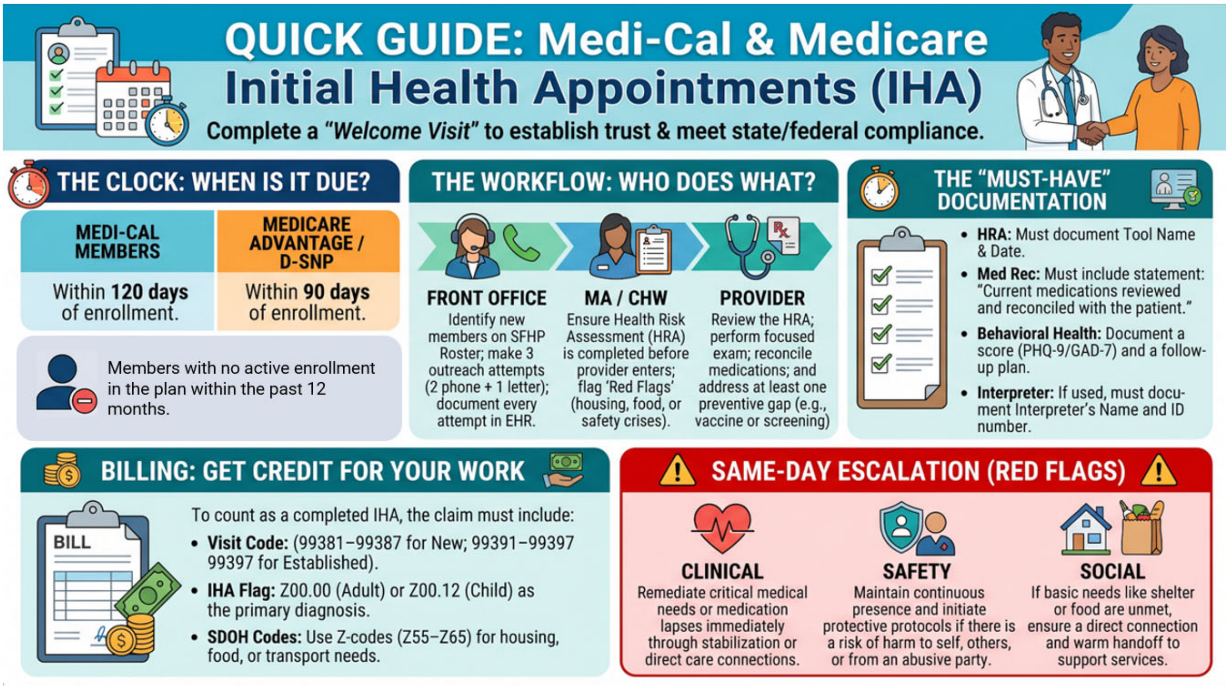
Key Takeaway:

- **The "Pathway"**: A clear, step-by-step guide for everyone to follow.

Core Components

This document provides a comprehensive framework for managing new patient intakes, including:

- **Regulatory Compliance**
- **Clinical Workflows**
- **Operational Job Aids**
- **Decision Support**
- **Timelines & Applicability**



Initial Health Appointment (IHA) Toolkit

1. Introduction

1.1 Purpose of the Toolkit

The IHA is the member's first comprehensive touchpoint with the health care system after enrollment. This toolkit standardizes how your organization completes the IHA tool:

- Identify medical, behavioral, functional, and social needs early
- Initiate preventive services and chronic disease management
- Close gaps in care and reduce avoidable ED/inpatient utilization
- Improve member experience, engagement, and retention
- Ensure documentation supports quality, risk adjustment, and audit readiness
- To shift the IHA from a passive requirement to an active, member-centric experience that establishes trust and promotes long-term engagement
- Streamlining the IHA process requires better data accuracy and clearer compliance guidelines for all parties, even with existing completion barriers

1.2 Overview of the IHA

An IHA typically includes:

- Health Risk Assessment (HRA) (often required within a defined timeframe)
- Comprehensive history and problem list development
- Medication reconciliation
- Preventive screening review (age/sex/risk-based)
- Behavioral health screening
- Social Drivers of Health (SDOH) screening and referrals
- Initial care plan with prioritized goals and follow-up

1.3 Applicability to Medi-Cal and Medicare Advantage

This toolkit is designed to work for:

- Medi-Cal managed care members, including seniors, persons with disabilities, and/or complex care cohorts
- Medicare Advantage members, including Special Needs Plans (SNPs) if applicable
- Delegated and non-delegated provider networks
- Primary care, FQHC/RHC, and medical groups with embedded care management

1.4 How to Use This Toolkit

Team Role	Primary Sections to Review	Key Tools to Use	Main Responsibility
Front Office & Scheduling	Section 3 – Workflows & Operational Guidance	Member Roster Tip Sheet (App D); Outreach Scripts (App E)	Identify new members and complete required 3attempt outreach
Clinical Support (MA/LVN/RN)	Section 4 – Components of the IHA	IHA Care Coordination Checklist (App I); Screening Tool Resources (App R)	Complete behavioral health & SDOH screenings prior to provider visit
Rendering Providers	Sections 4 & 5 – Clinical Documentation; Coding & Billing	Documentation Tip Sheets (App G); EMR Templates (App H)	Ensure audit ready notes, medication reconciliation, closed loop referrals
Quality & Care Management	Section 7 – Quality, Audit & Monitoring	Audit Tool Scorecard (App W); Process Improvement Tool (App Y)	Monitor IHA completion and address performance gaps
Clinic IHA Point Person (other labels may be: IHA Champion, IHA Subject Matter Expert, IHA Lead, etc.)	Section 6.1 – IHA Leadership	IHA Clinic Point Person (App V)	Ensure compliance; liaison with SFHP

1.5 Provider and Staff IHA Training

Access to SFHP's Litmos Provider Training Link can be found here from the SFHP website.

Appendix A: Where to Access Provider and Staff Training

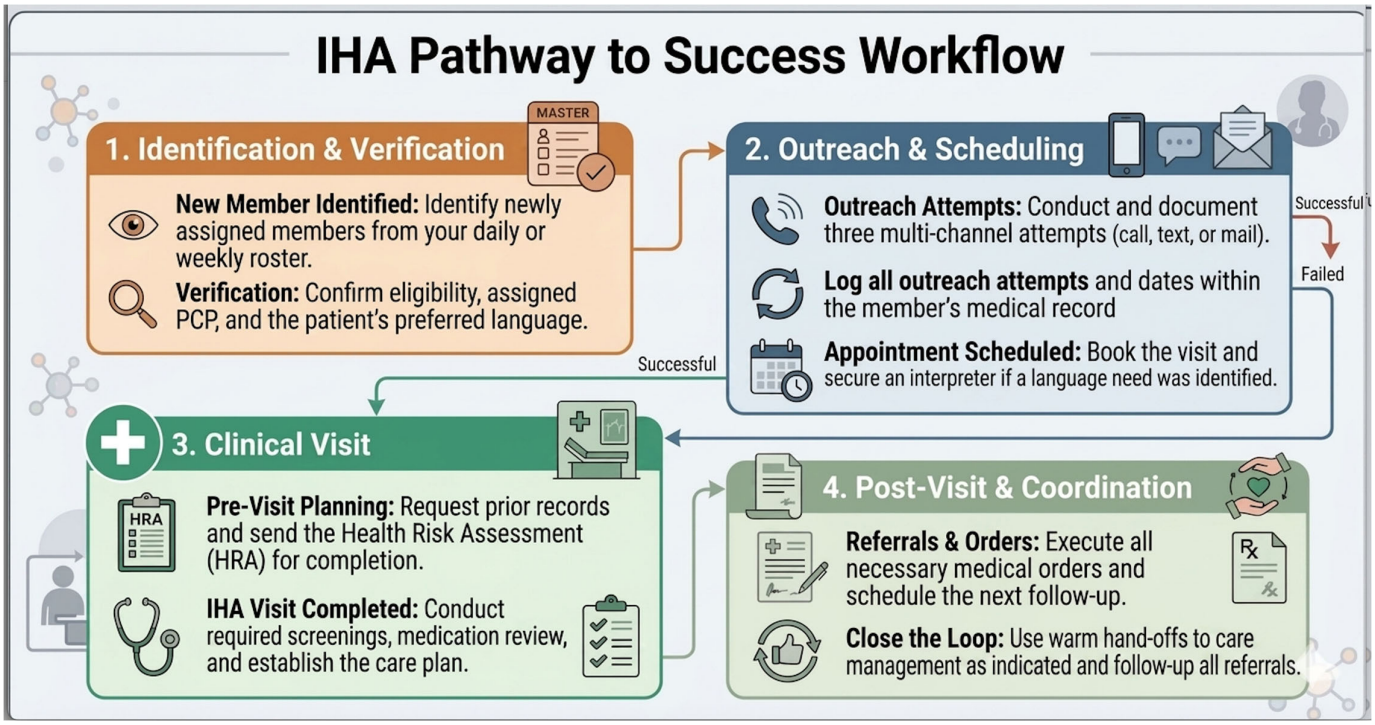
Additional training will be available on the Litmos platform in the near future. In the interim, refer to the SFHP IHA website for current guidance and resources. (Link to website)

To prepare for future training:

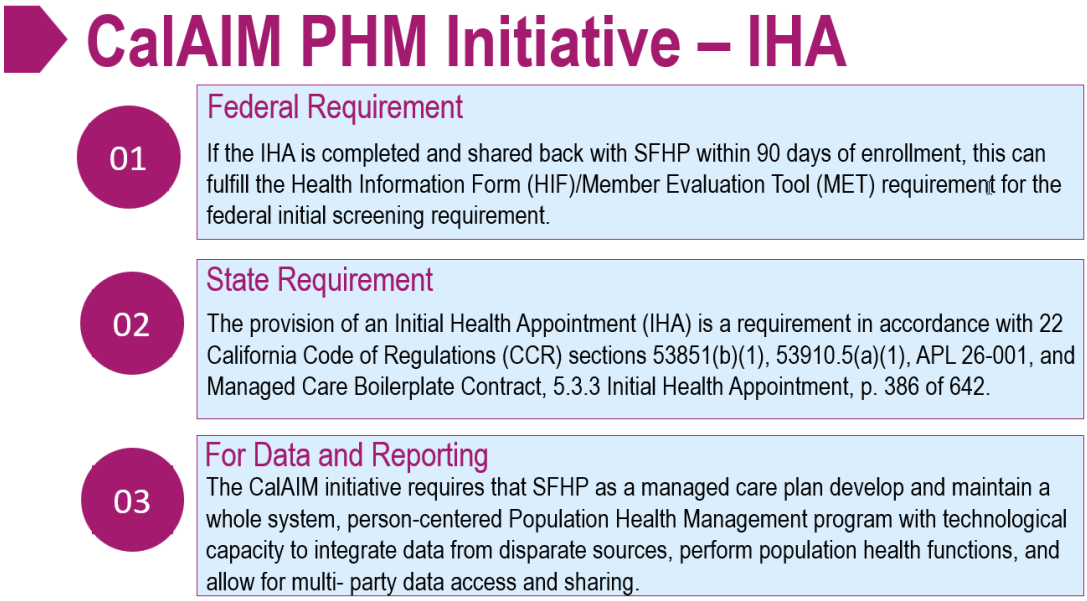
- Create a Litmos account using this link.
- Retain login credentials for future access to training.
- Sign-up for the provider's newsletter to learn when the training becomes available (link to provider newsletter).

1.6 “Pathway to Success” Roadmap

Appendix B: IHA Quick Guide



2. Regulatory and Compliance Requirements



2.1 State and Federal Requirements (High-Level)

Ensure the following:

- Timely completion of an initial assessment/visit after enrollment (timeframes vary)
- Completion of an HRA and documentation of required elements
- Demonstrated follow-up on identified needs (referrals, care management, etc.)
- Evidence of outreach attempts if member is unreachable or declines

2.2 Medi-Cal IHA Standards

- Required timeframes (e.g., within 120 days of enrollment)
- Required elements (HRA, comprehensive history, preventive review)
- Required screenings (behavioral health, SDOH, substance use, etc.)
- Member outreach requirements (3 outreach attempts, 2 phone + written, documentation)

2.3 Medicare Advantage Initial Visit / Annual Wellness / HRA Requirements

Medicare Advantage requirements commonly emphasize:

- Required timeframes (e.g., within 90 days of enrollment)
- Comprehensive risk assessment and documentation
- Chronic condition identification and accurate problem list maintenance
- Medication review and reconciliation
- Preventive services and immunizations
- Care planning and follow-up

2.4 Timeliness Standards

Timeliness standards ensure the IHA and HRA are completed before clinical or social needs escalate. Strict adherence to due dates and rapid follow-up for urgent findings—like suicidal ideation or uncontrolled BP—prevent gaps in care. Diligent referral tracking creates a high-reliability system where no "red flag" is left unmanaged. **Appendix C: IHA Timelines**

Best Practice Tip: Initial Health Appointment Timeliness Chart

Line of Business (LOB)	Requirement	Timeliness Expectation
Medi-Cal	Initial Health Appointment (IHA)	Within **120 calendar days** of enrollment.
Medicare Advantage	Health Risk Assessment (HRA)	Within **90 days** of initial enrollment and annually thereafter.
Medicare Advantage	Ongoing Monitoring - Covered as needed based on medical necessity to manage specific concerns.	Generally covered every 3 months.
Both	Urgent Findings	Follow-up action or appointment within 48 hours.
Both	Preventive Care Risks	Advice and referrals must be provided during or shortly after the visit.
Both	Non-Urgent Primary Care: For routine follow-up on non-urgent findings	The standard is usually within **10 business days**.
Both	Specialist Referral: For findings requiring a specialist	The appointment must be available within **15 business days**.
Medi-Cal (CalAIM)	Referral Completion Tracking (Closed-Loop)	Status updates must be collected at least **monthly**.

2.5 Required Elements and Documentation Standards

At minimum, standardize documentation for:

- Member identification, eligibility verification, consent
- HRA results (and tool used)
- Past medical/surgical history; family history; social history
- Medication list + reconciliation statement
- Allergies
- Vital signs (as applicable) and physical assessment
- Preventive screening status + plan
- Behavioral health and SDOH screening + interventions
- Assessment/problem list and plan
- Referrals and follow-ups (who/what/when)
- Member education and shared decision-making
- Interpreter used (if applicable)

Best Practice Tip: Sample IHA Example Policy

Sample_IHA_Clinic_Policy.docx

2.6 IHA Exceptions: Compliance and Completion Criteria

2.6.1 IHA Exceptions to IHA Completion Requirements

- Providers must document specific circumstances in the member's medical record when an Initial Health Appointment (IHA) cannot be completed within the 120-day window (or 90-days for eligible Medicare D-SNP members).
- Valid exceptions include:
    - **Early Disenrollment:** The member disenrolled from the Managed Care Plan (MCP) before the 120-day requirement was reached.
    - **Member Refusal:** The member declined the appointment.
        - Action: Clearly document in the member's medical record why a member was unwilling to participate (i.e., the encounter notes include written narrative explaining the reason the member declined participation).
        - Simply checking a box or selecting a drop-down menu item that the member refused or was unwilling to participate, without accompanying narrative (i.e., free text notes) does not constitute documented declination. (Source)
    - **Unsuccessful Outreach:** Reasonable attempts by the provider to contact the member were unsuccessful.
        - Action: Document all outreach attempts and dates within the member's medical record

2.6.2 IHA MCAS Compliance Proxies for IHA Fulfillment

- Providers ensure compliance for members with completed preventive services by documenting Managed Care Accountability Sets (MCAS) measures in the clinical record. These measures serve as proxies to demonstrate that IHA requirements have been met. Use these preventive appointments to address any other outstanding health needs, effectively completing the IHA and the screening requirement in a single visit.
    - **Qualifying Visits:** Prioritize scheduling and documenting the following services for new members:
        - Child and Adolescent Well-Care Visits
        - Breast Cancer Screenings
        - Cervical Cancer Screenings
    - **Ensure Proper Documentation:** Verify that these screenings are clearly recorded in the clinical record and coded correctly. These specific measures are used by the State (DHCS) to track plan compliance.

2.6.3 IHA Requirements for Transitioning Members

- Providers satisfy IHA requirements for new members transferring from another Managed Care Plan (MCP) by verifying and documenting their historical records within 120 days. The receiving MCP is not required to perform a new IHA if the PCP:
    - Reviews the medical record to confirm it contains complete, accurate health information.
    - Verifies the medical record was updated within the previous 12 months.
    - Documents clearly in the member's medical record that the IHA requirements have been satisfied based on this assessment.

Best Practice Tip - Operational Guidance
The IHA is not contingent upon receipt of records from a prior or competing health plan. When external records remain unavailable, providers should document good-faith record retrieval efforts, clearly note record limitations, and complete any required assessments or screenings that cannot be otherwise verified. Subsequent receipt of external records may be incorporated into the medical record but is not required for initial IHA compliance.

2.6.4 Integrated IHA Fulfillment: Dual-Eligible Members (D-SNP)

- For Dual Eligible Special Needs (D-SNPs) members ensure the medical record reflects the completion of the following unified Medicare-Medi-Cal processes:
    - **Comprehensive Health Risk Assessment (HRA) Documentation**: Confirm the member has completed their HRA - a screening of medical, behavioral, and social needs-within 90 days of enrollment.
    - **Active Care Plan Integration**: Incorporate the members' Individualized Care Plan (ICP) into their record. This plan is developed by SFHP's care team to coordinate benefits across both Medicare and Medi-Cal.
    - **Coordinated Care Participation**: Document any engagement with the members' Interdisciplinary Care Team (ICT) to address the medical and social determinants of health (SDOH) identified during the HRA process.

DSNP HRA & Care Plan as IHA – One Page Summary

Step	Question to Ask	Yes → Action	No → Action
1	Is the member enrolled in DSNP?	Proceed to Step 2	Complete standard MediCal IHA
2	Is an HRA and Care Plan available to the PCP?	Proceed to Step 3	Complete standard MediCal IHA
3	Is the HRA/Care Plan from a verifiable source (DSNP plan, delegated group, or member copy)?	Proceed to Step 4	Complete standard MediCal IHA
4	Was it completed or updated within the last 12 months?	Proceed to Step 5	Update missing elements or complete IHA
5	Does it reasonably cover IHA domains (medical history, BH, SDOH, functional status, prevention)?	Proceed to Step 6	Complete missing assessments
6	Has the PCP reviewed and documented use of the HRA/Care Plan in the medical record?	Counts as IHA	Complete standard MediCal IHA

A DSNP HRA and Care Plan may be counted as the IHA only when the PCP can verify, review, and document clinical use. Automatic equivalency is not assumed.

Recommended PCP Attestation:
"Reviewed DSNP HRA and Care Plan dated _____. Information incorporated into assessment and care plan; gaps addressed as noted."

2.6.5 Fulfilling Screening Requirements (HRA and HIF/MET) via the IHA

- Providers can satisfy mandatory federal and state screening requirements through the completion of the IHA:
    - **HIF/MET Requirement:** Sharing IHA results with the MCP within 90 days of enrollment fulfills the Health Information Form (HIF) and Member Evaluation Tool (MET) requirement. If the IHA is not completed within 90 days, the receiving MCP must complete a separate HIF/MET.

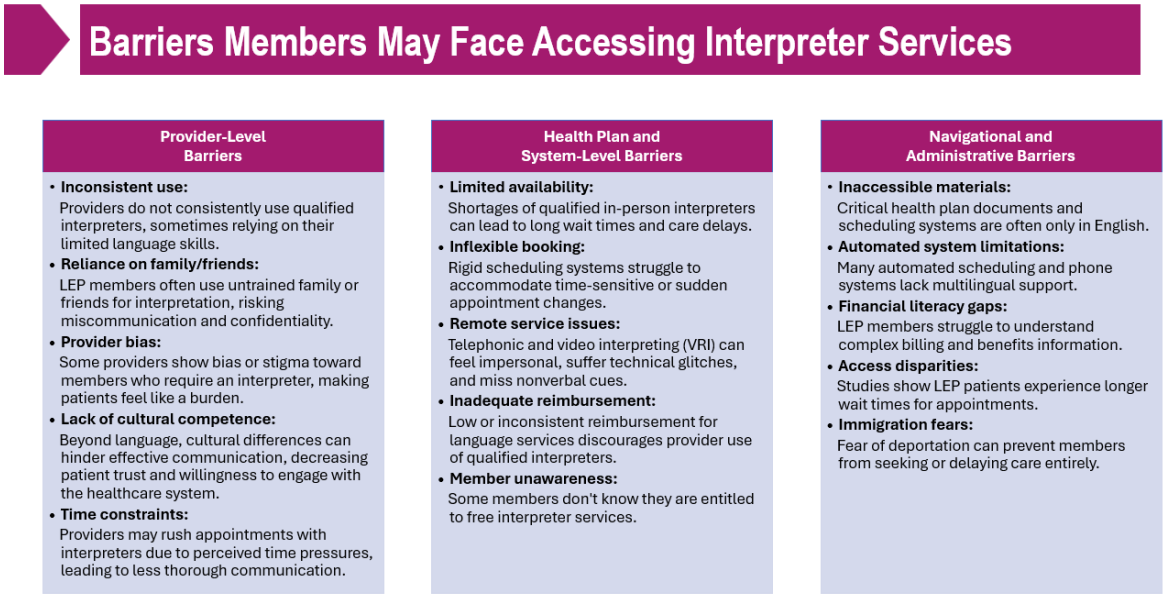
      Initial Health Appointment (IHA) information is primarily collected through claims and encounter data submitted by your clinic. While the Health Information Form (HIF) and Member Evaluation Tool (MET) are specific screenings, the Department of Health Care Services (DHCS) uses the IHA visit itself as a proxy for meeting these federal requirements.

    - **Transitioning Member HRA:** For high-risk (SPD) members with no HRA on record, it is important that the HRA is completed.

  The MCP may rely on an HRA conducted by a previous plan on or after January 1, 2023, unless the member has experienced a significant change in health status or level of care.

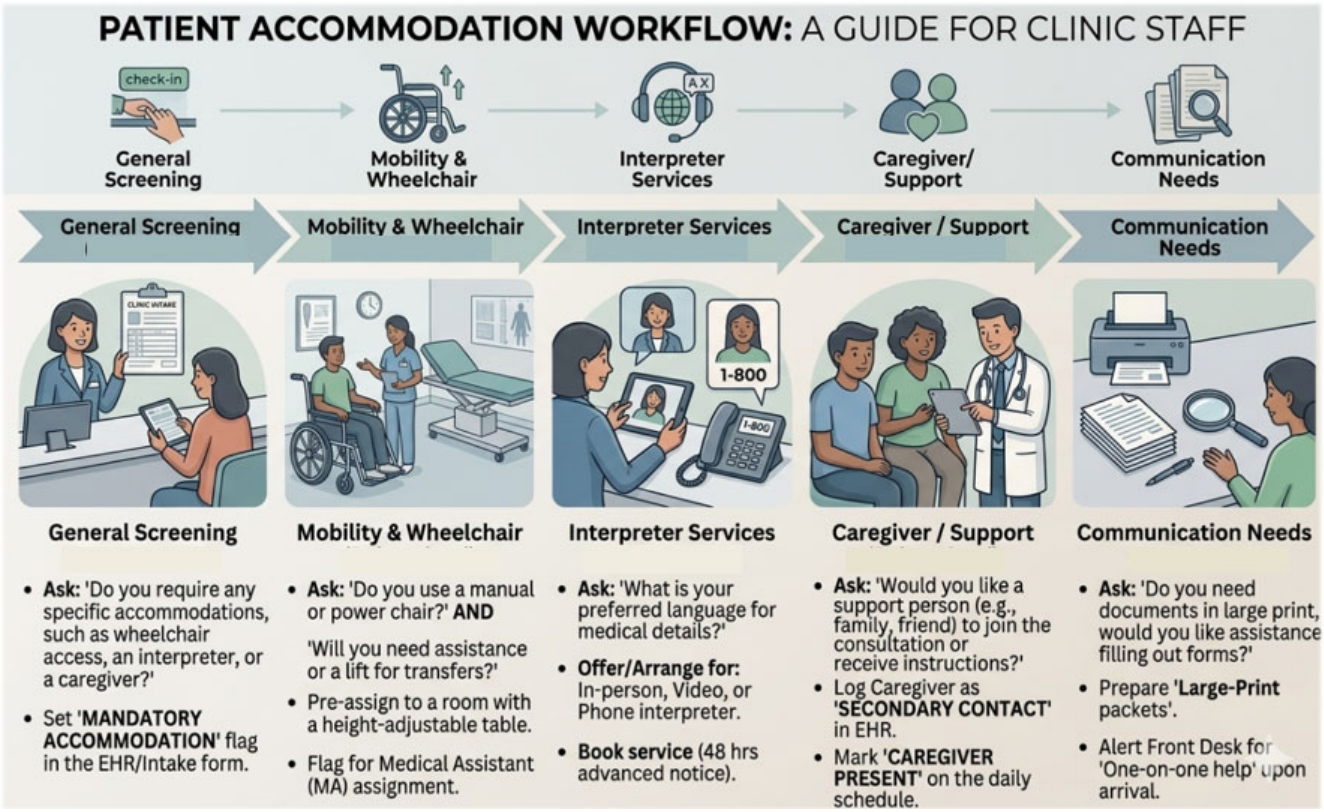
2.7 Understanding Patients' Challenges Impacting IHA Compliance

Understanding patients' challenges—like job instability, language barriers, and past negative experiences—is essential for staff because these real-world obstacles are often the reason patients miss their physicals, rather than a lack of interest in their own health.



Best Practice Tip – Patient Accommodation Workflow

At first contact with the new member, determine if there are barriers to completing their Initial Health Appointment. Intervene with accomodations if that will help facilitate a successful appointment.



(Can be enlarged and used to post in front desk or appointment scheduling areas)

3. Workflows and Operational Guidance

3.1 Reports Utilized in IHA Monitoring and Oversight

Report	Platform	Description
0694E IHA Rate Report and Member Lists	RAMP	Sent to Delegated Medical Groups on the 10th of each month Reports IHA rates by providers/delegates Reports on members without an IHA
0195E Monthly 60 Day IHA Mailer	RAMP	The purpose of this report will be used by marketing to send a reminder letter to newly enrolled members, 60 days after enrollment, who have no IHA on record within the last 12-months and are assigned to a non-delegated MG.
Clinic Site Visit Details	MicroStrategy	Member list for FSR Medical Record Reviews and IHA Delegation Oversight Medical Record Reviews

Providers are responsible for ensuring that all newly assigned members receive outreach to schedule an Initial Health Appointment (IHA) within the required timeframe. A key compliance requirement is that outreach attempts are completed, tracked, and followed through to confirm:

- The member received the IHA, and
- The IHA findings were reviewed by the Primary Care Provider (PCP).

You may choose whether to check with your medical group as to their process for cascading health plan IHA Rate Reports and Member Lists, or you can pull your own monthly member roster through the SFHP Provider Portal.

However the reports are accessed, providers are encouraged to pull a monthly member roster through the SFHP Provider Portal. Instructions can be found on page 15 of the Provider Portal User Guide. This roster helps clinics identify new members who are within their IHA window and prioritize outreach efforts.

3.2 Member Identification and Eligibility Verification

- Confirm member is enrolled in a Medi-Cal Managed Care Plan or Medicare Advantage Plan
- Confirm member is new or newly assigned to this PCP
    - New member

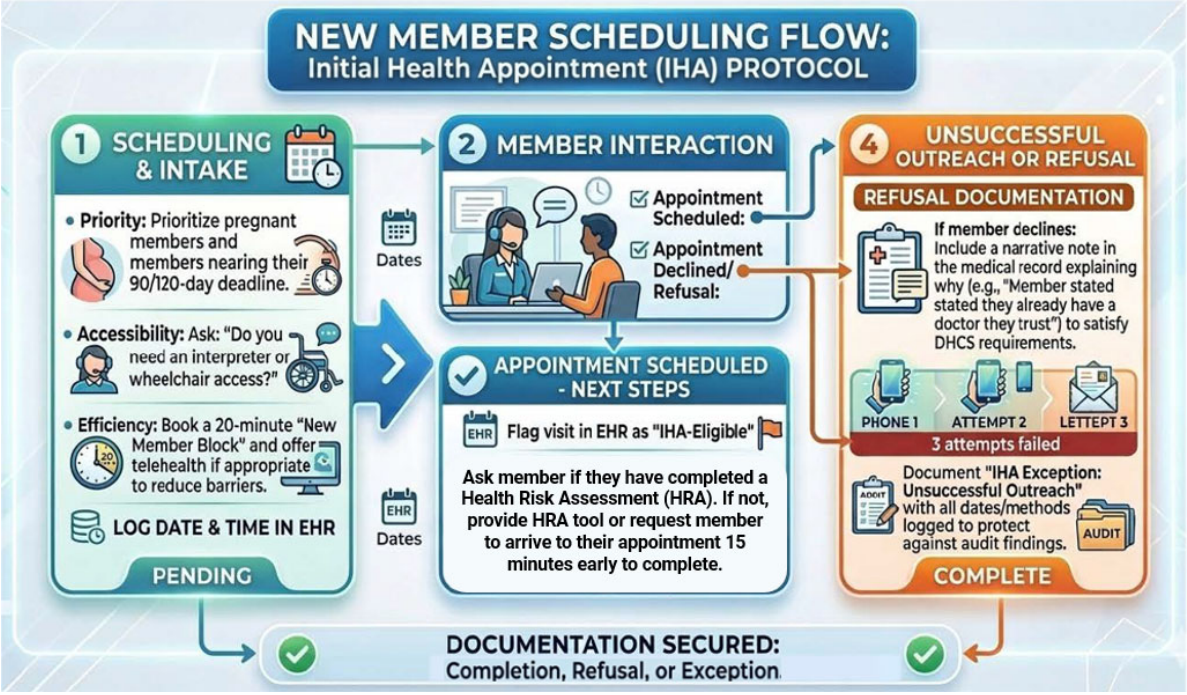
  [Note: A "new patient" is defined by plan enrollment history, not by whether the provider has previously seen the patient. A member is considered new if they are newly enrolled or re-enrolled after a gap of more than 12 months with the managed care plan.]
- For Medi-Cal - Confirm IHA is within 120 days of enrollment
- For Medicare Advantage - Confirm IHA is within 90 days of enrollment
- Flag visit in EHR as IHA-eligible
- Confirm contact information (phone, address, preferred language)
- Confirm consent for outreach methods (text/phone/mail)
- Identify accommodations needed (wheelchair access, caregiver presence, interpreter service)

Best Practice Tip: Checking Need for Social Support Services

Category	Staff Action / Screening Question	System/Documentation Requirement
General Screening	Ask: "Do you require any specific accommodations, such as wheelchair access, an interpreter, or a caregiver, to ensure a smooth visit?"	Set a mandatory "Accommodation" field in the intake form or EHR registration.
Mobility & Wheelchair	Ask: "Do you use a manual or power chair?" and "Will you need assistance or a lift for transfers to the exam table?"	Assign to a room with a height-adjustable table; flag for a medical assistant (MA) to assist with arrival.
Interpreter Services	Ask: "What is your preferred language for medical details? Would you like an in-person, video, or phone interpreter?"	Book the interpreter service 48 hours in advance; block an extra 15–20 minutes for the appointment.
Caregiver / Support	Ask: "Would you like a support person to join the consultation or receive your aftercare instructions?"	Add the caregiver as a "Secondary Contact" and note their presence in the daily schedule.
Communication Needs	Ask: "Do you need documents in large print, or would you like assistance filling out our clinic forms?"	Prepare digital or large-print packets; alert front desk to provide one-on-one help upon arrival.

Appendix D: Member Roster Tip Sheet

3.3 Outreach and Scheduling Workflow



The goal is to move members from "Unseen" to "Completed" before their regulatory window closes.

- Standardize outreach by following a set sequence—call, text, mail, then alternate contacts—and documenting every attempt.

- Calculate the compliance deadline based on the Member Effective Date found on your SFHP Roster:
  - Medi-Cal Members: 120 Days from enrollment.
  - Medicare Advantage (D-SNP): 90 Days from enrollment.

- Sort your monthly roster by the Enrollment Date and assign a priority level:

  The Priority "Traffic Light" System

Priority	Enrollment Days	Action Required
URGENT	60+ Days	**Call Today.** Member is at high risk of non-compliance.
TRACKING	30–60 Days	**Second Attempt.** If first call failed, send text, call, or mail.
NEW	0–30 Days	**Initial Outreach.** Send New Patient Packet & first phone call.

- Establish set IHA policies and protocols to streamline workflows. For example, use a telehealth pre-visit or an electronic/paper method to complete a new patient questionnaire or an HRA before the appointment. This allows the provider to focus entirely on patient care rather than paperwork once the official IHA visit begins.

- Remember that for "Unsuccessful Outreach" to count as a valid IHA exception, auditors look for at least three documented attempts on different days using at least two different methods (e.g., two phone calls and one letter).
- Even if the 120-day window passes without success, providers are encouraged to continue attempting to perform the IHA at any subsequent member visits.

- Starting January 1, 2026, other non-live methods, such as secure email or portal messages, may count as valid unsuccessful attempts for reporting purposes.

Appendix E: Member Outreach Scripts

Appendix F: Outreach & Engagement Log

Best Practice Tip: IHA Scheduling & Check-In Workflow Chart

Process Step	Action Item	Compliance Target / Rule
1. Identification	-Identify "unseen" members early using Monthly Eligibility Lists. -Cross-reference Health Plan Roster with EMR database.	Identify members within 120 days of enrollment.
2. Status Check	Verify if any provider in your same specialty saw the member face-to-face in the last 365 days.	If NO: Status is NEW. If YES: Status is ESTABLISHED.
3. Scheduling	-Launch a "Welcome Text" campaign, if available, to improve response rates. -Reserve daily 20-minute "New Member Blocks" in the schedule. -Book appointments as "IHA" (Medi-Cal) or "IPPE/AWV" (Medicare). -For identified at-risk members address any SDOH factors. To reduce barriers to care, consider: -Consider plan-funded transportation (NEMT) during scheduling. -Consider Telehealth for the initial intake/history	Document the three required Good Faith Efforts in either a Standardized Contact Log or dedicated EMR outreach fields Prioritize pregnant members for these slots to ensure the Initial Prenatal Visit occurs within 120 days.
4. Pediatric IHA		For infants under 18 months, the IHA must follow the AAP Bright Futures periodicity schedule if it falls before the 120-day limit.
5. Outreach	If member is unreachable, document outreach in EMR.	Min. 3 attempts (e.g., 2 calls + 1 letter).
6. Pre-Visit	Identify Language/Interpreter needs & send initial assessments.	Meet Cultural & Linguistic (C&L) standards.
7. Documentation	Depending on the Line of Business (LOB), Medi-Cal or D-SNP, ensure the mandatory health screening questionnaires are completed.	Must be completed/signed on date of service.
8. Eligibility	Re-verify Active Coverage on the morning of the appointment.	Prevents "Denied Claim" due to disenrollment.
9. Member Refusal		If a member refuses an IHA, this must be documented in their medical record to satisfy plan audit requirements.

3.4 Telehealth vs. In-Person IHA Visits

Telehealth acceptable when:

- Member preference, transportation barriers, stable condition
- You can capture essential components (history, screenings, care plan)

In-person recommended when:

- High risk, uncontrolled chronic disease, complex medication regimens
- Need vitals/exam or labs/immunizations same day
- Cognitive concerns or safety concerns

3.5 Language Assistance and Accessibility

Linguistic and physical accessibility is the foundation of a successful Initial Health Appointment. By proactively offering professional interpreters and accessible materials, the clinic removes critical barriers to care and patient safety. Documenting interpreter IDs and clarifying the role of authorized representatives ensures medical decisions are based on accurate, clear communication. This commitment empowers every member to be an informed partner in their health journey from the very first visit.

Best Practice Tip: Ensure compliance with linguistic and accessibility standards.

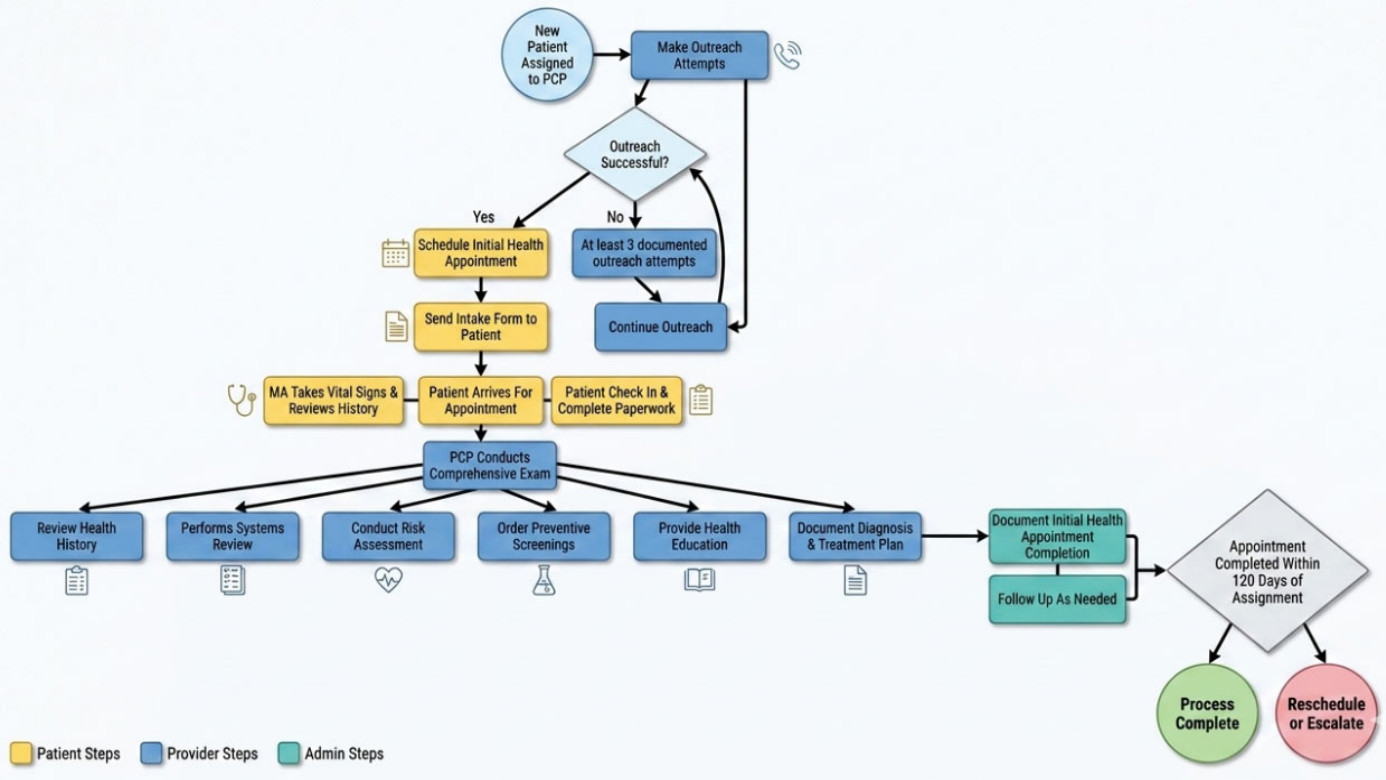
Action Item	Staff Instruction & Best Practices	Documentation Standard (EHR)
Proactive Offering	Ask every member: "In what language do you prefer to receive your healthcare information?" Offer free professional interpretation immediately if a preference other than English is noted.	Select the members' "Preferred Spoken Language" and "Preferred Written Language" in the demographic's header.
Interpreter ID	When using telephonic or video services, ask for the interpreter's name and unique Identification (ID) Number at the start of the session.	Record the Interpreter Name/ID, service type (e.g., VRI, Phone), and the start/end time of the interpreted encounter.
Translated Materials	Provide "Vital Documents" (consent forms, after-visit summaries) in the member's preferred language. Ensure translated titles are accompanied by English subtitles for staff reference.	Document that the translated educational materials or alternative formats (e.g., large print) were provided to the member.
Caregiver / Rep Role	Confirm the legal role of any accompanying person. Ask: "Is this person your authorized representative or a caregiver for clinical decisions?".	Update the "Authorized Representative" or "Personal Representative" field; include a scanned copy of any POA or legal consent form if applicable.

3.6 Documentation Workflow

A standardized documentation workflow is the backbone of a high-quality Initial Health Appointment. By using a uniform EHR template and auto-scoring screenings, the clinic ensures accurate, real-time data capture for every member. Closing the loop—by immediately entering referrals and assigning follow-up tasks—transforms a single visit into a reliable, trackable plan of care.

Appendix G: Documentation Tip Sheets

3.6.1 End-to-End Workflow



3.6.2 EMR Templates

Appendix H: EMR Template

Appendix S: Positive Screening Follow-Up

Best Practice Tip: Ensure you have a standard method to accurately document IHA clinical and compliance standards.

Step	Staff Action	EHR Workflow Detail
1. Template Launch	Use a Standardized IHA Template in the patient's chart at the start of the visit.	Prevents missing mandatory fields (e.g., SDOH, medical history, physical exam).
2. Active Screening	Complete all required screenings (e.g., PHQ-9, GAD-7, Substance Use) within the template.	Ensure results auto-score and populate into the "Assessment" or "Vitals" section for the provider.
3. Referral Entry	Enter all necessary specialist and community referrals (e.g., housing, food bank) before the patient leaves.	Link each referral to a specific diagnosis code (ICD-10) to ensure medical necessity is clear.
4. Task Assignment	Assign a Follow-Up Task to the Care Manager or MA for any "Red Flags" found during the IHA.	Set a specific due date (e.g., 48 hours for urgent, 7 days for routine) within the task module.
5. Closing the Loop	Review the Referral Tracking Log to confirm the "Order" status is set to "Active/Pending."	Ensure the patient's "Preferred Contact Method" is updated to facilitate successful outreach.

3.7 Care Coordination and Interdisciplinary Communication

Effective care coordination transforms the Initial Health Appointment from a simple check-up into a robust safety net for the patient. By aligning providers, care managers, and community partners, the clinic ensures that critical "red flags"—from medical crises to housing instability—never fall through the cracks.

Appendix I: IHA Care Coordination Checklist

Best Practice Tip – Hard-Wire EMR Safeguards

Make HRA tool/date, provider attestation, interpreter ID, and follow up date required fields before encounter closure.

3.8 Huddles and Hand-Offs

Through daily team huddles and proactive communication loops, staff operate as a unified front, preventing avoidable emergencies and building the foundation of trust needed for long-term health success. **Appendix J: Huddles, Handoffs, & Loop Closures**

Best Practice Tip: Communication Loops and Daily Huddles

Protocol Component	Staff Action & Instruction	Frequency / Trigger	Documentation Standard (EHR)
The Structured Handoff	Provider → Care Manager: Use a "warm handoff" or EHR task to flag social needs or complex medical gaps identified in the IHA. Care Manager → Community Resources: Initiate direct outreach to housing, food banks, or transport services; provide the member with a direct contact name.	Immediate (Day of Appointment)	Tag as "IHA Care Coordination" in the Referral or Task module; link to the specific SDOH code (e.g., Z59.0 for homelessness).
Interdisciplinary Huddles	High-Risk Case Review: Meet as a team (Provider, Nurse, Care Manager, Front Desk) to discuss new members with "red flags" (e.g., homelessness, severe chronic illness, or lack of support).	Daily (Morning) or Weekly (Review)	Log a "Huddle Note" or "Team Communication" in the patient's chart summary with the date and attending staff.
Urgent Escalation Path	Critical Findings: If an IHA reveals an acute clinical risk or immediate social crisis (e.g., no medication, elder abuse, or suicidal ideation), follow the "Fast Track" notification to the Clinic Management.	Real-Time (As discovered)	Mark the note as "URGENT" or "STAT"; use the "Flag" or "Alert" feature so it appears on the patient's header for all staff.
Communication Loop	Closing the Loop: Log all referrals in the tracking system. If a community resource or specialist doesn't respond within 48 hours, the Care Manager must re-engage.	Within 48-72 Hours	Update the referral status to "Active/Pending" or "Closed-Completed"; document the specific date the specialist report was received.

3.9 Community Health Workers

- Integrating Community Health Workers (CHWs) into your clinic workflow ensures that IHA and HRA requirements are met early, reducing the administrative burden on providers.
- How CHWs Drive Compliance
    - Audit Protection: CHWs provide the "boots on the ground" needed to document the unsuccessful outreach exception if a member cannot be reached.
    - HIF/MET Efficiency: By completing the IHA/HRA within 90 days, the CHW helps the clinic automatically satisfy the Federal Health Information Form (HIF) requirement.

- Dual-Eligible Support: For D-SNP members, CHWs assist the Interdisciplinary Care Team (ICT) by ensuring the Medicare HRA is finished within the mandatory 90-day enrollment window.

Best Practice Tip

Standardize social support tracking for all members identified by staff or CHWs to ensure consistent documentation and 360-degree care. See Tool In Appendix L for an example of a tracking log. Track the following:

- ***Status:*** *Transition from "Pending" to "Scheduled" or "Closed-Completed."*
- ***Barriers:*** *Document any new obstacles (e.g., lack of phone or childcare).*
- ***Provider Review:*** *Flag the entry for the PCP's review and signature.*

IHA & CHW Integration Workflow (120-Day Timeline)

Phase	Timeline	CHW Action Item	Compliance Goal
I. Outreach	Days 1–30	Initiate standardized outreach sequence (Call → Text → Mail). Document each attempt in the "Outreach & Engagement Log" to meet the 3-attempt/2-method audit standard.	High Engagement
II. Pre-Visit	Days 31–60	Conduct home or telehealth visits to complete the HRA and SDOH screening. Identify barriers like transportation or food insecurity.	HRA Completion
III. The Visit	By Day 90	Accompany the member to the clinic. Brief the PCP on identified SDOH risks, allowing the provider to focus on clinical care rather than paperwork.	90-Day HIF/MET Goal
IV. Follow-Up	Days 91–120	Execute the Individualized Care Plan (ICP). Link members to CalAIM Community Supports and track referral outcomes.	Closed-Loop Referral

Appendix K: Community Health Workers & the IHA

3.10 Comprehensive Referral Management

An important compliance requirement is to **ensure all clinical and social referrals initiated during the Initial Health Appointment (IHA) are tracked to completion, ensuring the member received the care and the findings were reviewed by the PCP.**

Below are general guidelines that may help check your clinic's protocol on when to trigger a "warm handoff" versus a standard referral, particularly for high-risk findings in behavioral health or social drivers of health (SDOH).

- **During the IHA Visit (Initiation)**
  - **Provider Action:** Identify the need (e.g., Cardiology, Behavioral Health Therapy, or Food Bank) and enter the order into the EHR.
  - **Urgency Check:** If the finding is Urgent (e.g., suicidal ideation or hypertensive urgency), follow the Same-Day Escalation Path
  - **Documentation:** Clearly state the referral reason and the expected outcome in the "Care Plan" section.
- **Administrative Processing (Post-Visit)**
  - **Staff Action:** Confirm the specialist/agency is within the SFHP network.
  - **Communication:** Send the referral and necessary clinical notes to the receiving provider.
  - **Tracking Log:** **Appendix L: Referral & Follow-Up Tracking**
- **Monitoring & Follow-Up (Monthly)**
  - **Status Updates:** Staff must collect status updates at least monthly for all open referrals.
  - **Barrier Assessment:** If a member has not scheduled or attended the appointment, staff must call the member to identify barriers (e.g., transportation, language, or cost) and offer assistance.
  - **Documentation:** Every outreach attempt to the member or specialist must be logged in the EHR/Tracking Log.
- **Ensuring Complete Care**
  - **Receipt of Findings:** Once the specialist consultation is complete, the front office/clinical staff retrieves the consultant's report.
  - **Provider Review:** The PCP must review the specialist's notes, update the member's problem list, and adjust the Care Plan as needed.
  - **Final Action:** Mark the referral as "Closed" in the tracking log only after the PCP has reviewed and signed off on the results.

Appendix M: SDOH Referral Routing Guide

Appendix N: Same-Day Referral Guide

What Constitutes Closed-Loop Referral Management

A referral is considered closed when the PCP has taken all reasonable steps to initiate and follow up on the referral and has documented the outcome or next clinical steps. Closed-loop referral completion is based on provider assessment and documented resolution—not on whether an external specialist or agency responds.

Approach	What the PCP Does	What to Document	Loop Considered Closed When…
Time Bound Escalation	Sends referral with defined 2–3 follow-up attempts over set timeframe	Dates, methods, and final nonresponse noted	Final attempt completed and disposition recorded
Patient Attested Outcome	Asks patient about referral outcome	Patient report (seen, declined, unable to schedule) and date	Patient outcome guides next clinical action
Clinical Substitution	PCP manages condition or refers to alternate service	Reason referral no longer needed and new plan	New care plan implemented
Formal Referral Closure	Closes referral with reason code in EMR	Closure reason (e.g., unresponsive, declined)	Referral status set to "closed"
Plan / Network Escalation	Escalates once to health plan or network	Date and entity escalated to	Escalation completed and next steps decided
Provider Attestation	PCP determines no further attempts are needed	Statement of due diligence and clinical judgment	Attestation documented
Referral Expiration Policy	Applies clinic defined expiration timeframe	Expiration date and PCP review note	Referral expires with documented resolution

Best Practice Tip:
Gold Standard "Closed Loop" Statement -"Referral initiated and multiple contact attempts documented. Receiving entity did not respond. Patient informed and alternative care plan discussed and implemented. Referral closed."

3.11 Digital Literacy Gaps

To ensure all patients are supported, this section details non-digital workflows for Initial Health Appointments (IHA) and Health Risk Assessments (HRA). While electronic portals are a primary efficiency tool, these manual strategies are essential for patients with limited digital literacy or for practices with restricted digital infrastructure.

Gap Category	Mitigation & Alternative Guidance
Alternative Modalities	For members without internet, provide the Health Risk Assessment (HRA) via traditional mail with a pre-paid return envelope, or conduct it telephonically through Member Services or dedicated health navigators.
In-Person Facilitation	Utilize in-clinic support where front-desk staff or medical assistants assist the member in completing the HRA on a clinic tablet or paper form during the check-in process.
Care Management Referral	Refer members with high social needs or complex barriers to Enhanced Care Management (ECM). ECM lead care managers can provide in-person community connection and help members navigate assessment requirements face-to-face.
Linguistic & Literacy Adjustment	Ensure all non-digital versions of assessments (paper/phone) are available in the member's threshold language and use plain language (ideally at a 6th-grade reading level or below) to account for varying literacy levels.
Telephonic Assistance	Direct members to call their plan's Member Services directly to complete the HRA over the phone with a live representative.

Best Practice Tip:
Digital access is increasingly recognized as a Social Determinant of Health (SDOH). If a member lacks digital literacy, this should be flagged in their profile to trigger non-digital communication for future appointments and screenings.

4. Components of the Initial Health Appointment

4.1 Health Risk Assessment (HRA)

Goal: Identify clinical, functional, behavioral, and social risks early.
Minimum documentation:

- Tool name/version (or embedded EHR form)
- Date completed and by whom
- Key positives/risks (e.g., falls risk, depression risk, food insecurity)
- Immediate actions/referrals
- Care plan updates linked to findings

Best practices:

- Pre-complete HRA via phone, text, or portal (if that is an option) before visit when possible
- Use "warm handoff" to care management for medium/high-risk findings

At least ONE risk assessment domain meets the standard.

San Francisco Health Plan (SFHP) uses the Jiva platform for care management documentation, which includes the recording of member Health Risk Assessments (HRAs).
Within this ecosystem, the workflow generally functions as follows:

- Documentation Site: Clinical staff and care managers use Jiva to document HRA completions, clinical notes, and care plans for both Medi-Cal and Medicare Advantage (D-SNP) members.
- Data Integration: Jiva serves as the central repository for member-specific health risks, allowing the plan to track compliance with the 90-day (D-SNP) or 120-day (Medi-Cal) assessment windows.
- SDOH and Referrals: Information captured in the HRA within Jiva often triggers internal referrals for social services or complex care management based on identified needs.
- Audit Readiness: By documenting these assessments in Jiva, the plan maintains a centralized, auditable record that demonstrates fulfillment of DHCS and CMS contractual requirements.

Best Practice Tip:
Auto flag members with housing instability or limited digital access for paper or phone HRAs. Not all members have access to digital devices or mechanisms.

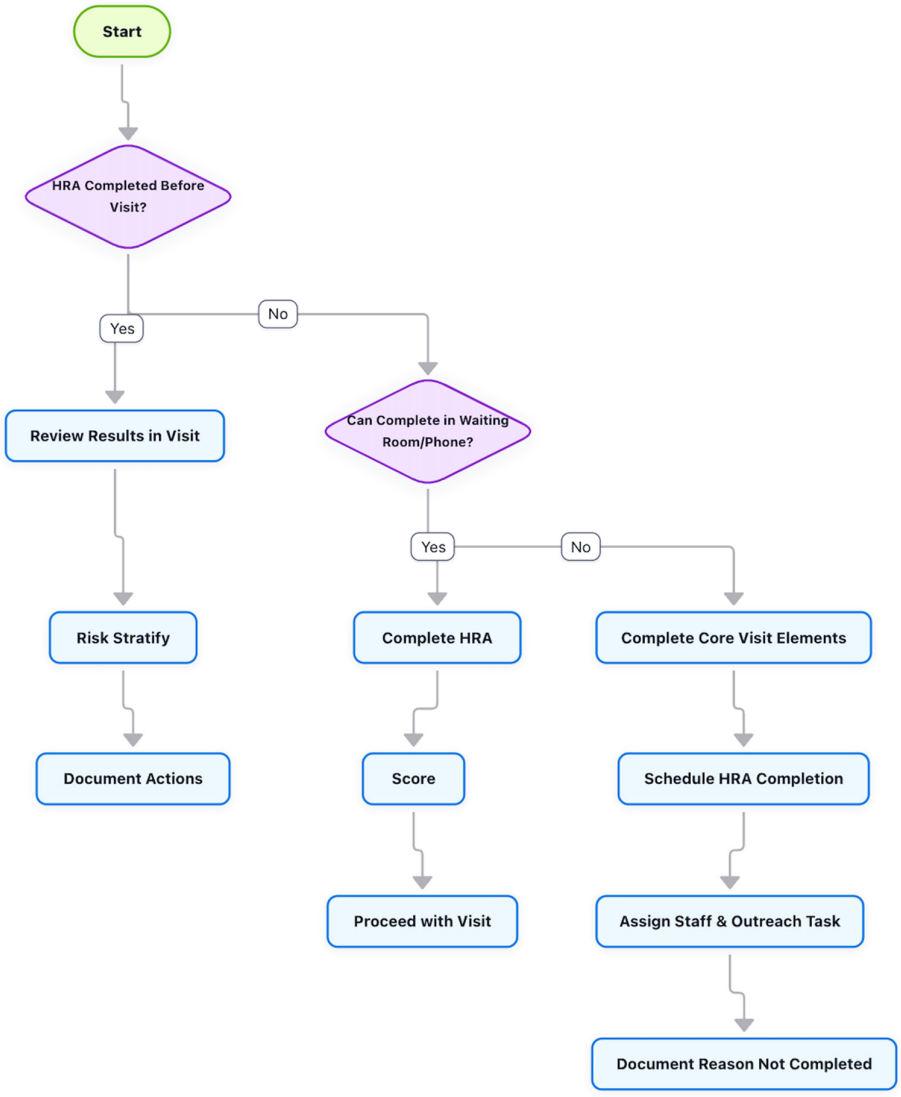
Domains:

- Health Risk Assessment (Pediatric and Adult)
  - HRA tools (typically the health plan HRA tool)
- Social Determinants of Health (SDOH) (Pediatric and Adult)
  - The AAFP Social Needs Screening Tool
  - PRAPARE (The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences)
  - AHC-HRSN (Accountable Health Communities Health-Related Social Needs) Screening Tool
- Adverse Childhood Experiences (ACEs) (Pediatric and Adult)
  - PEARLS ACE (Pediatric ACEs and Related Life-events Screener):
    - PEARLS child tool, for ages 0-11, to be completed by a parent/caregiver.
    - PEARLS adolescent tool, for ages 12-19, to be completed by a parent/caregiver.
    - PEARLS for adolescent self-report tool, for ages 12-19, to be completed by the adolescent.
  - ACE Questionnaire for Adults (18+)
- Cognitive Health Assessment (Adults Only-65+)
  - General Practitioner Assessment of Cognition (GPCOG)
  - Mini-Cog
  - Eight-item Informant Interview to Differentiate Aging and Dementia

Appendix O: Health Risk Assessment Guidelines

Appendix P: Behavioral Risk Tracking

Flowchart: “HRA Not Completed Yet” Decision Path



4.2 Medical and Surgical History

Include:

- Active chronic conditions and severity
- Significant past diagnoses/hospitalizations/ED use
- Surgical history and complications
- Family history (CVD, cancer, diabetes, mental health, substance use as relevant)

Best Practice Tip: Problem list updated with date/assessment status.

4.3 Behavioral Health Screening

Standard Provider Workflow
Every screening must include:

- **Documented Result:** Record the numerical score or risk level.
- **Clinical Plan:** Note brief counseling, referrals, or education provided.
- **Scheduled Follow-Up:** A specific date for the next evaluation or check-in.

Common screening domains:

- Depression/anxiety
- Suicide risk when indicated
- Substance use (alcohol/drugs/tobacco)
- Cognitive screening for older adults when indicated

Brief emotional/behavioral assessment: (e.g., depression inventory, attention deficit/ hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument.

- Examples:
    - Ages & Stages Questionnaires: Social-Emotional, Second Edition (ASQ:SE-2)
    - Survey of Well-being of Young Children (SWYC)
    - Patient Health Questionnaire, 15 items (PHQ-2) (If positive, administer PHQ-9)
    - Patient Health Questionnaire, 9 items (PHQ-9)
    - General Anxiety Disorder (GAD-7)

Appendix Q: SDOH Tools

Common validated tools to identify "Red Flags":

Adult (18+) Screening Tools

Screening Tool	Primary Use Case	Time to Administer	Key Features
PHQ-9	Depression Screening	2–5 minutes	Monitors severity of depression; Item 9 serves as a universal suicide risk screen.
GAD-7	Anxiety Screening	2–3 minutes	Validated for Generalized Anxiety Disorder, Panic Disorder, and Social Phobia.
AUDIT-C	Alcohol Misuse	1 minute	A 3-item rapid screen to identify hazardous drinking or alcohol use disorders.

Adolescent (12–17) Screening Tool

Screening Tool	Primary Use Case	Time to Administer	Key Features
PHQ-A	Adolescent Depression	3–5 minutes	Adapted from PHQ-9; includes specific questions regarding irritability and social withdrawal.
CRAFFT	Substance Use /Misuse	2 minutes	Validated for adolescents to detect high-risk alcohol and drug use behavior.

Older Adult (65+) Screening Tools

Screening Tool	Primary Use Case	Time to Administer	Key Features
GDS-15 (Geriatric Depression)	Universal screening for late-life depression	5–7 minutes	Simple Yes/No format; avoids physical somatic symptoms often confused with aging
GDS-5 (Brief Mood Screen)	Rapid "Tier 1" mood check for time-limited visits	<1 minute	Highest sensitivity (up to 97%) for catching potential depression; scores ≥2 suggest need for full GDS-15
Mini-Cog© **(Cognitive)**	Detect early-stage dementia or cognitive impairment	3 minutes	Combines 3-word recall with a clock drawing test; less influenced by education or language than MMSE

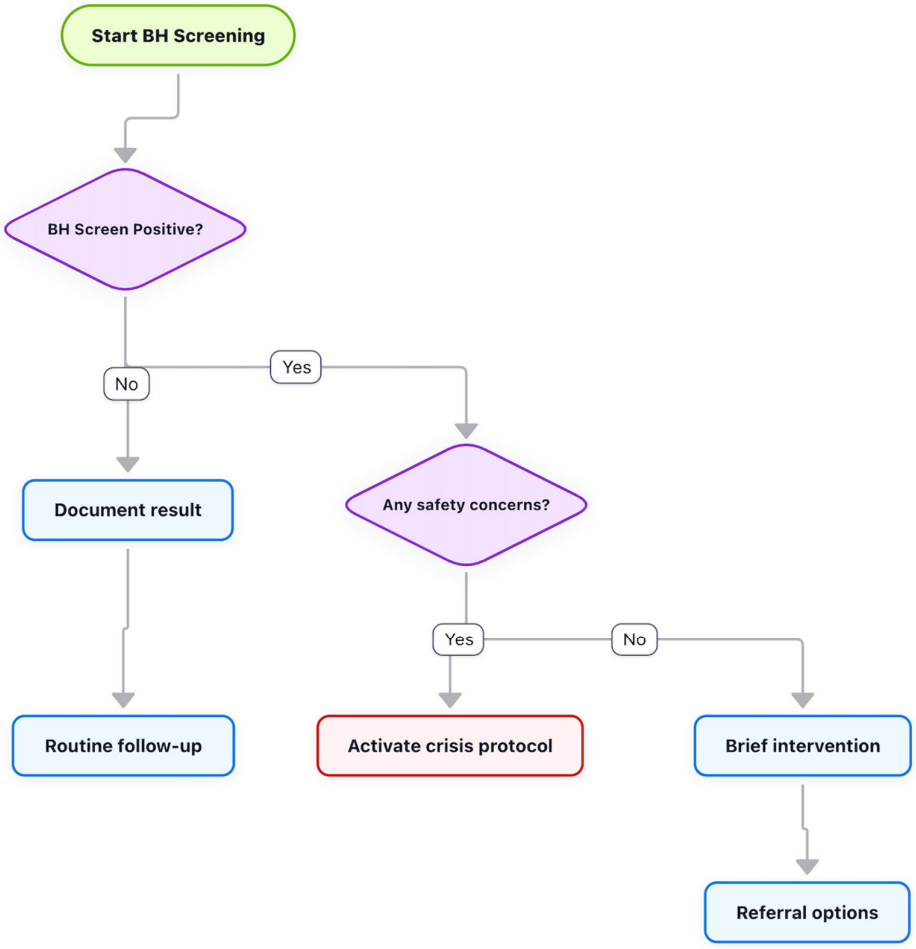
Safety Protocol:

Screening Tool	Primary Use Case	Time to Administer	Key Features
C-SSRS	Suicide Risk (Full Assessment)	2–5 minutes	High detail; standardized risk levels
ASQ	Suicide Risk (Universal Screen)	20 seconds	Best for busy medical settings
HITS	IPV (General)	<1 minute	Most used for physical/ emotional abuse
HARK	IPV (Includes Sexual Abuse)	<1 minute	High sensitivity for multiple types of abuse
AAS	IPV (OB/GYN & Pregnancy)	1 minute	Mandatory in many prenatal protocols

Best Practice Tips: Complete documentation must include the following:

- Record Screening Score/Result
- Document Intervention (Counseling or Referral)
- List Follow-up Appointment Date

Flowchart: Positive Behavioral Health Screen (Safety Escalation)



4.4 Social Drivers of Health (SDOH)

Risk Identification: Documented identification of risks through standard tools, including Social Determinants of Health (SDOH) and Adverse Childhood Experiences (ACEs).

Domains to cover (adapt to your EMR tool):

- Housing stability
- Food security
- Transportation
- Utilities/financial strain
- Safety/interpersonal violence
- Social isolation
- Health literacy and access barriers

Appendix R: Screening Tools Resource

4.4.1 Addressing Social and Cultural Needs

SDOH Screening Tools

Screening Tool	Primary Use Case	Time to Administer	Key Features
PRAPARE	Comprehensive Clinical Assessment	5–10 minutes	Standardized; 15 core + 5 optional items; direct EHR integration.
AHC-HRSN	Universal CMS/Medicare Screening	3–5 minutes	10 questions covering 5 core domains (food, housing, transport, utilities, safety).
WellRx	Broad Social Risk Identification	<2 minutes	11 questions; high domain coverage (9–10 domains including legal and income).
WE CARE	Pediatric Clinical Settings	2–5 minutes	One-page self-report; screens 8 domains specifically for families.

Best Practice Tips:

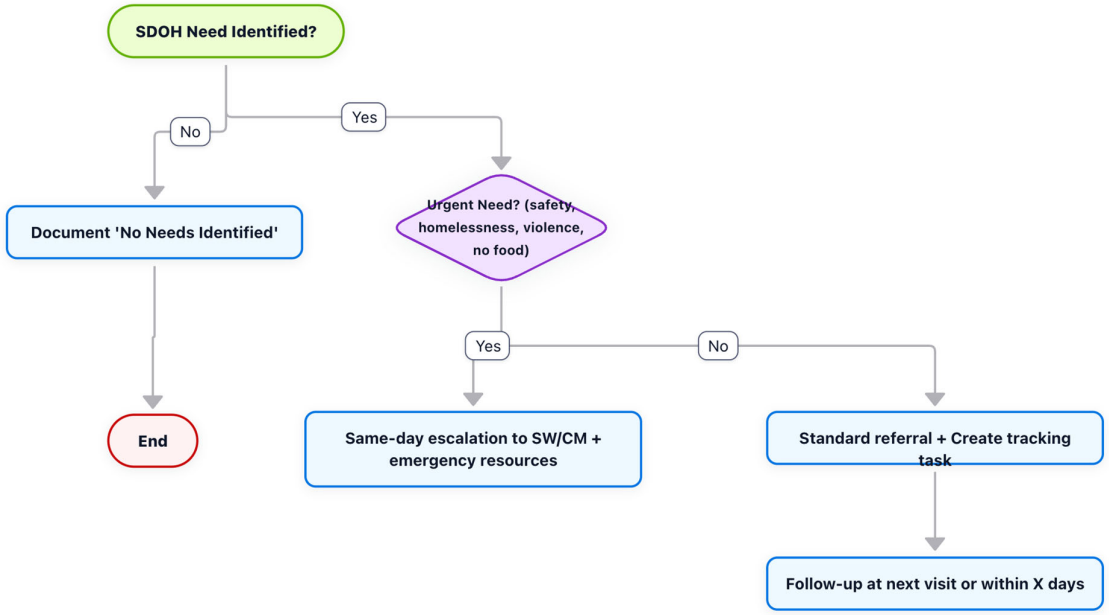
- Normalize SDOH questions ("We ask everyone…")
- Use culturally responsive education materials
- Incorporate caregiver and family supports with consent

Staff Action Checklist

For every positive result, verify these three items are documented:

- **Specific Intervention:** Name the resource, agency, or department where the patient was referred (e.g., *"Referred to County Behavioral Health"*).
- **Case Management Opportunity:** Document if a referral to a Case Manager (CM) or Care Coordinator was initiated.
- **Completion of Plan:** Ensure the patient received the necessary contact information or "warm handoff" before leaving.

Flowchart: SDOH Positive Screen → Resource + Tracking



4.5 Physical Examination

The Physical Examination is a core component of the Initial Health Appointment (IHA), designed to provide a comprehensive baseline of a new member's health status. This assessment allows providers to evaluate objective anatomic findings—such as height, weight, and blood pressure—and integrate them with the patient's history to identify acute, chronic, and preventive care needs.

Key Components of the Physical Examination

- **Vital Measurements**: Includes documenting height, weight, body mass index (BMI), and blood pressure.
- **Systematic Review**: A thorough assessment of all major organ systems and general appearance.
- **Clinical Screenings** Performance of age-appropriate services such as clinical breast exams or Pap smears for eligible members.
- **Functional Assessment**: Evaluation of physical function, including mobility, balance, and fall risk, particularly for older adults.
- **Integrated Care**: Identification of risk factors discovered during the exam to create a tailored plan of treatment and coordinate necessary community resources.

Providers must ensure that all findings are clearly documented in the member's medical record to facilitate ongoing care coordination and meet regulatory requirements.

4.6 Preventive Screening and Immunizations

Screening recommendations:

- Adults - Age-appropriate preventive services based on U.S. Preventive Services Task Force (USPSTF) Grade A and B recommendations for adults (18+)
- Pediatrics - Age-appropriate preventive services based on American Academy of Pediatrics (AAP) Bright Futures recommendations for members (0-21).

Immunization recommendations:

- Age-appropriate immunization recommendations based on Adult Immunization Schedule based on Age and The Advisory Committee on Immunization Practices (ACIP).

Core Preventive Services Chart – 2026 Clinical Screenings

Category	Service	Frequency / Notes
Wellness Visits	"Welcome to Medicare" Visit (Applies only to D-SNP)	One-time visit within the first 12 months of Medicare.
	Annual Wellness Visit (AWV) (Applies only to D-SNP)	Once every 12 months after the initial year.
Cancer Screenings	Breast Cancer (Mammogram)	Once every 12 months.
	Cervical & Vaginal Cancer	Pap test and pelvic exam every 24 months (or 12 months if high risk).
	Colorectal Cancer	Colonoscopy (every 10 years for most), FIT/Fecal occult blood test (annually).
	Prostate Cancer (PSA/DRE)	Once every 12 months for men over 50.
	Lung Cancer (Low-dose CT)	Annual screening for high-risk smokers.
Vaccinations	Flu, COVID-19, Pneumonia	Annual for Flu/COVID; Pneumococcal as recommended.
	Hepatitis B & Shingles	Covered for those at medium to high risk.
Health Screenings	Cardiovascular Disease	Blood pressure, cholesterol, and lipid screenings.
	Diabetes Screening	Up to two per year depending on risk factors.
	Depression Screening	Once every 12 months.
	Bone Mass Measurement	Once every 24 months for those at risk.
Counseling	Obesity & Nutrition	Behavioral therapy and medical nutrition therapy.
	Tobacco Cessation	Up to 8 face-to-face counseling sessions per year.

Documentation Requirements - Patient medical records must include:

- The service provided, for example: screen and brief intervention.
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record).
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the assessment tool is embedded in the electronic health record).
- Clearly identify and note the clinical plan including brief counseling, referrals, or education provided.
    - Specify if referral to an alcohol or substance use disorder program was made.
- Scheduled follow-up date for the next evaluation or check-in.

Appendix T: Follow-Up Care Checklist

4.7 Medication Review and Reconciliation

Medication Review and Reconciliation is a critical safety component of the Initial Health Appointment (IHA). This process ensures that a member's medication regimen is accurate, safe, and effectively managed to prevent adverse drug events and improve clinical outcomes. Providers must verify all current medications and address any potential barriers to adherence.

Required Documentation

- Comprehensive Medication List**:** Document all current Prescription (Rx)**,** Over-the-Counter (OTC)**,** herbal remedies**,** and supplements**.**
- Adherence Assessment**:** Identify and address barriers such as cost**,** side effects, or health literacy that may prevent the member from taking medications as prescribed.
- High-Risk Medication Review**:** Evaluate for medications that increase risks for falls or drug-drug interactions, particularly in older adults or complex patients.
- Reconciliation Statement**:** Include a definitive statement in the medical record, such as: "Reviewed and reconciled today.

Include:

- Current list (Rx/OTC/herbals/supplements)
- Adherence barriers (cost, side effects, literacy)
- Always document any patient education provided, or dosage changes made during the appointment.
- High-risk meds review (falls, interactions)

4.8 Care Planning and Follow-Up

The **Patient-Centered Care Plan** is a dynamic, tool that captures a comprehensive "snapshot" of a patient's unique needs, goals, and preferences. Designed for seamless sharing across the healthcare continuum, it ensures continuity of care by aligning the entire interdisciplinary team. By consolidating input from all providers, the Care Plan fosters better communication, eliminates clinical silos, and significantly enhances overall care coordination**.**

Accessing the Care Plan

Depending on your EHR system's interface, the care plan may be located in sections labeled, "Care Plan", "Patient Summary", or "Interdisciplinary Notes".

Medical Record Optimization

To support effective action plans and ensure patients receive high-quality, targeted care, providers should focus on two key areas of documentation during every appointment:

- **Continuous Problem List Maintenance:** Regularly evaluate and update the Medical Record Problem List**.** This includes active Diagnosis Problems as well as Social History/Risk Problems**,** which are essential for setting accurate clinical priorities.
- **Verification of Comprehensive Records:** Ensure the following elements are clearly documented:
    - Medical history and current diagnoses.
    - Specific treatment goals and detailed progress notes.
    - Projections for future care needs.

The Goal: Maintaining this level of detail ensures that every action plan is purposeful and directly aligned with the specific care needs of the patient.

5. Coding, Billing, and Encounter Submission

5.1 IHA-Related Code Categories

5.1.1 Medi-Cal and Medicare Advantage Initial Health Appointment (IHA) Codes

- **General Medi-Cal and Medicare Advantage Initial Health Appointment (IHA)** Specific billing codes (CPT, HCPCS, and ICD-10) are used to track and verify that a member has completed mandatory initial health assessments. A common combination to mark the initial health appointment requirements are **an encounter code (the visit itself)** and **a diagnosis code that specifies the nature of the assessment**.
    - **Diagnosis (ICD-10) Reporting Codes**:
        - Z00.00 / Z00.01**:** General adult medical examination.
        - Z00.1 / Z00.11 / Z00.12**:** Routine child health examinations (well-child visits).
    - **Procedure (CPT) Codes**:
        - 99381–99387**:** Preventive medicine services; new patient (varies by age).
        - 99391–99397**:** Preventive medicine services; established patient.
        - 99203–99205**:** Office or other outpatient visit; new patient.
        - 99213–99215: Office or other outpatient visit; established patient.
    - **Screening Codes** (depression, substance use, SDOH) where applicable
    - **Supplementary HCPCS Codes**:
        - G0466–G0470**:** Often used by Federally Qualified Health Centers (FQHCs) for visit reporting.
- **IHA and an additional Identified Problem**
  The ICD-10 coding for an initial health appointment where a problem is identified depends on the patient's age and the nature of the "problem" (whether it was a pre-existing complaint or an unexpected finding during a routine exam).

  If the provider performs a significant, separately identifiable evaluation and management (E/M) service for the problem, a separate E/M code (such as 99204–99205 for new patients) may be billed with modifier -25 attached to it, in addition to the preventive medicine service code.

    - General Adult Examinations with Abnormal Findings
        - Z00.01**:** Encounter for general adult medical examination with abnormal findings**.**
        - When to use: Use this code if the physician identifies a new problem or a change in the severity of a pre-existing chronic condition during the routine visit.
        - Additional Coding: You must also report the specific ICD-10 code for the abnormal finding itself (e.g., elevated blood pressure or a new diagnosis) as a secondary code.
    - Pediatric Health Examinations with Abnormal Findings
        - Z00.121**:** Encounter for routine child health examination with abnormal findings**.**
    - Medicare Initial Appointments with Abnormal Findings
        - For these Medicare-specific visits, Z00.01 is still the appropriate diagnosis code if abnormal findings are discovered.

5.1.2 Medicare Advantage Assessment Codes (Dual Eligibility)

- **Medicare Advantage Assessment (Dual Eligibility)**
  For "Dual Eligibles" (members with both Medi-Cal and Medicare), providers most often use the Medicare-standard G-codes first to satisfy primary payer requirements before secondary tracking occurs.
- Medicare monitoring focuses on the Initial Preventive Physical Examination (IPPE)**,** also known as the "Welcome to Medicare" visit, and subsequent Annual Wellness Visits (AWV) which include the required Health Risk Assessment (HRA).
  - HCPCS Level II Codes**:**
    - G0402**:** Initial Preventive Physical Examination (IPPE); face-to-face visit for new patients within the first 12 months of Medicare enrollment.
    - G0438: Annual Wellness Visit (AWV); includes a personalized prevention plan for the first visit.
    - G0439**:** Subsequent Annual Wellness Visit.
    - G0136**:** Administration of a standardized Social Determinants of Health (SDOH) assessment (often part of the modern HRA requirement).

Common Core IHA Codes

Code	Type	Code Description
99203	CPT	Office Outpt New 30 Min
99204	CPT	Office Outpt New 45 Min
99205	CPT	Office Outpt New 60 Min
99213	CPT	Office Outpt Est15 Min
99214	CPT	Office Outpt Est 25 Min
99215	CPT	Office Outpt Est 40 Min
99344	CPT	New patient, home or residence visit; Home or residence visit for a new patient involving moderate MDM or 60 minutes of total time on the date of the encounter.
99345	CPT	New patient, home or residence visit; Home or residence visit for a new patient involving high MDM or 75 minutes of total time on the date of the encounter.
99349	CPT	Established patient, home or residence visit; Home or residence visit for an established patient involving moderate MDM or 40 minutes of total time on the date of the encounter.
99350	CPT	Established patient, home or residence visit; Home or residence visit for an established patient involving high MDM or 60 minutes of total time on the date of the encounter.
99381	CPT	1st Preventive Medicine New Patient < 1yr
99382	CPT	1st Preventive Medicine New Patient Age 1-4 Yrs
99383	CPT	1st Preventive Medicine New Patient Age 5-11 Yrs
99384	CPT	1st Preventive Medicine New Patient Age 12-17 Yr
99385	CPT	1st Preventive Medicine New Patient Age 18-39yrs
99386	CPT	1st Preventive Medicine New Patient Age 40-64yrs
99387	CPT	1st Preventive Medicine New Patient Age 65yrs&>
99391	CPT	Periodic Preventive Med Established Patient <1yr
99392	CPT	Periodic Preventive Med Est Patient Age 1-4yrs
99393	CPT	Periodic Preventive Med Est Patient Age 5-11yrs
99394	CPT	Periodic Preventive Med Est Patient Age 12-17yrs
99395	CPT	Periodic Preventive Med Est Patient Age 18-39yrs

99396	CPT	Periodic Preventive Med Est Patient Age 40-64yrs
99397	CPT	Periodic Preventive Med Est Patient Age 65yrs&>
G0438	HCPCS	Annual Wellness Vst; Persnl Pps Init
G0439	HCPCS	Annual Wellness Vst; Pps Subsqt Vst
O09.90	Diagnosis	Supervision Of High-Risk Pregnancy, Unspecified, Unspecified Trimester
O09.91	Diagnosis	Supervision Of High-Risk Pregnancy, Unspecified, First Trimester
O09.92	Diagnosis	Supervision Of High-Risk Pregnancy, Unspecified, Second Trimester
O09.93	Diagnosis	Supervision Of High-Risk Pregnancy, Unspecified, Third Trimester
Z00.00	Diagnosis	Encounter Gen Adult Med Exam W/O Abnormal Find
Z00.00	Diagnosis	Encounter Gen Adult Med Exam W/O Abnormal Find
Z00.01	Diagnosis	Encounter Gen Adult Medical Exam W/Abnormal Find
Z00.01	Diagnosis	Encounter Gen Adult Medical Exam W/Abnormal Find
Z00.1	Diagnosis	Encounter For Newborn, Infant And Child Health Examinations.
Z00.110	Diagnosis	Newborn Exam, Under 8 Days
Z00.110	Diagnosis	Encounter For Health Exam Of Newborn Under 8 Days Of Age
Z00.111	Diagnosis	Newborn Exam, 8–28 Days
Z00.111	Diagnosis	Encounter For Health Exam Of Infant 8 To 28 Days Of Age
Z00.121	Diagnosis	Encounter Rtn Child Health Exam W/Abnormal Find
Z00.121	Diagnosis	Encounter Rtn Child Health Exam W/Abnormal Find
Z00.129	Diagnosis	Encounter Rtn Child Health Exam W/O Abnormal Find
Z00.129	Diagnosis	Encounter Rtn Child Health Exam W/O Abnormal Find
Z00.411	Diagnosis	Encounter For Gyn Exam (General) (Routine) W Abnormal Findings
Z00.419	Diagnosis	Encounter For Gyn Exam (General) (Routine) W/O Abnormal Findings
Z02.2	Diagnosis	Encounter Exam Admission Residential Institution
Z1032	HCPCS	First Prenatal Visit and Is Billed After The Pregnancy Has Been Confirmed.
Z1034	HCPCS	Antepartum Visits and Is Reimbursable Only When Obstetrical Care Is Billed On A Per-Visit Basis
Z1038	HCPCS	Postpartum visit
Z34.00	Diagnosis	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Diagnosis	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Diagnosis	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Diagnosis	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Diagnosis	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Diagnosis	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Diagnosis	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Diagnosis	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Diagnosis	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Diagnosis	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Diagnosis	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Diagnosis	Encounter for supervision of normal pregnancy, unspecified, third trimester
Z6500	HCPCS	Recipient receives all three initial nutritional, health education and psychosocial assessments and the initial pregnancy-related office visit within four weeks of entry into care.

5.1.3 Social Determinants of Health Coding

SDOH ICD-10 Coding & CalAIM Referral Map (Part 1 of 2)

Category	ICD-10 Code	Definition/ Description	CalAIM Community Supports	Referral Resources
Housing	Z59.00 - Z59.02	Homelessness (Unspecified, Sheltered, or Unsheltered)	Housing Transition Navigation Services; Housing Deposits	Local Housing Authority; Continuum of Care (CoC)
Housing	Z59.1, Z59.811 - Z59.819	Inadequate Housing; Housing Instability (at risk)	Housing Tenancy & Sustaining Services; Transitional Rent (up to 6 months)	Health Consumer Alliance; Eviction Defense
Food & Utilities	Z59.41, Z59.48	Food Insecurity; Lack of adequate food	Medically Tailored Meals; Medical Nutrition Therapy	WIC; CalFresh (Food Stamps)
Financial	Z59.861	Financial Insecurity (difficulty paying utilities)	Housing Deposits (can include utility set-up/arrears)	LIHEAP (Utility Assistance)
Education	Z55.0	Illiteracy or low-level literacy	Enhanced Care Management (ECM) to coordinate specialized support	Local Library Literacy Programs; Adult Education
Social Support	Z60.2, Z60.4	Living alone; Social exclusion or rejection	ECM Lead Care Manager for in-person community connection	Area Agency on Aging; Community Centers
Social Support	Z63.0-Z63.9	Other problems related to primary support groups, including family circumstances		
Social Support	Z63.0 - Z63.72	Family/Relationship Problems; Bereavement; Addiction in family	Short-Term Post-Hospitalization Housing (if stable support is lacking)	County Behavioral Health; Support Groups
Occupation	Z56.0-Z56.9	Problems related to employment and unemployment	Day Habilitation Programs (to improve social/vocational skills); ECM coordination for vocational barriers	Employment Development Department (EDD); Department of Rehabilitation (DOR); Local America's Job Centers
Occupation	Z57.0-Z57.9	Occupational exposure to risk factors	Enhanced Care Management (ECM) to link to legal/workplace safety advocacy	OSHA (Occupational Safety and Health Administration); Legal Aid at Work; Worker's Compensation
Psychosocial Circumstances	Z62.0-Z62.22 Z62.29- Z62.6 Z62.810-Z62.813 Z62.819-Z62.822 Z62.890-Z62.891 Z62.898-Z62.9	Problems related to upbringing	ECM Child/Youth Populations of Focus for specialized care coordination and trauma-informed support	Child Welfare Services (CWS); CASA; Youth Mentorship Programs; Foster Youth Services

SDOH ICD-10 Coding & CalAIM Referral Map (Part 2 of 2)

Category	ICD-10 Code	Definition/ Description	CalAIM Community Supports	Referral Resources
Psychosocial Circumstances	Z64.0- Z64.4	Problems related to psychosocial circumstances		
Psychosocial Circumstances	Z65.0- Z65.9	Problems related to other psychosocial circumstances		
Safety & Legal	Z65.1, Z65.2	Imprisonment or release from prison	Housing Transition Navigation (Transitioning from carceral settings)	Re-entry Support Programs; Parole/Probation Services
Safety & Legal	Z62.819	Personal history of childhood abuse	Referral to Trauma-Informed Behavioral Health Services	Victim Advocacy Centers

5.2 Billing Guidelines

- Confirm same-day billing rules (e.g., E/M + preventive + vaccines)
- Confirm telehealth modifiers and place of service
- Confirm documentation required for each billed service

5.3 Avoiding Common Errors

- Missing HRA date/tool reference
- No provider signature/attestation where required
    - For a medical record to be valid, the rendering provider must "attest" that they provided the services described.
- Problem list not updated → impacts Risk Adjustment Factor (RAF) and continuity
    - Beyond estimated healthcare costs for a patient, an outdated problem list means other providers may not be aware of a patient's full history, leading to fragmented care and missed opportunities for necessary screenings or chronic disease management.
- No documentation of follow-up for positive screenings
- Incorrect member "new vs established" status
    - A patient is considered new if they have not received any professional, face-to-face services from the physician or another provider of the same specialty in the same group practice within the past three years

Appendix U: Avoiding Common Billing Errors

Best Practice Tip: Determining New vs. Established Patient Status

New vs. Established" Patient Logic for IHA

- Scenario A: Patient is on the New Member Roster and has never been to your clinic.
  - *Action:* Use New Patient Template (99204–99205).
- Scenario B: Patient is on the New Member Roster but saw a different specialty (e.g., saw your group's Cardiologist, now seeing Primary Care) within 3 years.
  - *Action:* Use New Patient Template (99204–99205).
- Scenario C: Patient is on the New Member Roster but saw any PCP in your group 2 years ago.
  - *Action:* Use Established Patient Template (99212–99215).

5.4 Encounter Data Submission Requirements

- Timely submission within contract timeframe
- Data completeness (patient age/gender, diagnosis, procedure codes, dates, place of service, billing/rendering provider NPI)
- Reconciliation process for rejected encounters

For more information on SFHP Claims Submissions, Claims Operations Manual, and Claims Operations Manual FAQs, please visit Claims Submission - San Francisco Health Plan.

6. Pathway to Success: Best Practices for Primary Care

6.1 IHA Point Persons

- For practices with more than five staff members, designating a specific IHA Point Person is recommended (but optional) that may facilitate IHA best practice operations and prevent administrative bottlenecks.

- **Who are they?**
  IHA Point Persons are dedicated team members (usually lead Medical Assistant or Front Office lead) who act as the "go-to" experts for everything related to Initial Health Appointments. He/she maintains quality and solves barriers to IHA compliance.
  They are the enthusiastic advocates who keep the rest of the team motivated and on track.

- **What is their role?**
  Their job is to ensure the **"**Pathway to Success**"** actually happens on the ground. This includes:
  - **Troubleshooting:** Helping the team solve scheduling or referral hurdles as they happen.
  - **Training:** Onboarding new staff on how to make IHAs "member-centric" rather than just checking boxes.
  - **Quality Check:** Monitoring the tracking log to make sure we are "closing the loop" on all referrals and following up on no-shows.

- **How are they prepared to be the IHA champion for your clinic?**
  To ensure your clinic's success, San Francisco Health Plan (SFHP) provides dedicated professionals for your designated IHA Point Person. A collaborative team, including Provider Network Management (PNM) and Facility Site Review (FSR) staff, are available to provide support according to your business needs to ensure your clinic's IHA compliance.
  - **Key Responsibilities of the IHA Champion**
    The designated IHA Point Person will be the clinic's key driver of IHA compliance efforts through the following developmental pillars:
    - **Mastery of IHA Requirements:** Complete a deep-dive into the SFHP toolkit to gain expert knowledge of the specific IHA requirements for Medi-Cal and Medicare populations. Access SFHP IHA website with IHA resources.
    - **Strategic Process Design:** Collaborate with clinic leadership to address and implement standardized IHA policies, including effective outreach workflows and referral-tracking systems.
    - **Knowledge Leadership & Support:** Maintain knowledge of current evolving best practices and serve as a key internal resource for sharing that knowledge with the broader clinical team.

    - FSR Nurses will lead the "Clinic Champion Orientation" process and provide further instructions once the contact is received.

Appendix V: IHA Point Person

IHA Champion: First 30 Days "Getting Started" Checklist
This checklist is designed to help the newly designated IHA Champion establish a strong foundation for compliance and team leadership.

- ☐ **Identify Your Lead:** Designate a staff member to serve as the IHA Point Person to spearhead compliance and training efforts.
- ☐ **Review the SFHP Provider Toolkit:** Conduct a thorough initial read-through of all IHA guidelines, focusing on specific requirements for Medi-Cal vs. Medicare D-SNP members.
- ☐ **Audit Current Workflows:** Evaluate existing clinic processes for member outreach, appointment scheduling, and referral tracking to identify any gaps in IHA completion.
- ☐ **Define Clinic Policy:** Draft or update the clinic's formal IHA policy in collaboration with leadership to ensure it aligns with current CalAIM and SFHP standards. Depending on your medical group affiliation, most medical groups have adopted approved IHA policies as part of their Delegation Oversight Compliance Audit requirements. Check with your delegate group leadership for this policy to align with the clinic policy.
- ☐ **Set Up Tracking Systems:** Confirm that your Electronic Health Record (EHR) is aligned with IHA requirements or minimally ensure internal tracking to flag new members is configured.
- ☐ **Schedule a Team Briefing:** Conduct huddles with clinic staff to review the importance of IHA protocol and documentation requirements for clinic compliance.
- ☐ **Connect with SFHP Support:** If you need assistance, email your FSR Team at fsr@sfhp.org for guidance.

6.2 Staffing Constraints and IHA Compliance

Recognizing that smaller or independent practices may not have the capacity for "Point Person" duties, here is a “cheat sheet” to make the IHA process part of what you are already doing. Treat this as a 3-step checklist added to your normal rooming process.

The MA’s "Cheat Sheet" for IHAs

For the one doing it all.

If you are the IHA "Point Person," Office Manager, and Lead MA all at once, don’t treat the IHA as a new project. Treat it as a 3-step checklist added to your normal rooming process.

- The "Morning Huddle" Scan (2 Minutes)
    - When you look at your schedule, put a star next to any New Medi-Cal Member. That star means: “I need a Health Risk Assessment, Behavioral Risk Assessments, and physical for this person today.”

- The "Waiting Room" Task
    - Don’t wait for the doctor to ask for the assessment. Check if the HRA has been completed and prep for the appropriate screening tools to be completed by the patient the second they sit down.
        - Tell them: "We believe health is more than just a blood pressure check. These tools help us see if stress, sleep, or your mood are affecting your physical health. Everything you write is private and just helps us make sure we’re supporting you in every way we can.”
        - Tech issues? Skip the portal. Give them the paper version. Paper is better than "not done."

- Hand Off the Hard Stuff
    - Divide and conquer! If the patient says they are homeless, out of food, or need a ride:
        - Don’t fix it yourself.
        - Do this: Flag the "Positive Screening" on the form and call the Health Plan’s Care Management line.
        - The Script: "I have a member here with high social needs. I’m sending over the HRA; please have a Case Manager take over."

Best Practice Tips:
Run member rosters to anticipate new patients. Send new patient questionnaires and/or screening forms prior to the visit or ask the patient to arrive to their appointment early to complete the forms.

In addition, maintain a stock of new patient packets that include a checklist of required paperwork or the actual screening forms for immediate completion.

6.3 Improving Member Engagement

- Start with “What matters most to you?”
- Use teach-back for meds and next steps
- Make the first visit low-friction: same-day labs, clear instructions

6.4 Addressing Social and Cultural Needs

- Normalize SDOH questions (“We ask everyone…”)
- Use culturally responsive education materials
- Incorporate caregiver and family supports with consent

6.5 Integrating Behavioral Health and Whole-Person Care

- Warm handoffs for positive screens
- Closed-loop referrals
- Care team huddles for complex members

7. Quality, Audit, and Monitoring

7.1 Quality Monitoring

SFHP monitors your compliance with initial health appointment (IHA) and health risk assessment (HRA) requirements through a combination of methods such as automated data tracking, monthly IHA performance monitoring, Facility Site Review (FSR) and Medical Record Review (MRR) audits, Annual Delegated Oversight IHA audits, and as needed, based upon monthly IHA monitoring by SFHP.

"A high-quality IHA isn't just a requirement—it's the first step in a life-long partnership with your patients."

Data Capture & Measurement

Data is collected using appropriate diagnoses from claim submissions. For the full code list and descriptions, reference

- All Plan Letter 21-009 (Revised): Collecting Social Determinants of Health Data.

Key Performance Indicators Tracked:
SFHP monitors the following to assess quality and outcomes:

- IHA completion rate by provider/site
- HRA completion rate and risk stratification
- Preventive care gap closure rates (screenings/immunizations)
- Follow up on positive screenings (Behavioral Health, SDOH)
- Referral completion rates
- Successful "Warm Handoffs" for Social Needs

Monthly Reporting & Provider Support:
SFHP provides actionable data to medical groups through monthly reports generated by the Quality Data Analytics (QDA) team. These reports can help providers proactively close care gaps and improve compliance.

- Tracks overall IHA compliance
- Identifies members without a completed IHA after 120 days
- Includes member-level contact data for outreach

Facility Site Review (FSR) & Medical Record Review (MRR) Audits:
SFHP conducts periodic reviews to validate IHA compliance in accordance with All Plan Letter 22-017.

Delegation Oversight Audits:
SFHP conducts annual IHA Delegation Oversight audits for the medical groups. Audit components include policy and procedure review and medical record review.

The processes for HRA, Health Information Form (HIF)/Member Evaluation Tool (MET), and IHA are distinct but interconnected under California's CalAIM Population Health Management (PHM) initiative.

Best Practice Tip: Distinguishing HIF/MET, HRA, and IHA

Process	Care Management Role	Quality/Compliance Role	FSR
HIF/MET (Health Information Form/Member Evaluation Tool)	Screens new members within 90 days of enrollment to identify immediate needs and positive screening results.	Ensures the form is administered on time to all new members and tracks completion rates as a metric.	N/A
HRA (Health Risk Assessment)	Conducts a more in-depth assessment within 30 days of risk identification to identify complex needs (e.g., LTSS, behavioral health) and develops the resulting care plan.	Audits the timeliness and completeness of HRAs, ensuring proper referrals are made and documented in the member's record.	Clinical Protocol Oversight: During the review, DHCS-certified nurses ensure that the site has a consistent workflow to receive and integrate in-depth health assessments into the clinical record for continuity of care.
IHA (Initial Health Appointment)	Utilizes data from the HRA/HIF-MET to coordinate the members' first comprehensive visit with their PCP, facilitating referrals and transportation as needed.	Holds network providers accountable for completing the IHA and all required preventive screenings within the designated timeframe (typically 120 days for adults).	Medical Record Audit (MRR): As a component of the FSR, the Medical Record Review (MRR) specifically audits patient files to provide legal proof that the first visit and all required preventive screenings were completed within the 120-day timeframe.

7.2 Audit Readiness

Maintain:

- Standard template usage
- Required fields completion monitoring
- Outreach attempt logs for non-completers
- Signed documentation/attestation
- Evidence of follow-up

Appendix W: Audit Tool

Delegation Oversight (DO) Audit Activities (If that applies to your practice)

- Policy and Procedure Review - IHA
    - Delegate submits IHA Policy within 30 days of Open Audit Conference
    - Copy of medical group's policies and procedures, provider manual, and other supporting documents related to educating the Providers on IHA requirements and how they perform oversight are submitted to SFHP DO Program Manager
    - FSR reviewer will assess medical group IHA policies and enter findings into FSR external data management system, Readily
- Medical Record Review – IHA
    - FSR reviewer will conduct IHA MRR on minimum of 10 record samples and enter findings into Readily
    - Corrective Action Plan (CAP) will be assigned and reconciled with the delegated group leadership or assigned responsible person if any findings inconsistent with IHA requirements

7.3 Corrective Action Plans (CAP)

When metrics fall below target:

- Root cause analysis (access, workflow, documentation)
- Training + template improvements

Appendix X: Corrective Action Plan Inservice Guide

Audit Findings and Corrective Action Plan (CAP)

- The FSR reviewer will enter all audit data into designated data management system, which automatically tracks progress and notifies the DO Program Manager when the FSR Reviewer needs additional information and when the audit is complete.
    - Completed IHA Policy and Medical Record Review Tool
    - Findings Report
    - Corrective Action Plans (CAPs) and any required in-service materials
- FSR reviewer will participate in PNOC, where DO Program Manager will present initial audit review findings for approval
- Delegate will respond to CAP within specified period prior to final audit report is finalized
- FSR reviewer will participate in follow-up PNOC, where DO Program Manager will present final audit review findings
- The DO program manager will issue the CAP to the Delegate. The DO program manager will coordinate meetings with Delegate and FSR Reviewer to review CAP if needed.
- The Delegate will have 30 days to review and provide submissions for the CAP.
- Provider Network Management (PNM) representative will be the primary point of contact for the Delegate and DO SMEs during the DO audit process.
- For CAP related issues or escalations, contact Provider Relations Specialist
- DO Program Manager will email FSR reviewer once CAP submissions are placed in SharePoint.
- FSR Reviewer will review and approve CAP submissions.

7.4 Performance Improvement Strategies

- Provider scorecards
- Targeted coaching for documentation
- Pre-visit planning and panel management
- Partner with CM for high-risk cohorts

Appendix Y: Process Improvement Tool

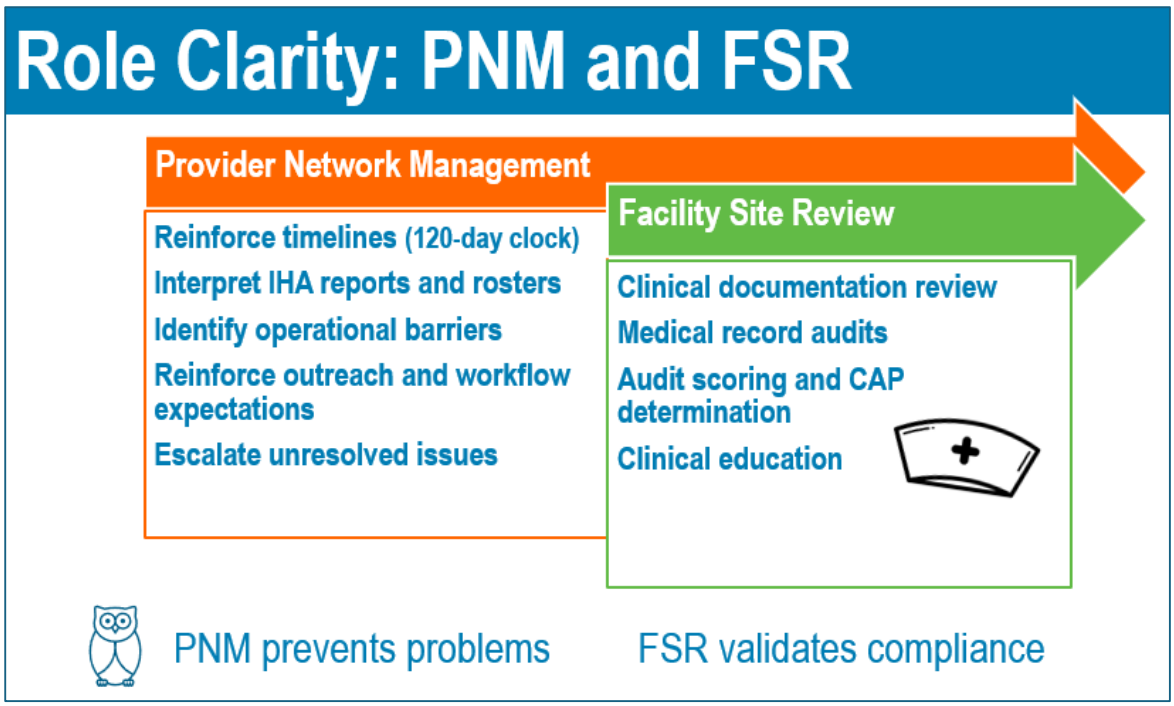
8. Contacts, Resources, and References

8.1 Plan policies, provider manual references

- CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026 - September 2025
- CalAIM Population Health Management Policy Guide, January 2026
- CMS Special Needs Plan Model of Care (SNPMOC) Program Area
- Core Measure 2.1: Frequently Asked Questions (FAQs), Last Updated: March 2024 (Provides clarification for reporting Core Measure 2.1: Members with an assessment completed within 90 days of enrollment.)
- DHCS All Plan Letter (APL) 22-030
- DHCS All Plan Letter (APL) 26-001
- MCP Boilerplate Contract: MCP Contract Exhibit A, Attachment 10, Scope of Services.
- PHM Policy Guide: CalAIM Population Health Management (PHM) Policy Guide – January 2026
- SFHP Provider Manual
- Special Needs Plan Model of Care (SNP-MOC) Audit Process and Data Request

8.2 San Francisco Health Plan Contact List

- **Behavioral Health (Carelon) – Mental Health Services**
  - PCP Referral Process Summary: Summary Sheet
  - Toll Free Access Line: 18553718117
  - Referral Form
- **Care Management Referrals**
  - Intake Line (Medi-Cal Members): 14156154515
  - Intake Line (SFHP Care Plus – DSNP Members): 14156154545
  - Email: caremanagement_referrals@sfhp.org
- **Encounter / Claims & Billing Support**
  - Claims Department Phone: 4155477818 ext. 7115
  - Email: claimsinfo@sfhp.org
  - Claims Operation Manual FAQ
- **Facility Site Review (FSR) Team**
  - Email: fsr@sfhp.org
- **Provider Relations**
  - Phone: 4155477818 ext. 7084
  - Email: Provider Relations
- **Quality Improvement Support – Population Health Management**
  - Phone: 4155477800
  - Email: healthimprovement@sfhp.org

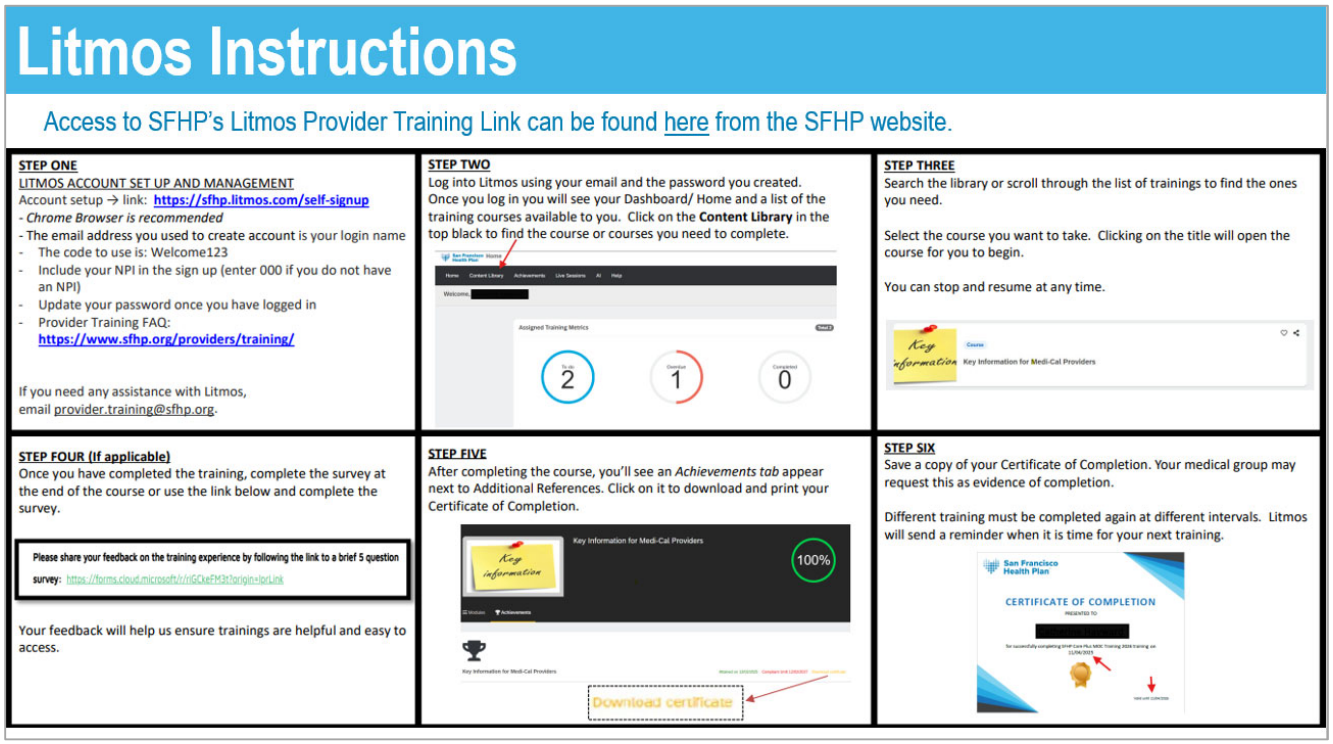


Appendix Overview

	IHA Toolkit Section	#	Tool or Information	Description
1.5	Provider and Staff IHA Training	A	IHA Training Info	Training presentation for onboarding staff on member-centric IHA goal and protocols.
1.6	"Pathway to Success" Roadmap	B	IHA Quick Guide	High-yield clinical reference for core visit elements under time pressure.
2.4	Timeliness Standards	C	IHI Timeliness Chart	Reference table for IHA and HRA completion deadlines.
3.1	Member Identification and Eligibility Verification	D	Member Roster	Guide for using eligibility lists to identify new members for outreach.
3.2	Outreach and Scheduling Workflow	E	Member Outreach Scripts	Standardized language for staff to use during initial patient contact.
3.2	Outreach and Scheduling Workflow	F	Outreach & Engagement Log	Template to document the three mandated "good faith" contact attempts.
3.5	Documentation Workflow	G	Documentation Tip Sheets	Instructions on capturing required clinical and compliance data in the EHR.
3.5.2	EMR Templates	H	EMR Templates	Standardized electronic forms to ensure all mandatory fields are completed.
3.6	Care Coordination and Interdisciplinary Communication	I	IHA Care Coordination Checklist	Step-by-step list to ensure all multidisciplinary needs are addressed.
3.7	Huddles and Hand-Offs	J	Huddles, Handoffs, & Loop Closures	Protocols and scripts for team communication and referral tracking.
3.8	Community Health Workers	K	Community Health Workers	Integration guide for utilizing CHWs to meet HRA and outreach goals.
3.9	Comprehensive Referral Management	L	Referral & Follow-up Tracking	Log for monitoring external clinical and social service referrals.
3.9	Referral Management	M	Referral Routing Guide	Map for directing patients to appropriate in-network specialists and agencies.
3.9	Referral Management	N	Same-Day Referral Guide	Escalation protocols for urgent medical or social findings.
4.1	Health Risk Assessment (HRA)	O	HRA Guidelines	Clinical instructions for administering and scoring Health Risk Assessments.
4.1	Health Risk Assessment (HRA)	P	Behavioral Risk Tracking	Tool for monitoring outcomes of positive mental health or substance screens.
4.3	Social Drivers of Health (SDOH)	Q	SDOH Tools	Validated forms (PRAPARE, WellRx) for identifying social barriers.
4.4	Preventive Screening and Immunizations	R	Screening Tool Resource	Crosswalk of age-appropriate preventive tools and periodicity.
3.5.2	EMR Templates	S	Positive Screening Follow-Up	Protocol for documenting interventions after a risk is identified.
4.6	Care Planning and Follow-Up	T	Follow-Up Care Checklist	Post-visit guide to ensure care plan tasks and orders are executed.
5.3	Avoiding Common Errors	U	Avoiding Common Billing & Encounter Errors	Tip sheet for correct CPT/ICD-10 coding and avoiding claim denials.
6.1	IHA Point Persons	V	IHA Point Person	Preparedness guide and checklist for the clinic's IHA expert.
7.2	Audit Readiness	W	Audit Tool (Scorecard)	Internal pass/fail checklist to evaluate chart readiness for plan audits.
7.3	Corrective Action Plans (CAPs)	X	Corrective Action Plan Inservice Guide	Framework for addressing performance gaps and workflow failures.
7.2	Performance Improvement Strategies	Y	Process Improvement Tool	Project Charter template for implementing site-level quality improvements.

Appendix A: Where to Access Provider and Staff Training

https://www.sfhp.org/providers/training/



Appendix B: IHA Quick Guide

The IHA High-Yield Guide

Time	Action Item	Goal
Min 1-3	**Social Triage**	Identify Z-code barriers (Housing/Food/Transport).
Min 4-6	**Risk Review**	Scan HRA/Behavioral results for "Red Flags."
Min 7-8	**Clinical Intake**	Med Reconciliation + Problem List update.
Min 9-10	**Closing Loop**	Set 1-2 member goals + initiate referrals.

QUICK GUIDE: Medi-Cal & Medicare Initial Health Appointments (IHA)

Complete a comprehensive "Welcome Visit" to establish trust and meet state/federal compliance.

1. The Clock: When is it due?

- **Medi-Cal Members:** Within 120 days of enrollment.
- **Medicare Advantage / D-SNP:** Within 90 days of enrollment.
- **The "New" Rule:** A patient is "New" if they haven't seen a provider of the same specialty in your group within 365 days.

2. The Workflow: Who does what?

- **Front Office**
  - Identify new members on the SFHP Roster; make 3 outreach attempts (2 phone + 1 letter); document every attempt in the EHR.
- **MA / CHW**
  - Ensure the Health Risk Assessment (HRA) is completed before the provider enters; flag "Red Flags" (housing, food, or safety crises).
- **Provider**
  - Review the HRA; perform a focused exam; reconcile medications; and address at least one preventive gap (e.g., vaccine or screening).

3. The "Must-Have" Documentation

- **HRA:** Must document the **Tool Name** and **Date**.
- **Med Rec:** Must include the statement: *"Current medications reviewed and reconciled with the patient."*
- **Behavioral Health:** Document a score (PHQ-9/GAD-7) and a follow-up plan.
- **Interpreter:** If used, you **must** document the Interpreter's Name and ID number.

4. Billing: Get Credit for your Work

To count as a completed IHA, the claim **must** include:

- **The Visit Code:** (99381–99387 for New; 99391–99397 for Established).
- **The IHA Flag: Z00.00** (Adult) or **Z00.12** (Child) as the primary diagnosis.
- **The SDOH Codes:** Use **Z-codes (Z55–Z65)** to report housing, food, or transport needs identified during the visit.

5. Same-Day Escalation (Red Flags)

- **Clinical:** Remediate critical medical needs or medication lapses immediately through stabilization or direct care connections.
- **Safety:** Maintain continuous presence and initiate protective protocols if there is a risk of harm to self, others, or from an abusive party.
- **Social:** If basic needs like shelter or food are unmet, ensure a direct connection and warm handoff to support services before the visit concludes.
- Use these validated tools to identify "Red Flags" during the 10-minute visit:
    - **Adults (18+):** PHQ-9 (Depression), GAD-7 (Anxiety), AUDIT-C (Alcohol).
    - **Adolescents (12-17):** PHQ-A (Depression), CRAFFT (Substance Use).
    - **Older Adults (65+):** GDS (Geriatric Depression), Mini-Cog (Cognitive).
    - **Safety Protocol:** If a screen is positive for Suicidal Ideation (SI), activate the Crisis Protocol immediately. Do not leave the member alone

Front Office & Scheduling Checklist

Goal: Identification, outreach, and barrier reduction before the patient arrives.

- **Identify New Members:** Review the **Monthly Eligibility List** or Health Plan Roster to find members within their first **120 days** (Medi-Cal) or **90 days** (Medicare).
- **Verify Status:** Check if any provider in your group saw the member in the last **365 days**. If "No," book as a **New Patient**.
- **Standardized Outreach:** If the member hasn't called, initiate the **Call → Text → Mail** sequence. Log at least **3 attempts** on different days to satisfy audit requirements.
- **Screen for Barriers:** Ask the member:
    - "What is your **preferred language** for medical details?" (Book interpreter 48hrs in advance if needed).
    - "Do you require **transportation assistance** or wheelchair access?"
- **Pre-Visit Prep:** Send the **Health Risk Assessment (HRA)** or new patient questionnaire via portal/mail to be completed before the visit.

Clinical Team (MA/Provider) Checklist

Goal: Accurate documentation of core components and "closing the loop" on findings.

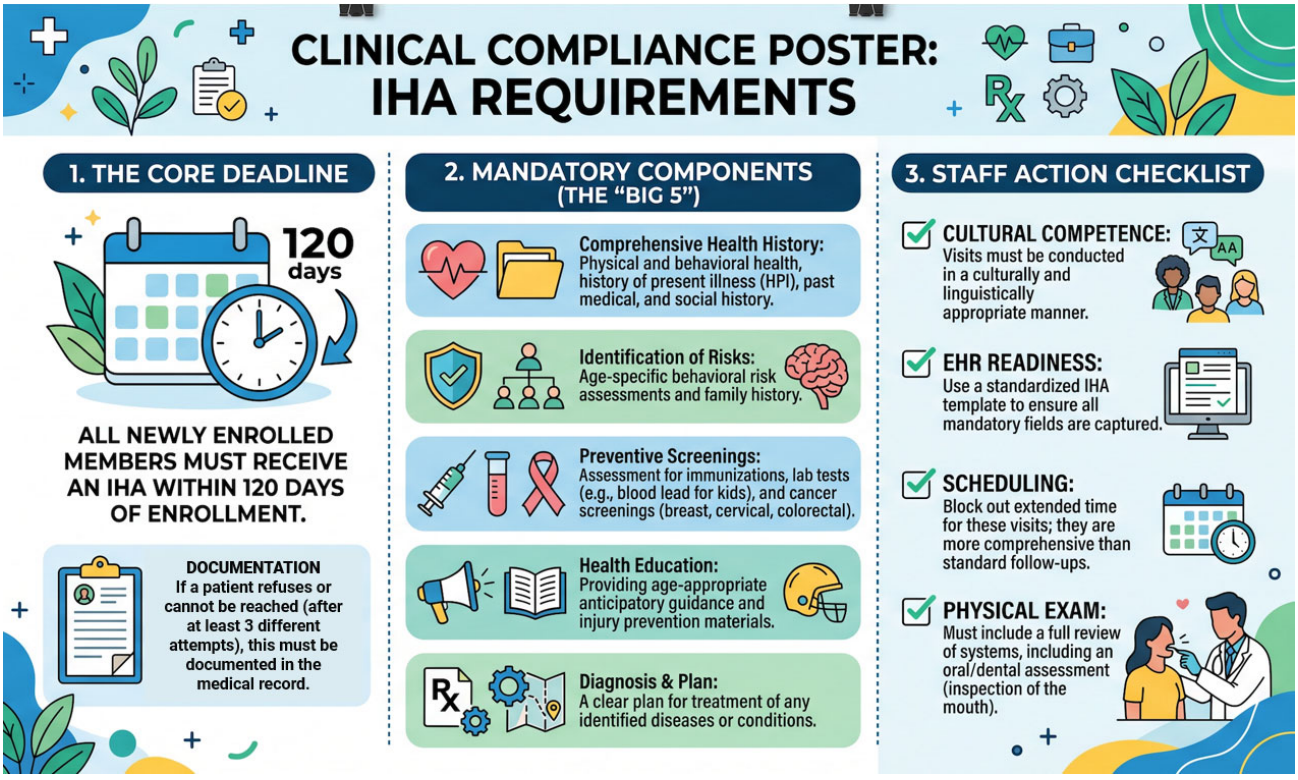
- **HRA Completion:** Confirm the HRA tool name, date, and version are recorded in the EHR.
- **Medication Reconciliation:** Document all Rx, OTC, and supplements. Include the definitive statement: **"Reviewed and reconciled today."**
- **Required Screenings:** Perform and record numerical scores for:
    - **Behavioral Health:** (e.g., ASQ:SE-2, SWYC, PHQ-9, GAD-7, or AUDIT-C).
    - **SDOH:** Identify risks in housing, food, and transportation.
- **Physical Exam:** Record vitals (Height, Weight, BMI, BP) and perform age-appropriate preventive screenings (e.g., breast exam, Pap).
- **Referral Management:**
    - Enter orders for any positive screenings.
    - Flag "Red Flags" (e.g., suicidal ideation) for **48-hour follow-up**.
- **Coding & Attestation:**
    - Ensure the rendering provider **signs/attests** the note.
    - Use correct ICD-10 codes (e.g., **Z00.00** for routine or **Z00.01** if abnormal findings were found).

Appendix C: IHA Timelines

Current timeliness state and federal regulatory standards for Medi-Cal managed care and Medicare Advantage (MA) plans as of 2026

Key Verification of the Chart's Data

- **Medi-Cal Initial Health Appointment (IHA):** The **120-calendar day** timeline is a strict contractual requirement from the California Department of Health Care Services (DHCS) for all new enrollees.
- **Medicare Advantage Health Risk Assessment (HRA):** MA plans are required by CMS to conduct an initial HRA within **90 days of enrollment** and at least annually thereafter.
- **CalAIM Referral Tracking:** Under the new California Advancing and Innovating Medi-Cal (CalAIM) requirements, managed care plans (MCPs) must implement **Closed-Loop Referral (CLR)** systems that collect status updates at least **monthly** from service providers.
- **Timely Access Standards:** The timelines for **Urgent Findings (48 hours)**, **Non-Urgent Primary Care (10 business days)**, and **Specialist Referrals (15 business days)** are mandated by California's timely access to care laws for managed care plans.
- **Preventive Care Risks:** Medicare and Medi-Cal guidelines specify that if a preventive exam identifies a risk (such as cognitive impairment or depression), providers must offer personalized advice or referrals **during or immediately following** that visit.



Appendix D: Member Roster Tip Sheet

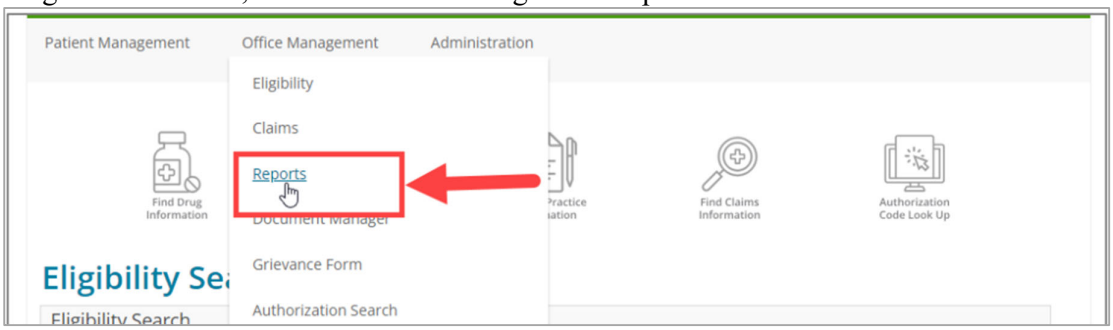
Providers are responsible for ensuring that all newly assigned members receive outreach to schedule an Initial Health Appointment (IHA) within the required timeframe. A key compliance requirement is that outreach attempts are completed, tracked, and followed through to confirm:

- The member received the IHA, and
- The IHA findings were reviewed by the Primary Care Provider (PCP).

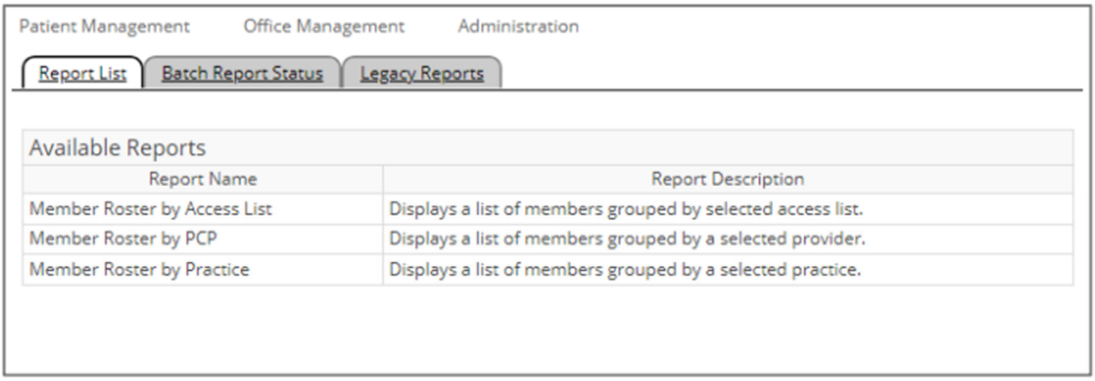
To support this requirement, providers are encouraged to pull a monthly member roster through the SFHP Provider Portal. Instructions can be found on page 15 of the Provider Portal User Guide. This roster helps clinics identify new members who are within their IHA window and prioritize outreach efforts.

Access to the Member Roster
The member roster function is only available to users with Office Manager or Provider roles in the Provider Portal. Access to this report may vary depending on the role and permissions assigned to each account, so different staff at your site may have different levels of access. If you do not see this option, your account may not have the appropriate role assigned.

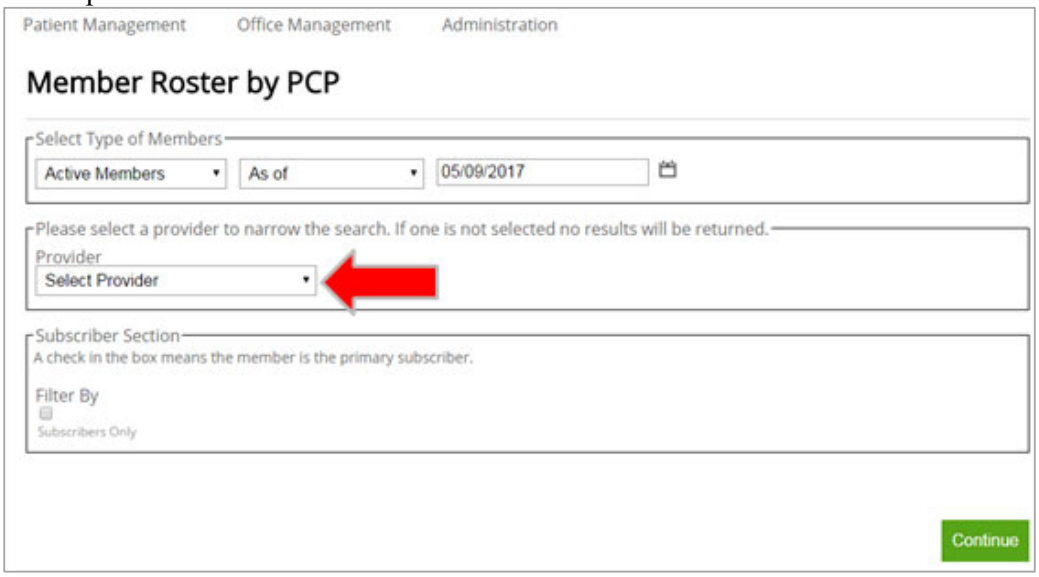
How to Generate the Monthly Member Roster
To generate a roster, click on Office Management Reports.



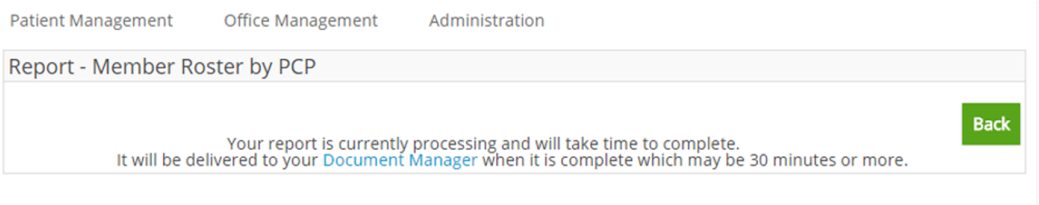
A new page will appear indicating which reports are available. You may choose to generate your rosters by having them grouped by PCPs, Access List, or by Practice.



Below is an example of a roster being generated by PCP. You will need to select a provider from the drop-down list.



Rosters will take approximately 20-30 minutes to generate. If you are unable to view or retrieve a roster, please contact Provider Relations at **1(415) 547-7818 extension 7084**.

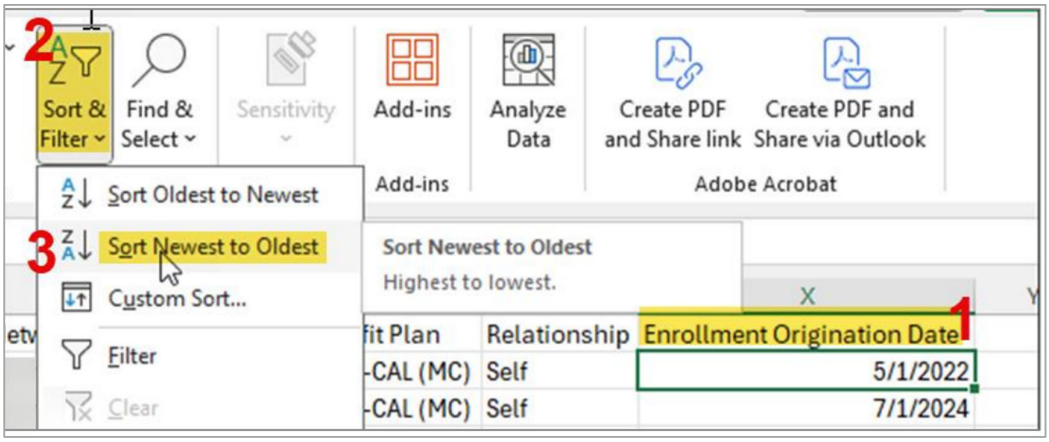


You can use your clinic roster to outreach your newly assigned members for an Initial Health Appointment (IHA).

Once the roster is generated, open it on your computer and sort the field (Screenshot below):

1. Click on Column "Enrollment Origination Date"
2. Click on "AZ Sort & Filter"
3. Click on "Sort Newest to Oldest".

Members who were assigned to your clinic in the last 120 days (4 months) will be on top and they are within their window for IHA visit.



If you have questions about the IHA, accessing the New Member Monthly Roster, or navigating the Provider Portal, SFHP's Provider Relation's team is ready to assist. Submit a request via providerportal@sfhp.org.

Appendix E: Member Outreach Scripts

For Member Outreach Scripts**,** the goal is to shift the conversation from a "requirement" to a "benefit." These scripts are designed for Community Health Workers (CHWs) and Front Office staff to build trust while ensuring compliance with the 3-attempt audit standard (3.2, 7.6).

Building Trust & Reducing Barriers to the Initial Health Appointment

📞 Member Outreach Scripts

- **Scenario 1: The Initial "Welcome" Call (Attempt #1)**
  Use this within the first 30 days of enrollment to establish a connection.
  - "Hi (Member Name), I'm (Name), a Community Health Worker with (Clinic Name). Welcome to our practice! I'm calling because you're new to the plan, and we want to make sure you have everything you need to stay healthy. (Or)
  - "Hi (Member Name), I'm calling from (Clinic Name) to welcome you! We see you are a new member with San Francisco Health Plan. We'd like to get you scheduled for your Welcome Visit. This is a special appointment where we get to know your health goals, review your medications, and make sure you have everything you need from your new plan. We have an opening on (Date/Time)—would that work for you?"
  - We'd like to schedule your Initial Health Appointment. This is a quick 10–20 minute visit where we get to know your goals, check your medications, and see if there are any benefits—like transportation or food programs—we can unlock for you. Do you have a few minutes next (Day) at (Time)?"

- **Scenario 2: Overcoming Barriers (If Member Hesitates)**
  Use this when a member mentions a barrier like work, kids, or rides.
  - "This visit is really helpful because it ensures your prescriptions are transferred correctly and we can set up any transportation or social services you might need right away." (Or)
  - "We really want to see you on (Date), but we know life happens. Are there any hurdles we can help with to make sure you can make it? For example, do you need us to book plan-funded transportation for you, or would you prefer this first visit be via telehealth (video/phone)?" (Or)
  - "I completely understand that life is busy. Many of our members have the same concerns. To make this easier for you:
    - **If Transportation is an issue:** I can book a plan-funded ride (NMT) for you today.
    - **If Time is an issue:** We can actually do the first part of this visit—the Health Risk Assessment—over the phone right now to save you time at the clinic.
    - **If Language is an issue:** We will have a professional interpreter ready for you in (Preferred Language) so you can speak directly with the doctor." (3.4)
    - **Other:** _____

      _____

- **Scenario 3: The "HRA-First" Approach (Pre-Visit Planning)**
  Save clinical time by getting the Health Risk Assessment done before the visit.
    - "To make your visit with (Provider Name) as smooth as possible, we have a short [Health Risk Assessment] form. It asks about things like your housing and food needs so we can have resources ready for you when you arrive. Can we complete that over the phone now (takes about 5 minutes), or would you prefer I text you a secure link?"

- **Scenario 4: The "90-Day" Urgent Script (Attempt #3)**
  Use this when the member is approaching their Medicare (90-day) or Medi-Cal (120-day) deadline. (7.6)
    - "Hi (Member Name), I'm following up to make sure we get you in for your new member visit. It's really important that we do this within your first few months of joining (Health Plan) so we can authorize any refills or referrals you might need later this year.
    - If you can't make it in-person, would you be open to a Telehealth visit from your phone? It counts as your initial visit and ensures your care isn't interrupted." (3.3)

- **Scenario 5: The Final "Good Faith Effort" Voicemail/Letter**
  Document the 3rd attempt for audit compliance.
    - "This is (Staff Name) from (Clinic Name). We have tried to reach you regarding your Initial Health Appointment, which is a benefit provided by your health plan to ensure you're getting the best care. Please call us back at (Phone Number) to schedule. If we don't hear from you, we will reach out again in (Re-attempt Cycle) to check in on your health needs."

Quick Tips for Success:

- **Identify Language Needs:** If the member sounds hesitant in English, immediately ask: *"Would you prefer to speak in (Spanish/Cantonese/etc.)?"* and use your interpreter line.
- **The "Warm Handoff":** If a Community Health Worker is making the call, they should mention they can accompany the member to the clinic to help with paperwork.

Appendix F: Outreach & Engagement Log

This log ensures a standardized sequence of attempts is documented for every new member, meeting compliance for "due diligence" in scheduling the Initial Health Appointment.

Outreach & Engagement Log (1.5, 3.2)

*To satisfy the "Unsuccessful Outreach" audit exception, you must log **3 attempts** on different days using **2 methods** (e.g., 2 calls + 1 letter).*

Attempt #	Date/Time	Method (Call, Text, Mail)	Contact Person (Member/Alt Contact)	Outcome / Status (Left VM, Text Sent, Wrong #, Appt Set)	Staff Initials
1		Call 1			
2		Text / SMS			
3		Call 2			
4		Mailed Letter			
5		Alt Contact			
Final		HRA Status		[ ] Pre-Completed [ ] Pending	

Social Needs Follow-Up

- **The Script:** "I'm following up on the food/housing referral we made. Were you able to connect? Do you need help with the paperwork or a ride there?"
- **Action:** Update the Referral Tracking Log to "Closed-Completed" once the loop is closed.

Appendix G: Documentation Tip Sheets

This template is designed to be converted into an EHR SmartPhrase (e.g., .IHA_DONE). It covers every "must-have" documentation element required by Medi-Cal and Medicare Advantage audits, ensuring your providers meet compliance with every click.

IHA Provider Attestation Template - Initial Health Appointment (IHA) Summary

Outreach Attempts:
Success: Member scheduled IHA for (Date). [(Insert relevant note, e.g., "NMT transportation booked").]
Refusal: Member declined appointment. Stated: (Insert Member's Reason). Educated on importance of IHA. (12.1)
Unreachable: Attempt #3: Called (Time); no answer. Left VM regarding 90-day assessment deadline. 2 calls + 1 letter completed. (3.2)

Health Risk Assessment (HRA):
Reviewed the (Insert Tool Name, e.g., SFHP HRA) completed on (Insert Date). Findings reviewed with patient, including clinical, functional, and social risks.

Medication Review & Reconciliation:
I have personally reviewed and reconciled the patient's active medication list (including Rx, OTC, and supplements) with the patient/caregiver today. Potential barriers to adherence were addressed.

Clinical Screenings & Gaps:

- **Behavioral Health:** Screening for (Depression/Anxiety/Substance Use) performed/reviewed. Result: (Insert Score). Plan: (e.g., Routine follow-up / Referral placed).
- **SDOH:** Social Drivers of Health assessed (Housing, Food, Transport). Needs identified: (None / List Needs).
- **Preventive:** Gaps in care (Cancer screenings/Immunizations) reviewed. Orders/Referrals placed for: (List Orders).

Care Plan & Member Agreement:
The patient's top priority is (Insert Patient Goal). I have developed a prioritized care plan to address identified medical and social needs. The patient/representative participated in this plan and agrees with the next steps.
Interpreter Services:
Not required (Patient/Provider proficient in same language)
Used (In-person / Video / Phone) Interpreter.
Interpreter Name/ID#: (Insert ID).

Attestation:
I, (Provider Name, Credentials), have personally performed the services documented above and attest that the medical record is an accurate reflection of the encounter.
Date of Service: (Insert Date) | NPI: (Insert NPI)

Appendix H: EMR Template

While specific electronic medical record (EMR) templates are developed by individual health plans and provider groups, the components required by the Department of Health Care Services (DHCS) for Initial Health Appointment (IHA) are consistent.

Providers can create a structured EMR template to ensure all mandatory elements are documented. This template is based on requirements found in DHCS All Plan Letter (APL) 26-001 and best practices.

VERSION 1 = Includes outreach fields, accommodations, referral status

INITIAL HEALTH APPOINTMENT (IHA) TEMPLATE
(SECTION 1: ENCOUNTER DETAILS)
Member: (Name) | ID: (ID#) | DOB: (DOB) | Due Date: (Date)
LOB: ☐ Medi-Cal (120d) ☐ MA/D-SNP (90d) | Modality: ☐ In-Person ☐ Video ☐ Phone
Encounter Type: ☐ Initial Health Appointment (IHA) ☐ More than 1 visit

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(SECTION 2: STAFF – ACCESS & OUTREACH (AUDIT CRITICAL))
Outcome: ☐ Completed ☐ Scheduled ☐ Refused (Reason: _____) ☐ Unable to Reach
Standardized Outreach Log (Min. 3 attempts, ≥2 methods, different days):

1. (Date) _____ ☐ Ph ☐ Txt ☐ Ptl ☐ Mail | Result: _____ Init: ____
2. (Date) _____ ☐ Ph ☐ Txt ☐ Ptl ☐ Mail | Result: _____ Init: ____
3. (Date) _____ ☐ Ph ☐ Txt ☐ Ptl ☐ Mail | Result: _____ Init: ____

   Language: (Language) | Interpreter: ☐ No ☐ Yes (ID/Name: _____)
   Accommodations Identified: ☐ Mobility ☐ Caregiver ☐ Transport ☐ Forms Asst
   Accommodation Arranged: ☐ Wheelchair ☐ Caregiver Support ☐ Transportation ☐ Other Assist
   Note: Ptl = Patient Portal

(SECTION 3: SCREENINGS & ASSESSMENTS)
HRA Tool: _____ Date: _____ By: ☐ Staff ☐ CHW ☐ Plan ☐ PCP
Key Findings Reviewed: ☐ Med ☐ Beh ☐ Func ☐ Soc | High-Risk? ☐ No ☐ Yes (See Plan)
Behavioral Health (Tool/Score): Dep: ____/ | Anx: ____/ | Sub: ____/
Cognitive/Fall Risk: Tool: _____ Result: _____ | Suicide Risk: ☐ Neg ☐ Pos (Safety Prot)
SDOH Needs: ☐ Housing ☐ Food ☐ Utilities ☐ Transport | Z-Codes Documented: ☐ Yes ☐ No

---

(SECTION 4: CLINICAL DOCUMENTATION (PROVIDER))
Chief Concern / HPI:
_____
Past History: PMH: _____ | PSH: _____ | Family: _____ | Social: _____
Vitals: Ht: ____ Wt: ____ BMI: ____ BP: _____ Pulse: ____
Physical Exam (PE/ROS): ☐ Gen: ____ ☐ CV: ____ ☐ Resp: ____ ☐ GI: ____ ☐ MSK: ____ ☐ Neuro: ____
Medication Reconciliation: ☐ Rx ☐ OTC ☐ Supp | Barriers: ☐ Cost ☐ Side Effects ☐ None

Provider Statement: *"I have personally reviewed and reconciled the patient's medications with the patient/caregiver today."*

(SECTION 5: ASSESSMENT & CARE PLAN)

Problem List (ICD-10): 1. _____ 2. _____ 3. _____

Preventive Care: ☐ Immunizations Updated (CAIR) ☐ Screenings Ordered ☐ Education/AG Provided

Referrals: ☐ Specialty ☐ Behavioral ☐ Dental ☐ ECM/CalAIM

Referral status set to: ☐ Active/Pending

Referral Report Received Date: _____ Result: _____ Reviewed Date: _____

Member Goal/Priority:

_____

Follow-Up: ☐ Routine (Date: _____) ☐ Urgent ≤48hrs

(SECTION 6: BILLING & ATTESTATION (REQUIRED))

Attestation: *I attest that I performed/reviewed the services above; this record reflects today's encounter.*

Provider Signature: _____ NPI: _____ Date: _____

Coding: Visit Code: _____ | Primary Dx: ☐ Z00.00 (Adult) ☐ Z00.12 (Ped) | SDOH Z-Code: ☐ Yes

---

To ensure your EMR build is audit-proof, these "Hard-Stop" (Mandatory) fields are the most frequent causes of failed records during DHCS or health plan reviews. Missing even one of these often results in the entire encounter being marked "non-compliant."

Required "Hard-Stops" for EMR Analysts

- Standardized Outreach Log (Section 2): To pass an "Unable to Reach" exception, the system must force entries for all 3 attempts including date, method, and different-day validation.
- Interpreter Documentation (Section 3): If a language other than English is preferred, the Interpreter Name or ID must be a required field.
- Health Risk Assessment (HRA) Details (Section 4): The system must capture the specific HRA Tool Name and Completion Date to link the clinical data to the state requirement.
- Numerical Screening Scores (Section 7): Do not allow "Positive/Negative" only. The system should require the numerical score for PHQ-9 and GAD-7 to prove a standardized tool was used.
- Medication Reconciliation Attestation (Section 8): The specific Provider Statement (reconciliation with patient/caregiver) should be a mandatory checkbox or auto-populated requirement.
- Primary IHA Diagnosis (Section 11): The claim will not "count" as an IHA without a Z-code from the Z00 series; this should be a required primary diagnosis choice for this visit type.
- Closed-loop Referral

Version 2 – Without outreach, referral status, or accommodation fields

Medi-Cal Initial Health Appointment (IHA) Template

Patient Information:

- **Member Name:** [Patient Full Name]
- **ID:** [Member ID]
- **Date of Appointment:** [Date]
- **Time of Appointment:** [Time]
- **Encounter Type:** New Patient / Initial Health Appointment (IHA)
- **IHA Completion Date:** [Date] (must be within 120 days of enrollment)

Initial Assessment: History

- **History of Present Illness (HPI):** [Document any acute complaints or concerns]
- **Past Medical History (PMH):** [Document past illnesses, injuries, and hospitalizations]
- **Past Surgical History (PSH):** [Document past surgeries]
- **Family History:** [Document significant family history, including inheritable conditions]
- **Social History:**
    - **Housing:** Stable / Unstable / At Risk
    - **Safety:** [Assess interpersonal safety risks, including domestic violence]
    - **Substance Use:** Tobacco / Alcohol / Illicit Drugs (specify type and amount)
    - **Education:** [Document level of education]
    - **Employment:** [Document employment status]
    - **Adverse Childhood Experiences (ACEs):** Administered PEARLS Screening (Result: [Score])
- **Behavioral Health History:** [Document history of mental health and substance use disorders, if any]

Initial Assessment: Physical Examination

- **Vital Signs:** Height: [cm/in] / Weight: [kg/lbs*] / BMI: [calculation] / Blood Pressure: [BP reading]
- **Constitutional:** [Appearance]
- **HEENT:** [Head, Eyes, Ears, Nose, Throat exam notes]
- **Cardiovascular:** [Heart exam notes]
- **Respiratory:** [Lung exam notes]
- **Gastrointestinal:** [Abdomen exam notes]
- **Genitourinary:** [Genital/Urinary exam notes, including Pap smear arranged for sexually active women]
- **Musculoskeletal:** [Extremities, range of motion]
- **Skin:** [Skin exam notes]
- **Neurological:** [Neuro exam notes]
- **Dental Assessment:** [Perform a visual dental screening and assess for needs]

Initial Assessment: Risk Identification

- **Age-Specific Risk Assessment:** [Screen for age-appropriate risks, such as falls in older adults or developmental risks in children]

- **Age-Appropriate Behavioral Risk Assessment:** [Document findings]
- **Social Determinants of Health (SDOH):** [Document screening results for housing, food insecurity, utility needs, etc.]
- **Health Risk Assessment:** [Administer and document results of HRA screening]
- **Cognitive Health Assessment (Ages 65+, no Medicare):** Administered GPCOG Screening (Result: [Score])
- **Fall Risk Screening:** [Document screening results]
- **Screening for [Condition]:** [Document any additional screenings for chronic conditions]

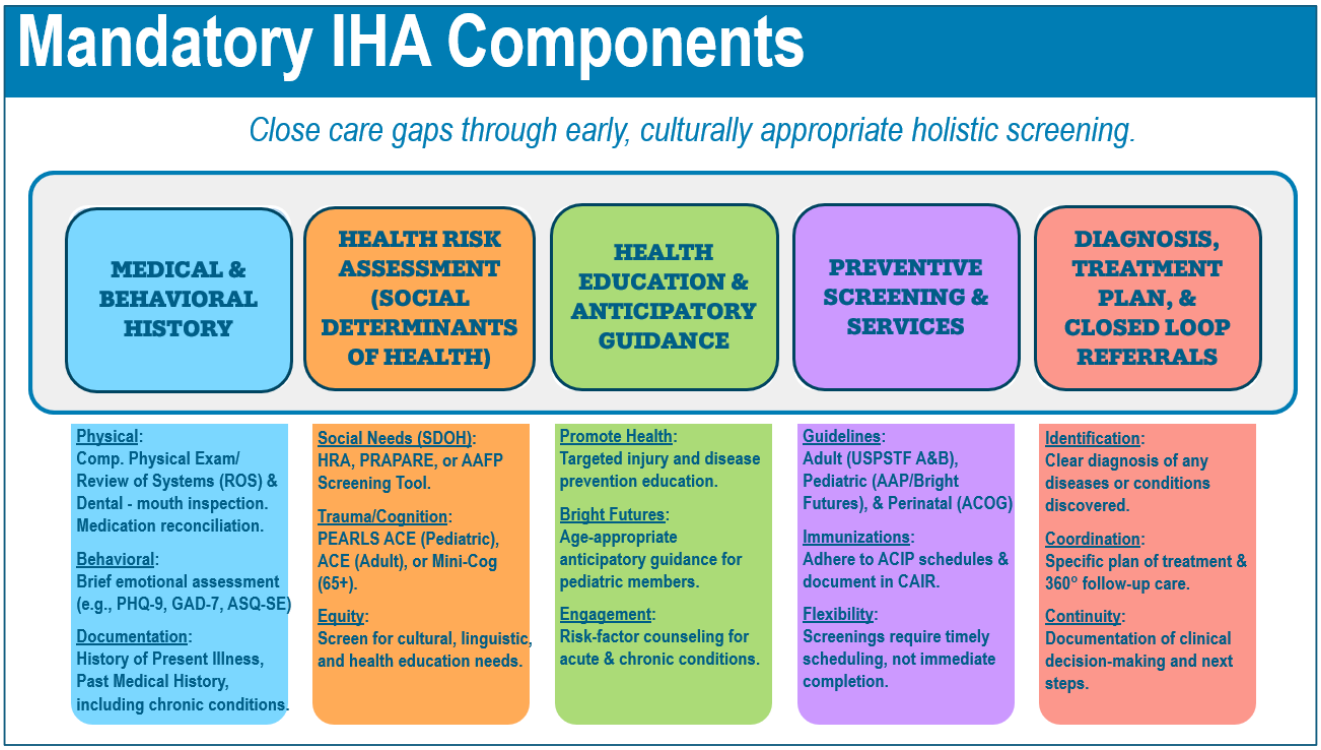
Comprehensive Physical Exam +/&		**Health Risk Assessment**			
Brief emotional/behavioral assessment		**At least *ONE* risk assessment domain meets the standard**			
Depression Screening	**Psychosocial/ Behavioral Assessment**	**Member Risk Assessment (*Site specific for members <21)**	**Member Risk Assessment (Adults)**	**Cognitive Assessment (Member tool)**	**Cognitive Assessment (Informant tools)**
12+	*18 to 21 years	*18 to 21 years	18+	65+	65+
PHQ-2	AAFP Social Needs Screening Tool	AHC HRSN	AHC-HRSN	CPCOG	IQCODE
PHQ-9	GAD-7	PRAPARE	Your Current Life Situation	Mini-Cog	AD8
PHQ-9A modified for teens	Other Social Needs Screening Tools	We Care	AAFP Social Needs Screening Tool		
		PEARLS	ACE for adults		

Initial Assessment: Plan of Care

- **Assessment/Diagnosis:** [ICD-10 Code] - [Diagnosis]
- **Assessment/Diagnosis:** [ICD-10 Code] - [Diagnosis]
- **Plan:**
    - **Medications:** [Document review and reconciliation of all medications]
    - **Immunizations:** [Review and update immunization status according to ACIP and DHCS guidelines]
    - **Preventive Services:** [Document recommended preventive services, including mammograms (women 50+), breast exams (women 40+), and cholesterol screenings (men 35+, women 45+)]
    - **Specialty Referrals:** [Document referrals for behavioral health, dental, or specialty care]
    - **Health Education/Anticipatory Guidance:**
        - **Topic:** [Provide topic, e.g., safe sleep for infants, nutrition, medication adherence]
        - **Intervention:** [Document education provided to member, ensuring it was culturally and linguistically appropriate]
- **Follow-Up:** [Document follow-up plan, including future appointments]

Attestation:

- **Provider Signature:** [Provider Signature]
- **Provider Name:** [Provider Name]
- **Billing Code:** [Use IHA-specific CPT code]
- **Service Code:** [Use IHA-specific service code if applicable]



Appendix I: IHA Care Coordination Checklist

IHA Care Coordination Checklist

Member Name: _____DOB: _____ PCP: _____

☐ PHASE 1: Pre-Visit Coordination

- **Identify New Members:** Cross-reference the **Monthly Eligibility List** or Health Plan Roster with your EMR to identify members within their first 90–120 days of enrollment.
- **Assess Barriers:** Confirm if the member requires **Plan-Funded Transportation (NEMT)**, wheelchair access, or a professional **interpreter** (record preferred language).
- **HRA Prep:** Check if the **Health Risk Assessment (HRA)** was completed via portal; if not, flag for in-office completion.

☐ PHASE 2: During the Visit (Intra-Visit)

- **Problem List Update:** Simultaneously update active **Diagnosis Problems** and **Social History/Risk Problems** (e.g., Z-codes for homelessness) to set clinical priorities.
- **Warm Handoff:** For positive behavioral or social screens, perform an immediate "warm handoff" or EHR task to a **Care Manager** or **Clinic Champion**.
- **Integrate HRA Findings:** Link identified medical, functional, or behavioral risks directly to the care plan and follow-up orders.

☐ PHASE 3: Referrals & Orders

- **Diagnostic Linking:** Link every specialist referral (e.g., Cardiology) or community referral (e.g., Food Bank) to a specific **ICD-10 code** in the EMR.
- **Urgent Escalation:** If "red flags" like suicidal ideation or uncontrolled BP are found, trigger the **Fast Track** notification to management within **48 hours**.
- **Member Education:** Use **teach-back** methods to ensure the member understands their medications and next steps before leaving.

☐ PHASE 4: Post-Visit & Closing the Loop

- **Tracking Log Entry:** Record all referrals in the **Integrated Referral Tracking Log** with a status of "Active/Pending".
- **Task Assignment:** Assign follow-up tasks to MAs/Care Managers with specific due dates (e.g., 7 days for routine findings).
- **Monthly Monitoring:** Staff must collect status updates at least **monthly** for all open referrals until they are "Closed-Completed".
- **Audit Check:** Verify the PCP has **signed and dated** all assessments, the reconciliation statement, and the final care plan.

Appendix J: Huddles, Handoffs, & Loop Closures

Primary Care Team Action & Documentation Form (Primary Care Practice Staff)

Complete this single-page form daily to document high-risk patients, facilitate "warm handoffs", and ensure referral loop closure for audit compliance.

Morning Kick-Off: Interdisciplinary Huddle (identifying "Red Flags")

Today's Date: _____ **Huddle Lead:** (Provider/Nurse/Lead MA)] _____

Huddle Attendants: _____

Daily Goal: (Check one) Identify "Red Flags" for the day's schedule | Other: _____

	Patient Name	Flagged Need (e.g., IHA, lack of support, transport)	Staff Responsible
1			
2			
3			

Huddle Actions (checklist):

- ☐ Leader review of schedule and identification of high-risk patients.
- ☐ Front Desk notified of transportation barriers (e.g., for Mr. Smith).
- ☐ Care Manager ready for 'warm handoff' if SDOH identified. (Linked Z-codes: Z59.0 housing, Z59.1 food security, etc.)
- ☐ Staff informed of Urgent Escalation Path for critical "red flags" (elder abuse, suicidal ideation).

2. "Warm Handoff" (Provider-to-Care Manager) During Appointment

Patient Name: _____ **Date:** _____

Staff Roles (to be signed by staff):

Provider: (Check all that apply): ☐ Introduced Care Manager. ☐ Identified gaps in ☐ food access ☐ transport ☐ other. ☐ Confirmed direct outreach initiated. ☐ Sent EHR task.

Care Manager: (Check all that apply): ☐ Initialed direct outreach to local food bank. ☐ Provided patient with direct contact name. ☐ Tagged EHR task as 'IHA Care Coordination'.

Identified SDOH Needs	Specific Z-codes to Link (Check box to select)	Care Manager Direct Action taken	EHR Task Sent & Tagged?
			Y/N Drop-down

3. Afternoon "Loop Closure" (Referral Communication) [Audit Compliance Check]

Weekly Audit Date: _____ **Care Manager Initials:** _____

	Open Referral List (checked from 48+ 48+ hours ago)	Status [e.g., Pending, No Response]	RE-ENGAGE Protocol Action: ☐ Call Specialist / ☐ Other	Re-engaged within 48-72 hours? Y/N	New Status (Update in EHR) [Active/Pending, Closed-Completed]	Documentation & Communication Loop Complete? Y/N	Audit-Ready?
1							Y/N
2							Y/N
3							Y/N
4							Y/N
							Y/N

Loop Closure Notes: _____

Save as PDF | Reset Form

IHA Staff Workflow: Huddles, Handoffs, & Loop Closures

This document outlines the three essential daily touchpoints required to manage high-risk patients, address Social Determinants of Health (SDOH), and maintain audit-ready documentation.

1. The Morning Kick-Off (Interdisciplinary Huddle)
Goal: Identify "Red Flags" for the day's schedule.

- **When:** First 5–10 minutes of the morning.
- **Who:** Provider, Nursing/MA, Front Desk, and Care Manager.
- **The Script in Action:**
    - **Leader:** "Good morning team. Looking at today's schedule, we have three new members in for their IHA. I've flagged Mr. Smith as high-risk due to a potential lack of support at home."
    - **Front Desk:** "I'll watch for any transportation barriers when he checks in."
    - **Care Manager:** "I'll be ready for a 'warm handoff' if we identify SDOH needs. I'll make sure to link the specific Z-codes, like Z59.0 for housing, in the EHR immediately."
    - **Leader:** "Remember, if anyone sees a 'red flag' like elder abuse or suicidal ideation, use the Urgent Escalation Path and notify Clinic Management in real-time."

2. The "Warm Handoff" (Structured Transition)
Goal: Connect patients to care management services in real-time during their visit.

- **When:** During the appointment, immediately after identifying a gap in care.
- **Who:** Provider and Care Manager.
- **The Script in Action:**
    - **Provider:** "Mrs. Jones, I'd like to introduce you to our Care Manager. Based on our physical today, we identified some gaps in your access to food and transport."
    - **Care Manager:** "Nice to meet you, Mrs. Jones. I'm going to initiate direct outreach to a local food bank for you right now. I'll provide you with a direct contact name before you leave today."
    - **Provider (to CM):** "I'm sending an EHR task now. Please tag it as **'IHA Care Coordination'** so we stay compliant with our documentation standards."

3. The Afternoon "Loop Closure" (Communication Tracking)
Goal: Ensure no patient falls through the cracks and all referrals are completed.

- **When:** Mid-afternoon or end-of-day.
- **Who:** Care Manager and Nursing/MA.
- **The Script in Action:**
    - **Care Manager:** "I'm reviewing our referral tracking system from 48 hours ago. The specialist for Mr. Doe hasn't responded yet."
    - **Nurse/MA:** "The protocol says we must re-engage if there's no response within 48-72 hours. Should I call the specialist's office now?"
    - **Care Manager:** "Yes, please. Once you get an update, change the status to **'Active/Pending'** or **'Closed-Completed.'** Make sure to document the exact date we receive their report, so our Communication Loop is audit-ready."

Appendix K: Community Health Workers & the IHA

CHWs detect social barriers and document them using specific codes to establish medical necessity. This documentation allows supervising providers to bill for services, track quality compliance, and unlock paid CalAIM benefits that address the member's essential needs.

Best Practice Tips: When documenting an Initial Health Appointment (IHA), a CHW often identifies why a member hasn't seen a doctor yet. Some examples are shown below.

Example 1: Transportation Barrier

- **Need:** Transportation Gap **(**ICD-10: Z59.82**)**
- **Subjective:** Member states, "I want to go to my check-up, but I don't have a car, and the bus takes two hours each way. I can't leave my kids that long."
- **Objective:** Member is a single parent with three school-aged children; nearest assigned PCP is 12 miles away. Member is unaware of the Managed Care Plan (MCP) transportation benefit.
- **Justification:** Scheduling a "Non-Medical Transportation" (NMT) van.

Example 2: Language/Cultural Barrier

- **Need:** Health Literacy/Language Barrier **(**ICD-10: Z71.89 or Z60.3**)**
- **Subjective:** Member reports feeling "overwhelmed" by the new member packet. States, "I don't know who my doctor is, and the papers are all in English. I'm afraid they won't understand me at the office."
- **Objective:** Member's primary language is Spanish. Review of records shows member has not selected a preferred language with the plan and has not scheduled an IHA since enrolling 45 days ago.
- **Justification:** Calling the doctor's office with the member using an interpreter line to book the IHA.

Example 3: Housing Instability (High Priority)

- **Need:** Homelessness **(**ICD-10: Z59.02**)**
- **Subjective:** Member states, "I'm staying on a friend's couch and keep losing my phone charger. I missed the call from the doctor's office because my phone was dead."
- **Objective:** Member is currently unhoused/couch-surfing. Lack of a stable mailing address or consistent phone access has prevented the "3 successful outreach attempts" required for Core Measure 2.1.
- **Justification:** Referring the member to Housing Transition & Navigation so they have a stable place to recover after their medical appointment.

CHW Pocket Card: SDOH Assessment & IHA Support

FRONT SIDE OF POCKET CARD

Identifying Needs & Linking to Services.

Member Need	ICD-10 Code	CalAIM Community Support Link
Homelessness	Z59.02	Housing Transition & Navigation
At Risk of Eviction	Z59.811	Housing Tenancy & Sustaining Services
Housing Deposits	Z59.861	Housing Deposits / Utility Assistance
Food Insecurity	Z59.41	Medically Tailored Meals / Grocery Support
Post-Hospitalization	Z59.1	Short-Term Post-Hospital Housing
Recent Prison Release	Z65.2	Enhanced Care Management (ECM)
Transportation Gap	Z59.82	Managed Care Plan (MCP) Transportation
Isolation / Fragility	Z60.2	Community Transition (Nursing Fac. to Home)

BACK SIDE OF POCKET CARD

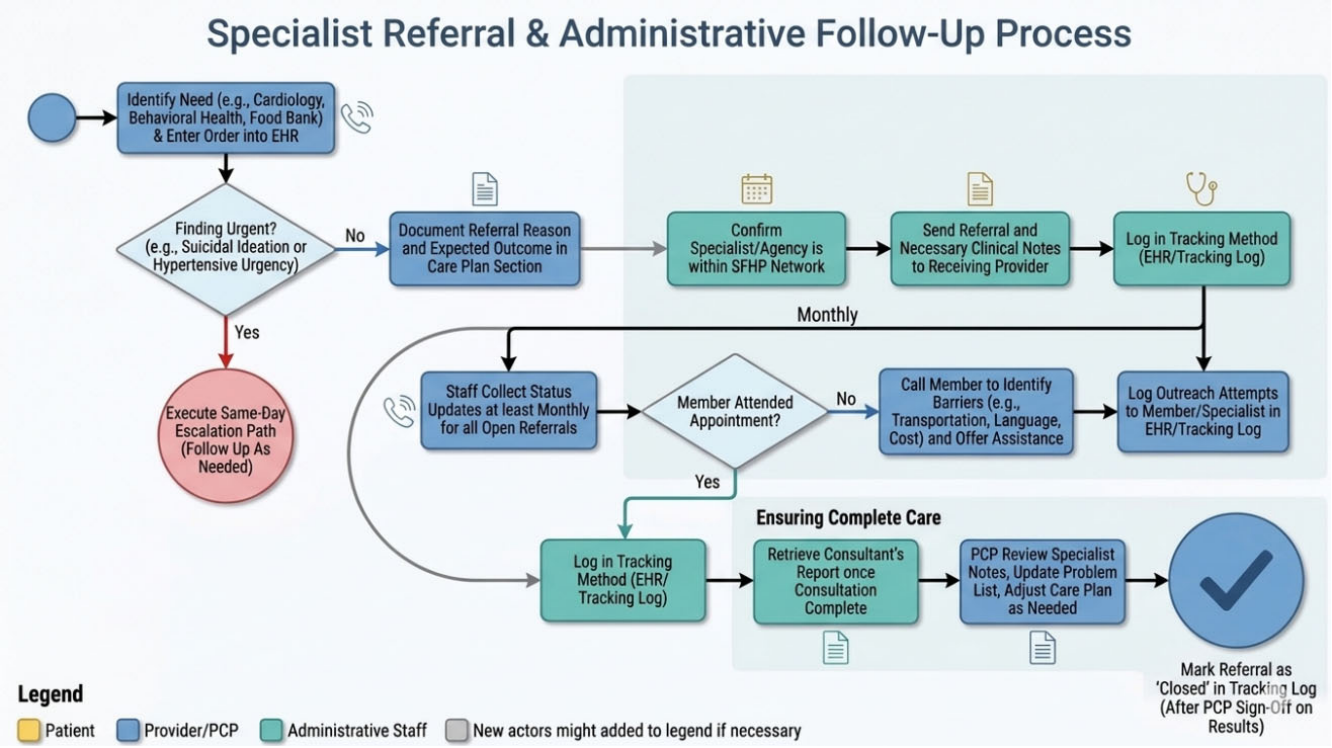
IHA & HRA Compliance Checklist

- **Outreach Standard:** Document at least 3 attempts on different days using 2+ methods (Call/Text/Home Visit) for audit success.
- **The "Golden" 90 Days:** Complete the HRA and IHA by Day 90 to clear the Federal HIF/MET screening requirement.
- **Dual-Eligible (D-SNP):** Ensure the Integrated Medicare HRA is recorded in the chart.
- **Closing the Loop:** When you refer to a CalAIM service, document the referral date and provider name in the member's record.

How to Use This Card:
Give this to Community Health Workers providing assistance with your patients. Ask them to clip this to their badge or keep it in their field kit. When you identify a need during a home visit, use the code to flag the file for IHA Support and the attention of the clinic point-of-contact, and/or the IHA Champion, and the Primary Care Provider. (Customize to your preferences.)

How to Make the Badge Card:
Using heavy cardstock for durability, print and cut the card to size using a paper cutter or scissors. Protect the card either by laminating and punching a slot at the top of the laminated badge for a lanyard clip or insert an unlaminated card into a clear vinyl badge holder to be worn on a lanyard.

Appendix L: Referral & Follow-Up Tracking



Integrated Referral & SDOH Tracking Log (Example)

Patient Name / ID	Referral Type (Medical/ BH/SDOH)	Specific Service (e.g., Cardiology, Food Bank)	Referral Status (Pending/ Scheduled)	SDOH Category (If Applicable)	Barrier Identified? (e.g., Transp.)	Monthly Update (Last Contact Date)	Closed Loop? (PCP Reviewed)
Jane Doe / 123	Medical	Orthopedics	Scheduled 5/10	N/A	No	4/14	No
John Smith / 456	SDOH	Housing Authority	Pending	Housing	Yes (No Phone)	4/12	Yes (4/14)
Maria R. / 789	BH	Therapy	No-Show	N/A	Yes (Language)	4/01	No

Appendix M: SDOH Referral Routing Guide

Map: Directs staff where to send members based on the SDOH identified (e.g., Food Bank, Housing Authority). (5.1.5)

SDOH Referral Routing Guide (San Francisco)

1. Housing & Homelessness
Objective: Assist members experiencing homelessness or at risk of losing housing.

Category	Primary Resource	Contact Information
Urgent Shelter	SF Dept. of Homelessness (HSH)	Dial 3-1-1 or visit an HSH Access Point.
Housing Transition (CS)	Brilliant Corners	(415) 618-0012
Eviction Prevention	Eviction Defense Collaborative	(415) 659-9184
Senior/Disabled Housing NPI: 1255730222	Institute on Aging (IOA)	(628) 239-3565

2. Food Insecurity
Objective: Provide immediate access to nutrition and long-term food support.

Category	Primary Resource	Contact Information
Food Stamps/CalFresh	SF Human Services Agency	(415) 557-5000 General Information
Emergency Pantry	SF-Marin Food Bank	Call 2-1-1 for nearest site
Tailored Meals (CS)	Project Open Hand	(415) 447-2326
Women/Infants	SF WIC Program	(415) 575-5788

3. Transportation
Objective: Ensure no-cost travel to health visits, pharmacies, and medical supply stores.

Category	Primary Resource	Contact Information
Provider Booking	Modivcare Facility/Provider Line	1 (866) 529-2128
NEMT (Medical Need)	SFHP NEMT Line	(415) 547-7807
Member Booking (NMT)	SFHP Customer Service	(415) 547-7800
Urgent Request	Modivcare Escalation	1 (866) 779-0569

4. Financial Strain & Utilities
Objective: One-time financial help for bills, furniture, or security deposits.

Category	Primary Resource	Contact Information
Utility Assistance	LIHEAP (SF-Peninsula Energy)	(415) 416-6660
Emergency Grants	Season of Sharing (St. Anthony's)	(415) 592-2855
Legal/Financial Aid	Health Consumer Alliance	(888) 804-3536

Appendix N: Same-Day Referral Guide

Same-Day Referral & Escalation Guide

Immediate intervention for "Red Flag" clinical or social findings to prevent emergency department (ED) utilization.

1. Clinical "Red Flags" (Immediate Medical Need)

Finding	Action Path	Destination/Contact
Uncontrolled BP (>180/120)	Stat Internal Consult	Clinic Lead/RN for immediate triage & medication adjustment.
Urgent Gap in Meds (Insulin, anticoagulants, etc.)	Immediate Rx Bridge	Call pharmacy or provide onsite samples; flag for Med Rec.
Acute Behavioral Health (Suicidal/Homicidal ideation) (SI/HI/Psychosis)	Safety Pivot	Do not leave patient alone. Activate Tool 4.3 (BH Safety).
New Pregnancy (High-Risk)	Initial Prenatal Path	Schedule OB/GYN intake and call Care Management for prenatal support.

2. Social "Red Flags" (Immediate Social Need)

Finding	Action Path	Destination/Contact
Homeless Tonight	Warm Handoff	Social Worker or CHW before discharge. Or Direct transfer to Housing Transition Navigator or local shelter liaison.
No Food Tonight	Voucher/Resource	Provide list of same-day food banks or emergency meal vouchers.
Interpersonal Violence	Confidential Triage	Move to private room; provide National Domestic Violence Hotline (800-799-7233).
No Utilities (Heat/Water/Power)	Resource Link	Flag for LIHEAP (Utility Assistance) referral; provide local agency info.

3. Operational Steps for the "Warm Handoff"

1. **Stop & Secure:** The Provider pauses the standard IHA flow to address the crisis.
2. **Alert the Team:** Use the EHR "Urgent" flag or an internal "Huddle" call.
3. **Physical Transition:** If in-person, the Provider or MA introduces the patient to the Social Worker/CHW: *"I've asked (Name) to join us because they specialize in (Housing/Food/Safety) and can help you today."*
4. **The "Check-Out" Audit:** Before the patient leaves, the Front Desk verifies that the **Tracking Log (Tool 9.2.13)** is updated with the referral status as "Active/Urgent."

Appendix O: Health Risk Assessment Guidelines

Best Practice: Pre-complete via phone or portal; otherwise, complete in the waiting room to allow for clinical review during the 10-minute visit.

The **HRA** is a mandatory screening tool used to identify a member's medical, behavioral, functional, and social needs within the first 90 days of enrollment.

1. Core Requirements

- **Timeliness:** Must be completed within **90 days** of enrollment for Medicare Advantage (D-SNP) and Medi-Cal members. For most new Medi-Cal members, the assessment must be completed within **45 to 105 days** of enrollment.
- **Required Domains:** At a minimum, the assessment must cover:
    - **Clinical:** Chronic conditions and physical health risks (e.g., fall risk).
    - **Behavioral:** Mental health and substance use screenings.
    - **Functional:** Activities of Daily Living (ADLs) and cognitive status.
    - **Social:** Social Drivers of Health (SDOH) like housing and food security.

2. Documentation Standards

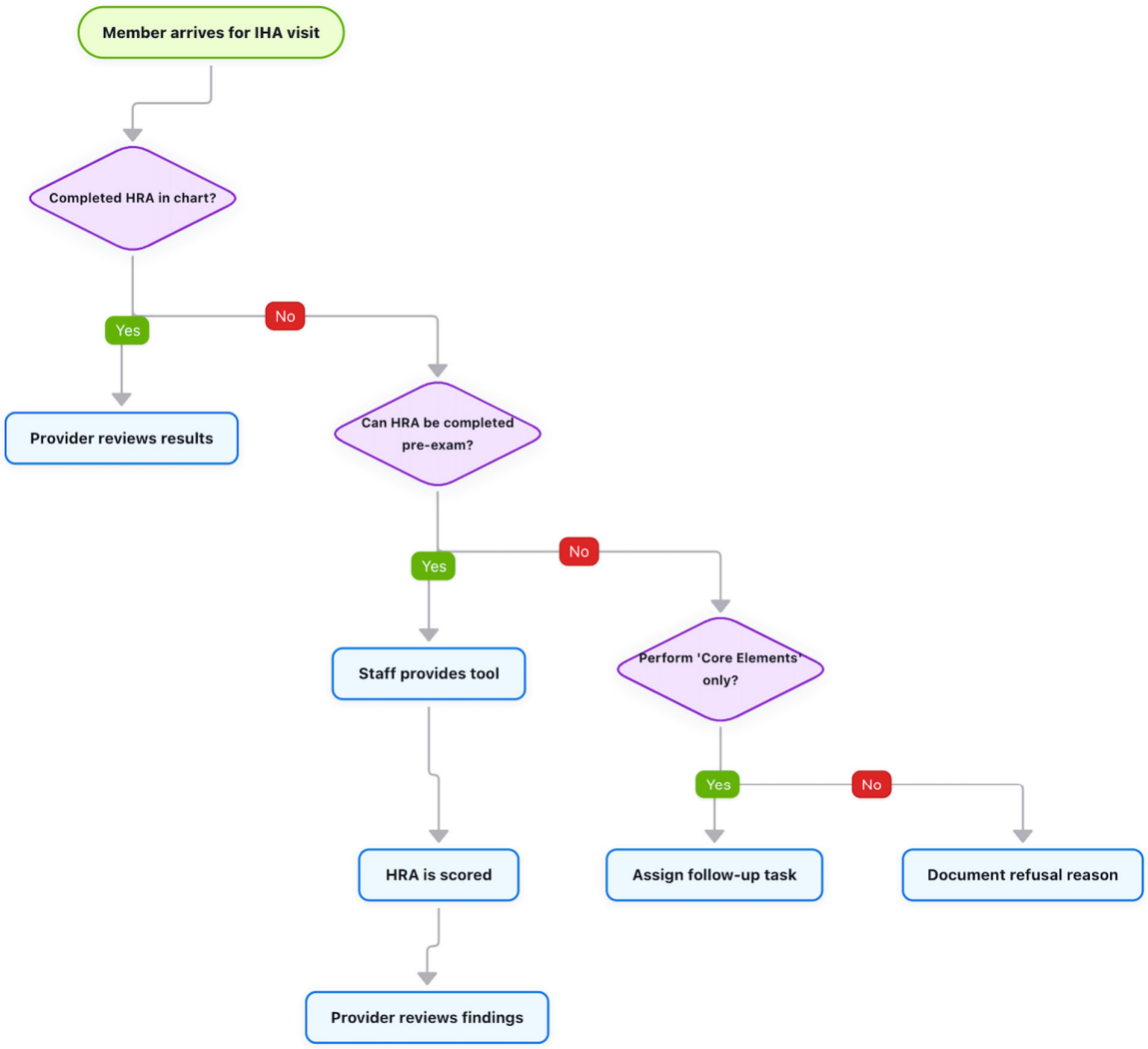
For audit readiness, every HRA must include:

- **Tool Details:** The specific name and version of the assessment tool used.
- **Attestation:** The date of completion and the name/credentials of the person who administered it.
- **Key Findings:** Documentation of all "positive" results or identified risks.
- **Action Plan:** Direct links between HRA findings and the resulting Care Plan updates or referrals.

3. Workflow Best Practices

- **Pre-Visit Completion:** Whenever possible, complete the HRA via phone or patient portal *before* the appointment to allow the provider to focus on care rather than data entry.
- **Interdisciplinary Review:** Share HRA results with the broader care team (Care Managers, CHWs) to coordinate complex medical and social needs.
- **Integrated Records:** Ensure the HRA is either embedded in the EMR or scanned/attached to the patient's chart as a permanent part of the medical record.

This HRA Decision Path Flowchart is designed for front-office and clinical staff to ensure that every patient interaction captures this mandatory data, even when pre-visit outreach fails.



Appendix P: Behavioral Risk Tracking

This tracking tool ensures that every positive behavioral health screen is met with a clinical intervention and a confirmed follow-up, closing the loop on patient safety and mental health care.

1. Screening Documentation

- **Capture the Score:** Record the exact numerical result from validated tools (e.g., PHQ-9, GAD-7, AUDIT-C) in the discrete EMR fields.
- **Risk Level:** Classify the result based on tool-specific thresholds (e.g., Mild, Moderate, or Severe) to determine the next steps in the safety protocol.

2. Clinical Action & Escalation

- **Urgent findings:** For results indicating immediate risk (e.g., positive suicide risk item #9 on PHQ-9), activate the **Safety Protocol** immediately. This requires follow-up action within **48 hours**.
- **Brief Intervention:** Document counseling, education, or crisis intervention provided during the visit.
- **Referral Linking:** Ensure behavioral health referrals are entered into the EMR and linked to the corresponding ICD-10 diagnosis code.

3. Referral & Follow-up Tracking

- **The "Warm Handoff":** For moderate-to-high risk findings, document a "warm handoff" to a Care Manager or mental health specialist.
- **Closed-Loop Status:** Log the referral in the **Integrated Tracking Log**. Mark it "Pending" until a consultation report is received and reviewed by the PCP.
- **Follow-Up Date:** A specific date for the next evaluation or check-in must be documented before the patient leaves.

4. Audit Compliance Checklist

- Tool name and version recorded.
- Numerical score/result documented.
- Evidence of intervention (Counseling/Referral).
- Scheduled follow-up date listed.
- PCP signature and date on the assessment.

Appendix Q: SDOH Tools

For 2026, providers addressing positive Social Determinant of Health (SDOH) screenings for Medi-Cal members must utilize a standardized referral process to connect patients with Enhanced Care Management (ECM) and Community Supports (CS). The workflow includes verifying eligibility, submitting referrals, and coding with specific ICD-10 Z codes to facilitate care for needs such as housing, food, and transportation.

- **Collecting Social Determinants of Health Data** – Department of Health Care Services All Plan Letter 21-009 *(Revised)*.
- **Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences** - PRAPARE®.
- **PRAPARE® Implementation and Action Toolkit**
- **Health Equity for EveryONE: Comprehensive - Online CME** – American Academy of Family Physicians (AAFP).
- **The EveryONE Project Assessment and Action Toolkit** – AAFP.
- **The EveryONE Project Neighborhood Navigator** – AAFP.
- **Using Z Codes Infographic** – Centers for Medicare & Medicaid Services.
- **Healthy People 2030 SDOH Workgroup** – Office of Disease Prevention and Health Promotion.

Appendix R: Screening Tools Resource

Summary: Pediatric Screening Tools from Getting Started Guide (AAP)

What It Identifies	Recommended Tools	Category	AAP-Recommended Screening Interval(s)	Typical Length	Cost	Age Range	Languages	Common CPT
• Communication delays • Motor delays • Early cognitive concerns +SDOH	ASQ-3	Developmental	9, 18, and 30 months; when concerns arise	10–15 min	Paid	1–66 months	Multiple	96110
	PEDS	Developmental	9, 18, and 30 months; when concerns arise	2–5 min	Paid	Birth–8 years	Multiple	96110
	SWYC (dev items)	Developmental/SDOH	9, 18, and 30 months; when concerns arise	~10 min	Free	1–65 months	English/Spanish	96110 (dev), 96160–96161 (SDOH)
• Behavioral dysregulation • Emotional concerns • Early signs of MEB disorders	ASQ-SE2	Social-Emotional	At every well visit birth–5 years	10–15 min	Paid	1–72 months	Multiple	96127
	BPSC/PPSC (SWYC)	Social-Emotional	At every well visit birth–5 years	~5 min	Free	BPSC: <18 mo.; PPSC: 18 mo.–5 yr	English/Spanish	96127
	BITSEA	Social-Emotional	At every well visit birth–3 years (as used)	~10 min	Paid	12–36 months	English/Spanish	96127
	ECSA	Social-Emotional	At every well visit (use per practice)	~10 min	Paid	18–60 months	Limited	96127
	SDQ	Social-Emotional / Global MEB	Annually ≥3 years; also when concerns arise; can be used ages 2–17	5–10 min	Free	2–17 years	40+	96127
• Social communication delay • ASD red flags	M-CHAT-R/F	Autism	18 and 24 months	5–10 min	Free	16–30 months	Multiple	96110
	POSI (SWYC)	Autism	18 and 24 months	2–3 min	Free	18–36 months	English/Spanish	96110
• Caregiver depression • Family stress impacting child health	EPDS	Perinatal Depression (caregiver)	1, 2, 4, and 6 months	~5 min	Free	Caregiver	Multiple	96161
	PHQ-2	Perinatal Depression (caregiver)	1, 2, 4, and 6 months (screen/triage)	<2 min	Free	Caregiver	Multiple	96161
	PHQ-9	Perinatal Depression (caregiver)	1, 2, 4, and 6 months (diagnostic follow-up)	~5 min	Free	Caregiver	Multiple	96161
• Food insecurity • Housing instability • Transportation needs • Safety concerns • Financial stressors (Note: This AAP Guide has been altered to remove Hunger Vital Sign)	PRAPARE	Social Drivers of Health (SDOH)	Every visit or as indicated	5–10 min	Free	All ages (caregiver)	Multiple	96160
	SEEK	SDOH (risk/safety)	Every visit or as indicated (0–5)	~5 min	Free	0–5 years	English/Spanish	96160
	Health Leads	SDOH	Every visit or as indicated	5–10 min	Free	All ages	Multiple	96160
	WE CARE	SDOH	Every visit or as indicated	~5 min	Free	All ages	Multiple	96160
	IHELLP	SDOH (mnemonic)	Every visit or as indicated	~5 min	Free	All ages	Multiple	96160
	Whole Child Assessment	SDOH	Every visit or as indicated (0–5)	10–15 min	Free	0–5 years	English/Spanish	96160

Sources:
AAP/ECDHS Getting Started Guide: Implementing a Screening Process — screening intervals and CPTs for 0–5 (perinatal depression at 1, 2, 4, 6 months; developmental at 9, 18, 30; autism at 18 & 24; social-emotional and SDOH at every visit). ECDHSCenter@zerotothree.org

AAP Clinical Report (Pediatrics, 2025): Promoting Optimal Development: Screening for Mental Health, Emotional, and Behavioral Problems — annual MEB screening ≥3 years and additional adolescent screening expectations.

Summary: Adult Screening Tools

Alcohol Disorder: Screening and Behavioral Counseling	Alcohol Use Disorder Screening and Behavioral Counseling	Anthropometric Measurements	Cognitive Assessment (Member tool)	Depression Screening	Depression Screening	Drug Disorder: Screening and Behavioral Counseling
11yrs-18yrs	18+	0 to 21 years	CPCOG (65+)	12 to 21 years	18+	11 to 21 years
At each well-visit	At each well-visit	At each well-visit	Mini-Cog (65+)	At each well-visit	At each well-visit	At each well-visit
CRAFFT+N	AUDIT	CDC growth chart	**Cognitive Assessment (Informant tools)**	PHQ-2	PHQ-2	CRAFFT+N
	AUDIT-C		IQCODE	PHQ-9	PHQ-9	DAST-20
			AD8	PHQ-9A modified for teens		
Drug Use Disorder Screening and Behavioral Counseling	**Elder Abuse Screening**	**Hepatitis B Virus Screening**	**Hepatitis C Virus Screening**	**HIV Screening**	**Intimate Partner Violence Screening for Women of Reproductive Age**	**Member Risk Assessment (*Site specific for members <21)**
18+	60+	18+	18+	13 to 65	18 to 49 Females	*18 to 21 years
At each well-visit	At each well-visit	All adults should be tested at least once.	One time or periodic if ↑ risk	One time or periodic if ↑ risk	At each well-visit	At each well-visit
CRAFFT+N	EASI	hepatitis B surface antigen (HBsAg)	Testing sequence for HCV	CDC HIV Screening Materials	E-HITS	AHC HRSN
DAST		antibody to hepatitis B surface antigen (anti-HBs)	HCV Antibody	Antibody tests	WAST	PRAPARE
TAPS		antibody to hepatitis B core antigen (anti-HBc)	HCV RNA	Antigen/antibody tests	PVS	We Care
				nucleic acid test (NAT)	HARK	PEARLS
Member Risk Assessment (Adults)	**Psychosocial/ Behavioral Assessment**	**Subsequent Risk Assessment (Children/Youth)**	**Subsequent Risk Assessment (Adults)**	**Sudden Cardiac Arrest and Sudden Cardiac Death Screening**	**Suicide-Risk Screening**	**Tuberculosis Screening**
18+	*18 to 21 years	*18 to 21 years	18+	*18 to 21 years	*18 to 21 years	1+
At each well-visit	At each well-visit	At each well-visit	At each well-visit	Needs to be done at least every 3 years.	At each well-visit	Annually or periodic if ↑ risk
AHC-HRSN	AAFP Social Needs Screening Tool	AHC-HRSN	AHC-HRSN		PHQ-9A modified for teens	CA TB Risk Assessment
Your Current Life Situation	GAD-7	ACE for adults	CPCOG (65+)		ASQ	
AAFP Social Needs Screening Tool	Other Social Needs Screening Tools		Mini-Cog (65+)			
ACE for adults						

Key:

Acronym	Description	Age Range	Tool Specifications
ACEs	Adverse Childhood Experience Questionnaire for Adults		Measure of traumatic experiences that examines the relationship between adverse childhood experiences and adult health and social outcomes.
AD8	Aging and Dementia (Eight-item Informant Interview to Differentiate)		Assesses intra-individual change across a variety of cognitive domains compared to previous levels of function and is sensitive to early signs of dementia regardless of etiology.
AHC HRSN	Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool		To identify patient needs that can be addressed through community services in 4 domains (economic stability, social & community context, neighborhood & physical environment, and food).
ASQ	Ask Suicide Questions		Measures development in 5 domains: communication, gross motor, fine motor, problem solving, personal-social.
AUDIT	Alcohol Use Disorders Identification Test	14-18+ years	10-item questionnaire that screens for hazardous or harmful alcohol consumption
AUDIT-C	Alcohol Use Disorders Identification Test-Modified		3-item alcohol screen.
CDC	The Centers for Disease Control and Prevention		The nation's leading science-based, data-driven, service organization that protects the public's health.
GPCOG (65+)	General Practitioner assessment of Cognition		Screening tool for cognitive impairment.
CRAFFT	Car, Relax, Alone, Forget, Friends, Trouble		Screening for substance-related risks and problems in adolescents.
DAST	Drug Abuse Screen Test (Adult)		Potential involvement with drugs other than alcohol.
DAST-20	Drug Abuse Screen Test (DAST-20: Adolescent version)		Potential involvement with drugs other than alcohol.
EASI	Elder Abuse Suspicion Index	56 and older	Validated in a primary care setting and can be used by physicians to screen cognitively intact patients during routine visits for elder abuse suspicion index.
GAD-7	General Anxiety Disorder		Measure or assess the severity of generalized anxiety
HARK	Humiliation, Afraid, Rape, Kick	14-46 years	Screening for physical, sexual and emotional violence.
HITS	Hurt, Insult, Threaten, Scream	14-46 years	4 items assess the frequency of IPV
HRA	Health Risk Assessment		An assessment of health status, and personalized feedback about actions that can be taken to reduce risks, maintain health, and prevent disease.
IQCODE	Informant Questionnaire on Cognitive Decline in the Elderly		Assess cognitive decline and dementia in elderly people.
Mini-Cog (65+)			Simple screening test for cognitive impairment.
PEARLS	Pediatric ACEs and Related Life-events Screener	0-19 year(s)	The Pediatric ACEs and Related Life-events Screener (PEARLS) is used to screen children and adolescents ages 0-19 for adverse childhood experiences.
PHQ-2	Patient Health Questionnaire-2		
PHQ-9	Patient Health Questionnaire-9		Five modules covering 5 common types of mental disorders: depression, anxiety, somatoform, alcohol, and eating.
PVS	Partner Violence Screen		3 question short screening tool for interpersonal violence.
SDOH	Social Determinants of Health		Growing evidence shows that dealing with unmet Health-Related Social Needs (HRSN) like homeless-ness, hunger, and exposure to violence, can help undo their harm to health.
PRAPARE	The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences		Screening to better understand and act on their patients' social determinants of health.
TAPS	Tobacco, Alcohol, Prescription medication and other Substances		Combines screening and brief assessment for commonly used substances, eliminating the need for multiple screening and lengthy assessment tools
WAST	Woman Abuse Screen Tool	14-46 years	8 items assess physical and emotional IPV
We Care	Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education Survey Instrument		10-item questionnaire assessing needs in 4 domains (economic stability, education, neighborhood & physical environment, and food).
WHO	World Health Organization		The United Nations agency working to promote health, keep the world safe and serve the vulnerable.

Quick Reference: Screening Cut-Offs & Actions

Category	Screening Tool	"Red Flag" Score	Required Documentation / Action
Depression	**PHQ-9**	**Score ≥ 10**	**Moderate Risk:** Document brief counseling and BH referral.
Suicide Risk	**PHQ-9 (Item 9)**	**Score > 0**	**Urgent:** Activate Safety Protocol & 48-hour follow-up.
Anxiety	**GAD-7**	**Score ≥ 10**	**Moderate Risk:** Document intervention and referral.
Alcohol	**AUDIT-C**	**Men: ≥ 4 / Women: ≥ 3**	**Positive:** Document brief intervention (SBT) and education.
Cognitive	**Mini-Cog©**	**Score ≤ 2**	**Positive:** Document score; referral for full evaluation.
Pediatrics	**M-CHAT-R**	**Score ≥ 3**	**At Risk:** Referral for developmental assessment.
Food	**Hunger Vital Sign**	**Any "Yes"**	**Positive:** Provide food bank info; referral to Social Worker.
Housing	**PRAPARE**	**Any "Yes"**	**Positive:** Link to Z-code (Z59.0); referral to CM/CHW.

Documentation "Must-Haves" for Every Positive Screen

To pass a plan audit, every "Red Flag" result above **must** include these three elements in the visit note:

1. **The Result:** The specific numerical score and the name of the tool used.
2. **The Intervention:** A narrative note of what you did (e.g., "Educated patient on local resources," "Refusal of referral documented").
3. **The Timeline:** A specific date for the next follow-up or check-in regarding this finding.

Appendix S: Positive Screening Follow-Up

To help your providers document follow-ups quickly and meet audit requirements, here are three SmartPhrase/Auto-Text templates. They can be customized to be used with your EMR (Epic, Cerner, NextGen, etc.).

Template 1: Behavioral Health (BH) Follow-Up
Trigger: .BHPOS
"Positive screening identified via (Tool Name, e.g., PHQ-9) with a score of (Score).

- **Risk Level:** (Mild / Moderate / Severe)
- **Intervention:** Brief counseling provided; discussed coping strategies and medication adherence.
- **Action:** Referral initiated to (Agency/Provider Name) for further evaluation. Warm handoff completed with (Staff Name/Role).
- **Safety Plan:** (No immediate safety concerns / Safety protocol activated).
- **Follow-Up:** Member scheduled for a nurse/PCP check-in on (Date)."

Template 2: Social Drivers of Health (SDOH) Follow-Up
Trigger: .SDOHPOS
"Positive SDOH screen identified for (Housing / Food / Transport / Financial Strain).

- **Specific Need:** (Free text, e.g., Patient at risk of eviction)
- **Action:** Member provided with contact information for (Resource Name/CalAIM Community Support).
- **Coordination:** Referral sent to (Care Manager/CHW) to assist with barrier removal.
- **Closed-Loop Plan:** Referral entered in tracking log; status will be monitored monthly."

Template 3: Urgent "Red Flag" Escalation (48-Hour)
Trigger: .URGENTIHA
"* URGENT FOLLOW-UP REQUIRED ***
Finding: (e.g., Suicidal ideation Item 9 / BP 180/110)

- **Immediate Action:** (e.g., Clinic crisis protocol activated / Same-day specialist consult).
- **Clinic Notification:** Management/Lead Provider notified at (Time).
- **Member Instruction:** Member/Caregiver advised on (Emergency signs/ER location).
- **Required Action:** Care Manager to verify appointment completion within 48 hours."

How to Use These for Audits:

- **Discrete Data:** Ensure the **numerical score** is also typed into your EHR's specific screening flowsheets.
- **Signature:** Remind providers that these notes must be **signed and dated** on the day the intervention occurs.

Appendix T: Follow-Up Care Checklist

Self-Check: Documentation Requirement
To satisfy SFHP audit standards for "Demonstrated Follow-up," you must document the specific referral name and the timeframe for follow-up (e.g., *"Referred to SF Food Bank today; Care Manager to follow up in 48 hours"*).

This scorecard allows your Quality Lead or Clinic Champion to perform a "mock audit" of your patient charts. It is designed to mirror the criteria used by San Francisco Health Plan during **Medical Record Review (MRR)** and **Facility Site Review (FSR)** audits (p. 37).

Tool 9.3.1: IHA Internal Audit Scorecard

Reviewer Name: _____ **Date of Audit:** _____

Patient MRN: _____ **LOB:** Medi-Cal Medicare Advantage/D-SNP

Section 1: Timeliness & Eligibility		
Audit Item	Compliance Requirement	Pass/Fail
Completion Date	Medi-Cal: Within 120 days of enrollment. Medicare: Within 90 days.	
Patient Status	Correctly identified as New vs. Established per 3-year rule.	
Exception Note	If IHA not met, are 3 outreach attempts (2 methods) logged?	

Section 2: Clinical Core Elements		
Audit Item	Compliance Requirement	Pass/Fail
Health Risk Assessment	HRA tool name, date, and clinician review signature present.	
Medication Reconciliation	Documentation includes the statement: "Reviewed and reconciled".	
Physical Exam	Vitals (BP, HR, BMI) and focused exam documented.	
Problem List	History of chronic conditions updated and dated.	

Section 3: Screenings & Interventions		
Audit Item	Compliance Requirement	Pass/Fail
Behavioral Health	Depression/Anxiety score documented with follow-up plan.	
SDOH Screening	Housing, food, and transport assessed (ICD-10 Z-codes used).	
Preventive Gaps	Orders placed for overdue cancer screenings or immunizations.	
Language/Access	Preferred language noted; Interpreter ID logged if used.	

Section 4: Care Planning & Closing the Loop		
Audit Item	Compliance Requirement	Pass/Fail
Care Plan	Clear prioritized goals and member agreement documented.	
Referral Tracking	All referrals initiated have a "Pending" or "Closed" status in the log.	
Provider Attestation	Signature and NPI of the rendering provider present on the note.	

Scoring Legend

- 10–12 Points: Audit Ready. High compliance.
- 7–9 Points: At Risk. Documentation gaps found; requires Clinic Champion coaching.
- <7 Points: Immediate CAP Needed. (Corrective Action Plan) required to address systemic workflow failures.

Appendix U: Avoiding Common Billing Errors

Avoiding Common Billing & Encounter Errors

Accuracy in coding is what transforms a clinical visit into a "compliant encounter" for state and federal reporting. Use this checklist to review claims before submission.

1. The "New vs. Established" Mismatch

- **Error:** Billing a New Patient code (99381–99387) for a patient who saw a specialist in your group 18 months ago.
- **The Rule:** A patient is "Established" if they have received *any* professional face-to-face service from your group (same specialty) within the past 3 years.
- **Fix:** Check the internal group roster before the provider opens the note template.

2. Missing the "IHA Flag" (Diagnosis Z-Codes)

- **Error:** Submitting a claim with only a chronic condition code (e.g., Hypertension) without a general exam code.
- **The Rule:** SFHP and DHCS look for Z00.00 (Adult) or Z00.12 (Child) to "count" the visit as a completed IHA.
- **Fix:** Ensure the IHA template auto-populates the correct Z-code as the primary diagnosis for the encounter.

3. "Z-Code" Ghosting (SDOH Reporting)

- **Error:** Documenting that a patient is homeless or lacks food in the clinical note but not including the ICD-10 Z-code on the claim.
- **The Rule:** CalAIM initiatives require SDOH data (Z55–Z65) on claims to trigger community support funding.
- **Fix:** Use Tool 5.1.5 (SDOH Map) to link clinical findings to billing codes like Z59.0 (Homelessness).

4. Telehealth Modifier Errors

- **Error:** Billing a telehealth IHA without the required "95" modifier or the correct Place of Service (POS) 02/10.
- **The Rule:** Telehealth is acceptable for IHAs if essential components are met, but billing must reflect the mode of delivery.
- **Fix:** Update EHR "SmartSets" to automatically apply the 95 modifier when a visit is marked as "Video/Phone."

5. Missing Provider Attestation

- **Error:** The encounter is submitted, but the note lacks a final signature or contains an "Unsigned" status in the audit.
- **The Rule:** For a record to be valid, the rendering provider must attest to the services.
- **Fix:** The clinic should have a designated person that will run a weekly "Unsigned Notes" report to close these gaps before the claim deadline.

Appendix V: IHA Point Person

The **IHA Point Person** is the site's dedicated expert (typically a Lead MA or Office Manager) responsible for driving IHA compliance and ensuring every new member experience is high-quality and person-centered.

1. Core Responsibilities

- **Process Expert:** Acts as the "go-to" resource for team questions regarding Medi-Cal (120-day) vs. Medicare (90-day) requirements.
- **Workflow Oversight:** Monitors the "Pathway to Success" to ensure outreach is documented, HRAs are completed, and referrals are closed.
- **Quality Monitor:** Regularly reviews the clinic tracking log and EMR records to ensure they are "audit-ready" with required signatures and dates.

2. First 30 Days "Getting Started" Checklist

- **Master the Toolkit:** Deep-dive into SFHP requirements for Medi-Cal and Medicare populations.
- **Meet Mentors:** Establish contact with your assigned SFHP Provider Network Management (PNM) and Facility Site Review (FSR) support.
- **Audit Current State:** Review existing clinic outreach and scheduling processes to identify gaps in IHA completion.
- **Update Policy:** Collaborate with leadership to formalize a site-specific IHA protocol that aligns with CalAIM standards.
- **Train the Team:** Lead a "kick-off" huddle to introduce the IHA goals and the new standardized EMR templates.

3. Ongoing Success Pillars

- **Daily Huddles:** Brief the team on "unseen" members from the roster to prioritize for scheduling.
- **Troubleshooting:** Solve real-time hurdles like transportation barriers or language needs before the patient arrives.
- **Closed-Loop Check:** Verify that all "red flags" from the previous day's IHAs have assigned follow-up tasks and pending referrals.

Appendix W: Audit Tool (Scorecard)

IHA Medical Record Factor	Scoring	Score	Notes
1. Medical Records or response received	Met = 1 Not Met = 0		
2. *Exception*: Member completed IHA within previous 12 months of enrollment	Met = 1 Not Met = 0 (missing IHA components) N/A = Not applicable, there was a recent IHA visit		
3. *Exception*: Member refused completion of IHA	Met = 1 N/A = Not applicable, there was a recent IHA visit		
4. *Exception*: Member non-response, provider outreach attempts documented	Met = 1 Not Met = 0 (No IHA visit and no outreach within 120 days) N/A = Not applicable, there was a recent IHA visit		
5. *Exception*: Member dis-enrolled with MCP before IHA completion requirement could be met	Met = 1 N/A = Not applicable, there was a recent IHA visit		
6. History of member's physical health	Met = 1 Not Met = 0 N/A = Exception or refusal		
7. History of member's mental health	Met = 1 Not Met = 0 N/A = Exception or refusal		
8. Identification of risks *For D-SNP members, the HRA must be completed within 90 calendar days of enrollment.*	Met = 1 Not Met = 0 N/A = Exception or refusal		
9. Assessment of need for preventive screens or services	Met = 1 Not Met = 0 N/A = Exception or refusal		
10. Health Education	Met = 1 Not Met = 0 N/A = Exception or refusal		
11. Diagnosis and plan for treatment of any diseases	Met = 1 Not Met = 0 N/A = Exception or refusal		

Best Practice Tip:
Monthly, use this scorecard to self-audit 5-10 medical records to prevent audit-time surprises. If you need assistance, email your FSR Team at fsr@sfhp.org for guidance.

Appendix X: Corrective Action Plan Inservice Guide

Example:

INITIAL HEALTH APPOINTMENT DELEGATION OVERSIGHT AUDIT INSERVICE FORM			
Delegate Name		**Facilitator**	
Provider/Clinic Name			

INITIAL HEALTH APPOINTMENT TRAINING	
Initial Health Appointment (IHA) Overview	• The Initial Health Appointment (IHA) is a requirement for all new San Francisco Health Plan (SFHP) Medi-Cal members as indicated in the DHCS All Plan Letter (APL) 26-001. It is a comprehensive assessment that must be completed within 120 calendar days of enrollment with SFHP or documented within the 12 months prior to Plan enrollment/PCP effective date. • During the IHA, the primary care provider assesses and manages the acute, chronic, and preventative health needs of the member that are culturally and linguistically appropriate for the members. • The requirements can be completed over the course of multiple visits. One or more components of the IHA can be completed via telehealth. However, not all components may be achieved via telehealth. For IHAs conducted via telehealth, Medi-Cal requires a subsequent in-person, comprehensive physical exam. • The IHA includes a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. • **Note:** Health Information Form (HIF)/Member Evaluation Tool (MET) that addresses the needs of Seniors and People with Disabilities (SPDs) is required to be completed within 90 days of enrollment for new members or transitioning members between health plans. IHA results that are completed and shared back with the MCP within 90 days of enrollment would fulfill the HIF/MET requirement
Outreach Attempts	• If an IHA is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented. • Providers are required to make at least two documented outreach attempts by phone and one written outreach to contact new members for scheduling the IHA. • All efforts, including refusals or no-shows, must be recorded in the medical record. • We encourage providers to download their new member rosters from Provider Portal. Instructions on how to download lists can be found on the Provider Portal User Guide.
History of the member's physical	History of the member's physical to include: • Physical Exam (PE)/Review of Systems (ROS) • Dental ROS documentation that indicates "inspection of mouth" or "seeing dentist" meets PE criteria • History of present illness (HPI) • Past medical history (PMH)
History of the member's behavioral health	History of member's behavioral health should include: brief emotional/behavioral assessment (e.g., depression inventory, attention deficit/ hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument.

Example of Some Tools	Ages
Ages and Stages Questionnaire: Social-Emotional (ASQ-SE or ASQ:SE-2)	1 to 72 months
Survey of Wellbeing of Young Children (SWYC)	1-65 months
Strengths and Difficulties Questionnaire (SDQ)	2–17 Preschool version: 2– 4 School-aged: 4–10 Adolescent : 11–17 Self-report measure for 11- to 17- year-old as well as age 18 and older
Pediatric Symptom Checklist (PSC)	as young as 4 years old
Patient Health Questionnaire, (PHQ-2) (If positive, administer PHQ-9)	12+

1

	General Anxiety Disorder (GAD-7) | 11+
Identification of risks	Initial HRA related to 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). At least ONE risk assessment tool meets the standard. Examples of tools: • Health Risk Assessment (HRA) (Pediatric and Adult) • Social Determinants of Health (SDOH) (Pediatric and Adult) • The AAFP Social Needs Screening Tool o PRAPARE (The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) o AHC-HRSN (Accountable Health Communities Health-Related Social Needs) Screening Tool o Adverse Childhood Experiences (ACEs) (Pediatric and Adult) ▪ PEARLS ACE (Pediatric ACEs and Related Life-events Screener): ▪ PEARLS child tool, for ages 0-11, to be completed by a parent/caregiver. ▪ PEARLS adolescent tool, for ages 12-19, to be completed by a parent/caregiver. ▪ PEARLS for adolescent self-report tool, for ages 12-19, to be completed by the adolescent. ▪ ACE Questionnaire for Adults (18+) o Cognitive Health Assessment (Adults Only-65+) ▪ General Practitioner Assessment of Cognition (GPCOG) ▪ Mini-Cog For positive findings, order as appropriate and follow up as needed
Assessment of need for preventive screens or services	• Administration of preventive services will no longer be required to be completed during the IHA as long as members receive all required screenings in a timely manner consistent with guidelines, including: o Members ages 18 and up: PCP provides preventive services by most recent edition of the Guide to Clinical Preventive Services of the US Preventive Services Task Force Grade A and B recommendations for providing preventive services, testing, and counseling services. o Members under 21 years of age: For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be covered in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule, as referenced in APL 23-005. PCP provides preventive services specified by the most recent American Academy of Pediatrics/Bright Futures age-specific guidelines and periodicity schedule. o Perinatal services: PCP provides services according to the most current standards of the American College of Obstetrics and Gynecology (ACOG) guidelines. o Immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines for adults and pediatrics. Providers are required to use the California Immunization Registry (CAIR).
Health education	• Provide health education and anticipatory guidance according to but not limited to age, risk factors, or acute/chronic continuous conditions to promote injury and disease prevention • Anticipatory Guidance can be found on the American Academy of Pediatrics (AAP) Bright Futures website at aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/
Diagnosis and plan for treatment of any diseases	• Diagnosis of diseases • Plan of treatment for any disease or health condition identified • The IHA must include the identification of specialty care needed and the initiation of appropriate referrals and labs. Care coordination is a foundational component of the IHA to ensure the member receives the follow-up services identified during the exam.

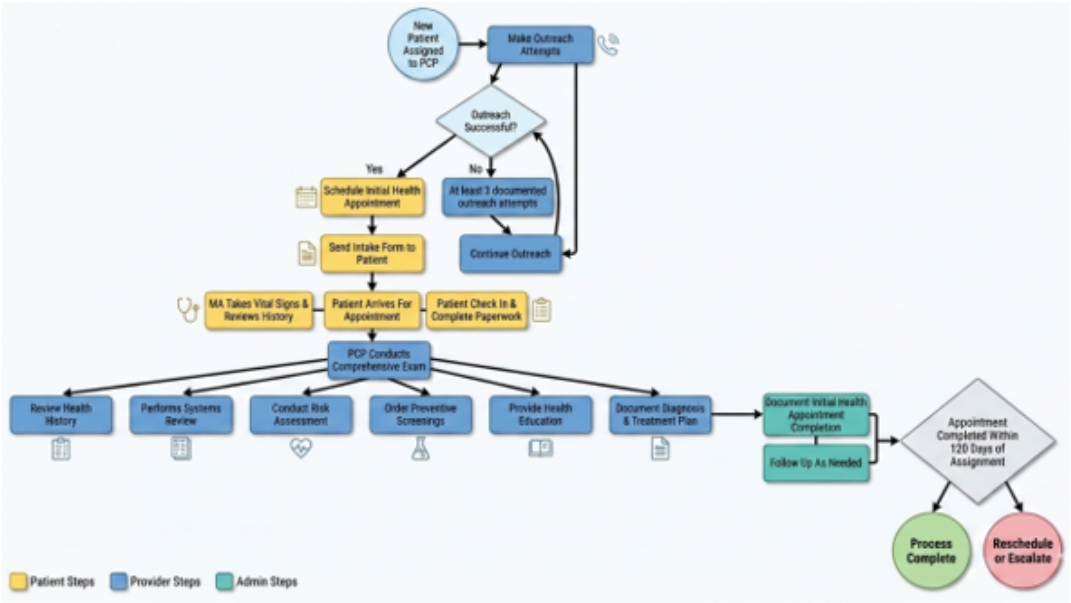
2

Closed Loop Management	• Closed-loop processes must be applied to both referrals and ordered labs/diagnostics, meaning they are not only initiated but tracked through completion. The PCP or care team is responsible for confirming that: o The member schedules and completes referred specialty appointments and completes all ordered labs and diagnostic tests. o Results from specialists, labs, and diagnostic studies are received, reviewed, and documented in the medical record. o Findings are incorporated into the member's care plan and communicated to the member as appropriate. o Any missed, delayed, or incomplete referrals or lab services are actively followed up with documented outreach efforts and interventions to address barriers (e.g., scheduling, transportation, health literacy). • All components of the closed-loop process—including referrals, lab completion status, outreach attempts, barrier resolution, and follow-up actions—must be clearly documented in the medical record to demonstrate continuity of care and compliance with care coordination standards.

IHA Clinical Guide With Coding Tips

Visit SFHP Website for the IHA Clinical Guide with Coding Tips: https://www.sfhp.org/providers/improving-quality/initial-health-appointment/

IHA Primary Care Office Flow Map Example



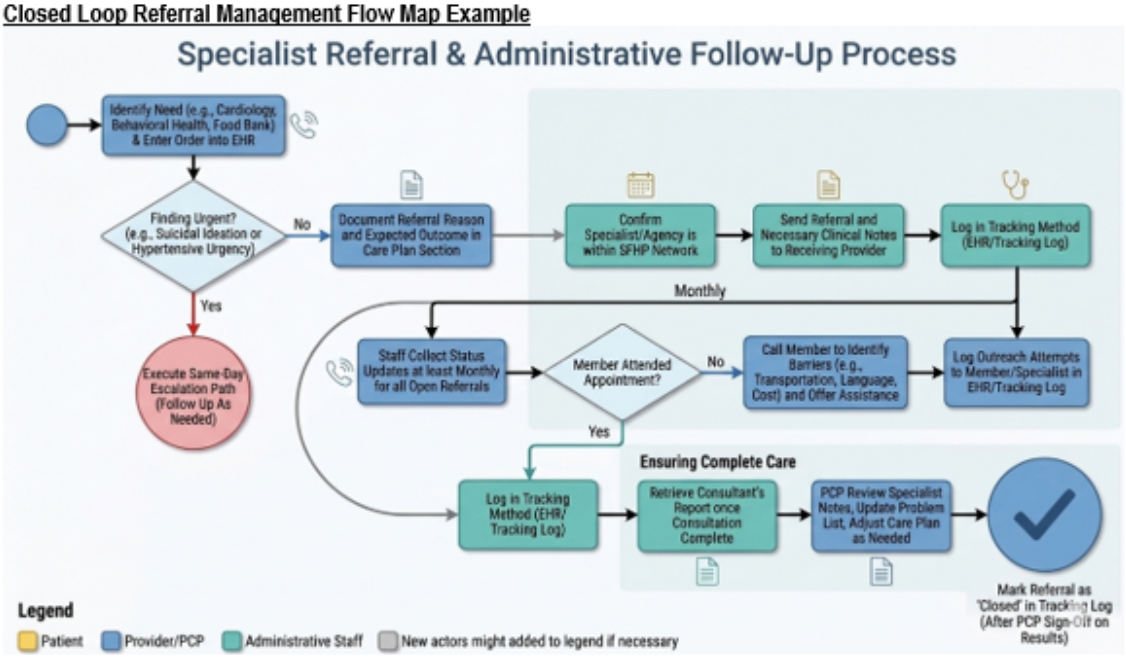
3

What Constitutes Closed-Loop Referral Management

A referral is considered closed when the PCP has taken all reasonable steps to initiate and follow up on the referral and has documented the outcome or next clinical steps. Closed-loop referral completion is based on provider assessment and documented resolution—not on whether an external specialist or agency responds.

Approach	What the PCP Does	What to Document	Loop Considered Closed When…
Time Bound Escalation	Sends referral with defined 2–3 follow-up attempts over set timeframe	Dates, methods, and final nonresponse noted	Final attempt completed and disposition recorded
Patient Attested Outcome	Asks patient about referral outcome	Patient report (seen, declined, unable to schedule) and date	Patient outcome guides next clinical action
Clinical Substitution	PCP manages condition or refers to alternate service	Reason referral no longer needed and new plan	New care plan implemented
Formal Referral Closure	Closes referral with reason code in EMR	Closure reason (e.g., unresponsive, declined)	Referral status set to "closed"
Plan / Network Escalation	Escalates once to health plan or network	Date and entity escalated to	Escalation completed and next steps decided
Provider Attestation	PCP determines no further attempts are needed	Statement of due diligence and clinical judgment	Attestation documented
Referral Expiration Policy	Applies clinic defined expiration timeframe	Expiration date and PCP review note	Referral expires with documented resolution

Closed Loop Referral Management Flow Map Example



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Appendix Y: Process Improvement Tool

PROBLEM STATEMENT

What is the problem? What happens, when, how often/how much, to whom does it happen? 2-3 sentences

IMPORTANCE

Why is this project important? How will the improvement benefit patients? What is the potential downside of this effort for patients? What background information (data/analysis/literature) supports the choice of this effort? What area or organizational goals does this project align with/support? 4-5 sentences

SCOPE

In Scope:	Out of Scope:

SMART AIM (Outcome Measure)

How good? For whom? By when? 1-2 sentences

EXAMPLE AIM STATEMENTS

MEASURES (Process, Balancing, Structure)

Brief measure descriptions summarized from more detailed measures table or Key Driver Diagram. Process (2-5) and balancing (1-2) measures. Structure measures are added as needed.

STAKEHOLDERS & PROJECT TEAM MEMBERS

Who are the key stakeholders in your system and processes? How will you incorporate multidisciplinary input? Will your stakeholder be a team member (attend meetings) or a consultant (attend when needed)? How will you incorporate patients' and families' perspectives? How will you incorporate the perspectives of historically marginalized communities in this work?

Stakeholder Role *(e.g., provider/specialty, nurse/unit, tech, executive, etc.)*	**Stakeholder Name** *(name of person who will represent the stakeholder role)*	**Regularly Attend Team Meetings?*** *(yes/no) *Or as needed*	**Responsibility Assignment** R=Responsible. A=Accountable C= Consulted. I=Informed

RISKS/BARRIERS *What are the major challenges you anticipate? IT? Attitudes? Behaviors? Culture? Time? What is your plan to address these risks and barriers?*

Risk Barrier	Plan to Address

KNOWN OR POTENTIAL INEQUITIES *What inequities currently exist in your processes? What inequities could be potentially introduced as you improve? What are your plans to address current or potential future inequities?*

KEY DELIVERABLES BY QUARTER *Indicate if deliverable is planned or achieved.*

Quarter 1 (Oct-Dec)	
Quarter 2 (Jan-Mar)	
Quarter 3 (Apr-Jun)	
Quarter 4 (Jul-Sep)	

Pause for Equity *Indicate pause learnings, planned actions and outcomes.*

What We Learned	**Plan**	**Outcome**
Quarter 1 (Oct-Dec) Date:		
Quarter 2 (Jan-Mar) Date:		
Quarter 3 (Apr-Jun) Date:		
Quarter 4 (Jul-Sep) Date:		

SUSTAINMENT PLAN *How do you plan to sustain your gains? What resources will be needed to sustain?*

SPREAD PLAN *Do you plan to spread your projects to other units/teams after you identify the changes that create the improvement you are seeking? If yes, what units? How will spread?*

Source: Quality Improvement Essentials Toolkit, Institute for Healthcare Improvement (IHI)
Note: You will need to sign in but it is free.

Initial Health Appointment Toolkit: Share Disclaimer

IMPORTANT NOTICE & LEGAL DISCLAIMER

Purpose and Scope: This Initial Health Appointment (IHA) Toolkit (the "Toolkit") is provided by the author to local Managed Care Plans (MCPs), delegated medical groups, and healthcare providers strictly for informational, educational, and operational guidance purposes. The strategies, workflows, and references contained herein are intended to support health plans in standardizing and improving IHA and screening compliance.

No Regulatory or Legal Endorsement: While every effort has been made to ensure the accuracy, completeness, and alignment of this information with current state and federal regulations—including the California Department of Health Care Services (DHCS) All Plan Letters (APLs), Centers for Medicare & Medicaid Services (CMS) mandates, and CalAIM Population Health Management (PHM) guidelines—this Toolkit does not constitute official legal, regulatory, or compliance advice. Regulations evolve frequently; the receiving entity maintains sole responsibility for regularly consulting, verifying, and adhering to the latest state and federal updates, commercial coding standards, and individual plan contract requirements.

No Guarantee of Audit Outcomes: This document functions as an operational resource and benchmarking guide. The utilization, adoption, or modification of any checklists, EMR templates, or workflows outlined in this Toolkit does not guarantee specific state or federal audit outcomes, passing scores on Facility Site Reviews (FSR) or Medical Record Reviews (MRR), or any particular financial reimbursement or incentive outcomes from regulatory bodies.

Clinical Responsibility: The ultimate responsibility for clinical compliance, provider attestation, documentation accuracy, and actual patient care remains entirely with the rendering healthcare providers and their clinical staff. The author assumes no liability for administrative errors, contract citations, or financial penalties resulting from the implementation or interpretation of the material provided in this guide.

Questions may be sent to: fsr@sfhp.org