Health matters MD

HealthPlan OF SAN MATEO
Healthy is for everyone

FALL 2019

HPSM's CareAdvantage Ranked #1 in Member Satisfaction Poll

In a recent University of California, San Francisco (UCSF) member satisfaction poll of Cal MediConnect (CMC) members, HPSM's CareAdvantage CMC program was ranked first among the seven counties with CMC plans. The UCSF evaluation results are based on phone surveys of CMC plan members over time. Since 2016, 10,000 CMC members in the seven participating counties have been periodically interviewed about their experiences with the program. The results showed that CareAdvantage members were the most likely to:

- Have a personal doctor
- Have the same doctor they had before joining CareAdvantage
- Be happy with their choice of doctors
- Be happy with their choice of hospitals (*tied with San Bernardino County*)
- Have the most In-Home Support Services (*IHSS) hours (tied with Santa Clara County*)

HPSM CEO Maya Altman said "The successful HPSM results show HPSM's positive impact on our community and strengthen our role as a health care leader in the state. This kind of official recognition lets us know that we're on the right track and I hope will encourage more people to join CareAdvantage."

HPSM's CareAdvantage Program

RANKED
NUMBER ONE
for member satisfaction
in a poll by the
University of California
San Francisco

Ratings based on phone surveys of 10,000 Cal MediConnect (CMC) members in seven counties from 2016 to 2019

You and your patients get more — with CareAdvantage

Do you have patients who:

- Live in San Mateo County
- Have Medicare Parts A & B and
- Have full-scope Medi-Cal

They can join CareAdvantage! Tell them to call:

- **650-616-1500**
- Toll free: **1-888-252-3153**
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To learn more, visit
www.hpsm.org/join-careadvantage

Benefits of having CareAdvantage patients

- Competitive reimbursement rates
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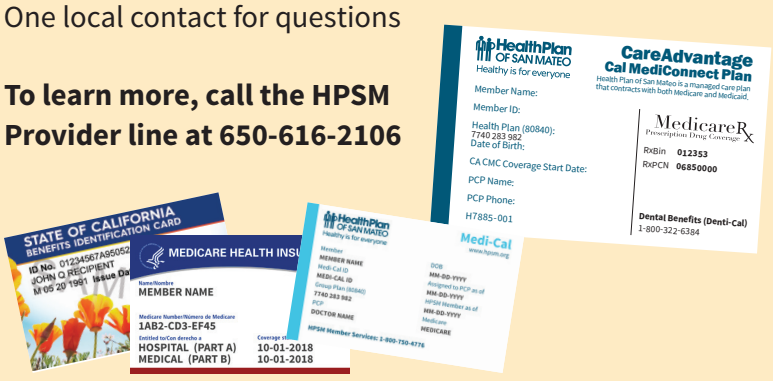
- No referral authorization required for outpatient services
- One local contact for questions

To learn more, call the HPSM Provider line at 650-616-2106



PCP Spotlight — Congratulations to the LiveWell Medical Clinic

HealthMatters MD is excited to introduce the first installment of our new series spotlighting the exemplary work being done by HPSM's network providers. We start with LiveWell Medical Clinic in South San Francisco (not to be confused with the LiveWell™ training method described on page 5 of this newsletter). This pediatric primary care clinic was among the first to participate in HPSM's new Medi-Cal Primary Care Benchmark Pay for Performance (P4P) Program, which launched in July 2018. They were also the first clinic to achieve full credit on all P4P quality benchmarks, receiving more than double their base capitation payments in quality and access bonuses. HPSM asked the clinic's director, Dr. Maria Osmena, how they manage to excel on so many quality measures.

Dr. Maria Osmena
Director, LiveWell Medical Clinic

Q ***In your opinion, what key strategies led to your clinic's success in the new Benchmark P4P program?***

A One key area we've focused on is increasing the number of appointments kept and minimizing no-shows. HPSM's eReports really help with this because they tell us which patients are due or overdue for certain services (whether for well visits, immunizations, etc.). We weren't able to pull these lists so quickly and efficiently before eReports, so we are happy that they've made our work easier by enabling us to identify patient care needs. I pull the lists every second or third day of the month and divide them among my medical assistants for review and follow-up. The majority of their work hours are spent on the phone, conducting patient outreach and scheduling appointments or following up on missed appointments. If a patient doesn't answer, we leave messages when able, and after three call attempts, we send a letter.

We also call each patient the night before their scheduled appointment to remind them. This way, patients almost never miss their appointments. If they do, even with the reminder, they can always reschedule. We never charge for missed appointments, and we always try our best to reschedule appointments instead of cancelling them – even if a patient is not eligible at that time. We recommend scheduling a month in the future to allow any insurance discrepancies to be reconciled, but patients can choose whatever timeframe works for them. Extended office hours are another way we improve accessibility. Being open until 6:30 p.m. five nights per week, every Saturday from 9:30 a.m. to 1:30 p.m. and most holidays makes it much easier for patients to fit doctor's appointments into their busy schedules.

Our electronic medical records (EMR) system, eClinicalWorks, lets us schedule appointments a year in advance. Also, per our office protocol, every patient makes their next annual well visit appointment before leaving the clinic. The system automatically checks eligibility three days prior to an appointment, though my medical assistants sometimes manually check eligibility if the computer is unable to do so for whatever reason.

Q ***What specific steps were taken to drive the outcomes of your quality scores?***

A For each measure, we simply called as many patients as we could and got them into the clinic to complete all of their needed services. We also have patients complete a lot of screening questionnaires, and we are getting a new system called Chadis that will make that process easier by allowing people to answer questionnaires online before they come in using their phones. They can also fill them out on our office iPads during visits.

Q ***What internal changes or workflows were required to operationalize this approach?***

A My medical assistants create phone encounters for every follow up to a missed appointment. In our EMR, we log the date and time of all three phone calls as well as when we sent the letter. These contacts are permanently documented in every patient's chart.

Q ***Were members engaged during this process in any new or innovative ways to assist with improving outcomes or compliance?***

A New patients are quickly made aware of our clinic's mandatory protocol to make appointments before leaving the clinic. Our patients even know to ask when their next Well Child appointment is scheduled, even if they are in for a sick visit. It is key to have this visit in the system so we can remind them the night before.

Q ***Do you believe these approaches could be adopted by other providers and practices, or is there something about your method that is specific to your practice?***

A Every provider who has an EMR system can do exactly what our clinic does. There just needs to be a medical assistant or several medical assistants who share in making the three phone calls and sending the letter.

Q ***What were the biggest challenges with implementing these changes and how did you address those issues?***

A Practices need to have the medical assistants dedicated to performing the tasks associated with benchmarks, especially phone calls. This consumes a lot of time. I like to have all my medical assistants share in all their tasks. This way they all get some patient contact and all do their share of phone calls. However, I have a few "champions" that take charge of making sure the tasks get done. For example, we have someone who makes sure patients have updated vaccines and someone who makes sure patients finish their questionnaires. We also have someone who is in charge of managing missed appointments, but that's a larger task so everyone helps.

Q ***Did you find that efforts to improve quality in one measure led to quality improvements in other measures as well?***

A Absolutely, the measures are all linked. If patients come in for their visits, then they complete their questionnaires and get any needed vaccines, etc.

PCP's – Take the Next Steps:

- Sign up for access to your eReports **www.hpsm.org/provider/portal**
- Learn more about HPSM's P4P program **www.hpsm.org/provider/p4p-quality-initative**
- Read about the LiveWell Medical Clinic **www.livewellmedicalclinic.com**

Recognize your colleagues

Submit nominations for HPSM's next PCP Spotlight

1. Go to **www.hpsm.org/provider-nomination**
2. Fill out the online form
3. Click the "Send" button

Healthy Kids Members Will Transition to Medi-Cal on October 1st

Starting on October 1st, 2019, HPSM's Healthy Kids HMO program will sunset and most members will be transitioned into HPSM's Medi-Cal program. HPSM has reached out to families about this change in partnership with the California Department of Health Care Services (DHCS) and the San Mateo County Health Coverage Unit. Here is a quick summary of what you might need to know if you are treating Healthy Kids members.

Eligibility

All Healthy Kids members who are eligible for the County Children's Health Insurance Program (CCHIP) will begin receiving Medi-Cal benefits. Out of around 1,600 Healthy Kids members, only about 20 don't qualify for CCHIP. They will be offered free health care coverage for 12 months through a Kaiser Silver plan as part of the San Mateo County Children's Health Initiative.

Services

Medi-Cal covers the same services that Healthy Kids does, including medical visits, prescription drugs, vision services, behavioral health services and substance abuse treatment. Dental care is provided through Medi-Cal Dental (Denti-Cal). The change will also increase some benefits through a program called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). You can learn about EPSDT at **www.medicaid.gov/medicaid/benefits/epsdt/index.html.**

Have You Updated Your Provider Directory Data?


HPSM Provider Update

Each quarter, HPSM sends faxes to all of our contracted providers to make sure we have your most up-to-date information for our provider directory. If your data has changed, it is vital that you respond to this fax because:

- Members use our directory to find providers. If your contact information (e.g., address or phone number) is incorrect, members won't be able to reach you.
- Members also often call HPSM for help finding the right provider for their specific needs. Our staff then uses the provider directory to search by factors like specialty or languages and recommend good matches. If that information is outdated, we can't refer the right patients to your practice.
- Accurate provider directory information is critical to member care because it helps ensure that HPSM members have access to the care they need. That is why regulatory agencies routinely audit our provider directory for accuracy.

New for 2019 – Please provide email addresses

Starting this year, we began asking providers for email addresses – one for internal HPSM communications and one for your public directory listing.

HPSM is working to build out more email communication channels with our providers. Having your email address helps ensure that we can reach you with important information.

Thank you for keeping your provider directory listing current!

Network

The Healthy Kids network is also contracted for Medi-Cal, so PCPs and specialists who treat Healthy Kids members can continue with those patients. Additionally, the Medi-Cal network is more extensive than the Healthy Kids network today, so newly-eligible CCHIP members will have a greater choice of providers starting October 1st.

- **PCPs:** If you are currently seeing a CCHIP child through the Healthy Kids program, the child will be automatically transitioned to your Medi-Cal panel on October 1st, 2019. We will notify you if any of the children currently on your panel are not CCHIP eligible, as these children will be transitioned to a Kaiser provider.
- **Specialists:** If you are currently seeing a CCHIP eligible child through the Healthy Kids program, the child's eligibility will automatically show as Medi-Cal as of October 1st, 2019. Please bill under Medi-Cal for all services rendered. If you are treating a non-CCHIP child through Healthy Kids, they will show as ineligible with HPSM as of October 1st, 2019 and services will not be covered.

▶ If you have questions about how the transition may affect your practice, contact HPSM Provider Services at **650-616-2106**.

HPSM Partners with SNF/LTC Facilities to Improve Care

In October 2018, HPSM started providing training to long-term care (LTC) facilities and skilled nursing facilities (SNFs) in our network based on the LiveWell™ method. The program uses group and one-on-one coaching to infuse organizations with a culture of continuous improvement. Key components include:

- **Engagement** Increasing the amount of time facility caregivers spend on direct patient care
- **Measurement** Developing quality-of-care and access metrics to track progress
- **Incentive** Implementing a new payment model that rewards high-quality care and access
- **Collaboration** Creating an ongoing forum to share best practices, identify challenges and engage in joint problem-solving
  - HPSM first met with administrators and staff at their facilities in October 2018
  - Since then, we have met with them quarterly
  - HPSM staff also visits facilities in between each session to get progress updates, share success stories and learn how we can better support care together

Program at a glance

The LiveWell™ training program was developed by the National Health Service (NHS) in England and adapted by the State of Oregon as a foundational program for quality assurance and performance improvement (QAPI). It supports facility staff development and training, with a mix of executive leadership and direct caregivers participating to accelerate the spread of new ideas and improved processes.

These field-tested strategies have been proven to improve organizations' quality of care. They also enhance employees' job satisfaction while dramatically enriching residents' quality of life.

▶ To learn more about this learning collaborative, and how you can more effectively coordinate care with sub-acute and long-term care facilities, please email Kati Phillips at kati.phillips@hpsm.org.

High-Priority Quality Measures: The Bar is Rising

At HPSM, we work with our network of primary care providers to ensure that our members receive high-quality and appropriate care. We closely monitor performance on various quality measures, including Healthcare Effectiveness Data and Information Set (HEDIS) rates. The Managed Care Accountability Set (MCAS) is a subset of HEDIS measures that the California Department of Health Care Services (DHCS) holds Medi-Cal managed care health plans like HPSM accountable for.

DHCS has recently raised the minimum performance level across these measures from **25th percentile to 50th percentile**, raising the bar across the state in an effort to improve access to primary care services for Californians.

HPSM has conducted an assessment on current MCAS measure performance and identified several high-priority measures as opportunities for improvement due to low rates across HPSM's network. The high priority MCAS measures are listed in the reference table below. The last column is a quick guide to coding that will help you document, bill for services and get credit for the care you provide to our members. We've designed this table to work as a poster. If you are reading the print version of this newsletter, pull it out and tack it to the wall at your work station for easy reference. You can order an 11" X 17" printed copy at **www.hpsm.org/provider/resources/newsletters**.

▶ **Did you know?**
Depending on your participation in the Pay for Performance (P4P) program, you may be eligible for bonus payments attached to these measures. HPSM's Primary Care P4P program consists of three track choices with different levels of risk and reward. Learn about your options at **www.hpsm.org/provider/p4p-quality-initative**.

High Priority MCAS Measures

Preventative Care				
Measure	**Eligibility**	**Proof of Documentation**	**Coding**	
W15 Well Child Visits in the first 15 months of life	Children who turned 15 months of age during the measurement year and had 0-6 well child visits with a PCP during their first 15 months of life	The following components of the well child visit must be documented: • Health history • Mental development history • Physical development history • Physical exam • Anticipatory guidance counseling	CPT 99381-99385, 99391-99395, 99461	HCPCS G0438, G0439 ICD10CM Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.82, Z76.1, Z76.2
AWC Adolescent Well Care	Adolescents and young adults 12-21 years of age who have at least one comprehensive well care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year	The following components of the well visit must be documented: • Health history • Mental development history • Physical development history • Physical exam • Anticipatory guidance counseling	CPT 99384, 99385, 99394, 99395 HCPCS G0438, G0439	ICD10CM Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0- Z02.6, Z02.71, Z02.82, Z76.1, Z76.2
CHL Chlamydia screening in women	Women ages 16-24 who were identified as sexually active and had at least one test for chlamydia during the measurement year	Collection date and result of **at least one** chlamydia test during the measurement year: • Chlamydia culture taken during the Pap Smear • Urine sample	CPT 87110, 87270, 87320, 87490, 84491, 87492, 87810	

High Priority MCAS Measures

Chronic Conditions Management

Measure	Eligibility		Proof of Documentation	Coding	
ABA Adult BMI Assessment	Adults 18-74 years of age who had an outpatient visit and whose BMI was documented during the measurement year.	Adults 18-19 years of age	On the date of service, documentation in the medical record must indicate: • Height • Weight • BMI percentile	ICD10CM Z68.51-Z68.54	
		Adults 20 years and older	On the date of service, documentation in the medical record must indicate: • Weight • BMI value	ICD10CM Z68.1 Z68.20-Z68.29 Z68.30-Z68.39 Z68.41-Z68.45	
CDC Comprehensive diabetes care: Hemoglobin A1c (HbA1c) testing	Adults 18-75 years of age with diabetes (type 1 and type 2) and had a Hemoglobin A1c (HbA1c) test during the measurement year		• HbA1c test collection date • HbA1c value	CPT 83036, 83037	
CDC Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) control	Adults 18-75 years of age with diabetes (type 1 and type 2) and had a Hemoglobin A1c (HbA1c) test during the measurement year		• HbA1c test collection date • HbA1c value	CPT 83036, 83037	CPT II 3044F (A1c <7.0%) 3045F (A1c 7.0-9.0%) 3046F (A1c > 9.0%)
AMR Asthma Medication Ratio	Patients aged 5-64 with persistent asthma, which is defined as having: • At least one ED visit or one acute inpatient visit (with an asthma diagnosis) • Four inpatient or observation visits and at least two asthma medication dispensing events • At least four asthma medication dispensing events		Prescription fills of both reliever and controller medications. (Consider prescribing 60-90 days of controller medications to improve on this measure).	Persistent Asthma ICD-10: J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998 ED CPT codes: 99281-99285 Inpatient CPT: 99221-99233, 99238-99239, 99251-99255, 99291	Outpatient CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 99455, 99456 Outpatient HCPCS codes: G0402, G0438, G0439, G0463, T1015

HPSM Opioid Initiative Helps Identify Medication Overuse

HPSM is committed to combatting the nationwide opioid epidemic by partnering with our provider community in San Mateo County. Opioid misuse puts people at high risk of addiction, overdose and death. By flagging mutual patients who may be overusing opioids, we hope to reduce this risk, improve people's health and potentially save lives.

Member focus

The CDC Guideline for Prescribing Opioids for Chronic Pain has established daily opioid dosages of 90 morphine milligram equivalents (MME) as a level that prescribers should generally avoid reaching. Based on that standard, HPSM utilizes pharmacy claims data to identify patients on an average daily opioid dosage of ≥ 90 MME who meet ***either*** of the following criteria:

- Prescriptions from three or more prescribers and dispensed from three or more pharmacies over the past six months
- Prescriptions from five or more prescribers over the past six months

≥ 90 MME
The CDC's recommended prescription limit

▶ **To learn more about HPSM's Opioid Initiative** and how you can help prevent medication overuse, please call HPSM's Pharmacy department at **650-616-2088**

Prescriber outreach

When a patient is identified as at risk, an HPSM physician or pharmacist may reach out to the provider's office by telephone to discuss an appropriate action plan. This might include:

- Monitoring opioid use
- Assessing whether opioid treatment is meeting their treatment goals
- Exploring alternative pain management interventions
- Considering potential dose reduction, tapering and discontinuation of opioids if benefits are likely to outweigh harm
- Offering naloxone and education on overdose prevention when appropriate (as mandated by California Law – AB 2760)

Case Example: Opioid Oversight

An HPSM pharmacist identified a member who had been getting opioid prescriptions from multiple prescribers (PCP, ER doctors and a skilled nursing facility) and at multiple pharmacies. The pharmacist reached out to the member's PCP, who agreed to have their patient assigned to case management. Working with the provider, HPSM successfully reduced the member's opioid utilization without compromising their pain control.

Emergency Medication Supply for Emergencies & Transitions

Is your patient being discharged from the hospital and having problems obtaining their medications?

HPSM's Pharmacy Services department can provide up to a 72-hour supply of most medication(s) without restriction. This can help in emergency situations and ease a patient's transition from the hospital to their home. This includes prescriptions awaiting submission or approval of a prior authorization request. Certain limitations apply. For details, call HPSM's Pharmacy Services department at **650-616-2088**.

Institute on Aging Receives Innovation Award for CCSP

The **Institute on Aging** (IOA) is a San-Francisco based organization that serves many HPSM members in our county. They offer a range of services and supports that help seniors maintain their independence, including home care, case management, adult day care centers, a 24-hour suicide prevention line and other services. HPSM identified the **Community Care Settings Program** (CCSP) as a strategic investment in 2014 and works closely with IOA and Brilliant Corners to serve our members through this program. Since then, CCSP has helped 281 aging and disabled people transition from long-term care facilities back into their own homes. With a 93 percent success rate, CCSP reduces health care costs while improving people's quality of life. It is therefore no wonder that health plans in other California counties are starting their own programs modeled on CCSP.

To recognize the positive health impact that the IOA's CCSP has had on the community, on July 30th, the Aging and Disability Business Institute presented IOA with The John A. Hartford Foundation 2019 Business Innovation Award for the program.

"The Institute on Aging is honored to be recognized by the Aging and Disability Business Institute and The John A. Hartford Foundation for its innovative Community Living Solutions work," said Tom Briody, the Institute's President and CEO. "We look at ourselves as a laboratory for new models of care in the areas of dementia, caregiving, social isolation and alternatives to long term placement. We're humbled by the thought that we've had an influence on shaping what's considered possible around community living. Sometimes systems change is more about breaking down unnecessary barriers to achieve the simple solution than anything else, and we will continue to innovate and challenge current system structures for the betterment of all."*

About The John A. Hartford Foundation Business Innovation Award

Candidates for this prestigious award are nominated each year in an open application process. Applications are reviewed by health care representatives, foundation staff and community-based organizations. Nominees are assessed based on:

- Their ability to successfully partner with a health care entity (such as HPSM)
- The impact their partnership has on older adults and people with disabilities
- The degree to which the nominee takes risk in pursuing innovative new approaches

> "The Institute's ability to bring together a variety of partners to help older adults transition from institutional settings to the community is a remarkable testament to the fact that community-based organizations can work together to make a meaningful difference in the lives of older adults who want to live at home and in the community but often encounter obstacles that prevent them from doing so. The Institute on Aging has created a program that can and does serve as a model that can be replicated in communities around the country."*
>
> Sandy Markwood
> CEO of the National Association of Area Agencies on Aging

> "HPSM congratulates IOA for receiving this award. We are proud to partner with them on this innovative program that serves as a blueprint for other health organizations."
>
> Maya Altman
> CEO of Health Plan of San Mateo

* Quotes are from the Aging and Disability Business Institute - **https://tinyurl.com/yxdgeejp**

A Few Words About People First Language

by Kathie Snow *(reprinted courtesy of Disability Is Natural—visit www.disabilityisnatural.com to see the original, full-length article)*

People with disabilities constitute our nation's largest minority group. It's also the most inclusive: all ages, genders, religions, ethnicities, sexual orientations, and socioeconomic levels are represented.

Yet the only thing people with disabilities have in common is being on the receiving end of societal misunderstanding, prejudice, and discrimination. And, this largest minority group is the only one that *anyone can join, at any time*: at birth, in the split of a second of an accident, through illness, or during the aging process. If and when it happens to you, how will you want to be described?

Words matter! Old and inaccurate descriptors perpetuate negative stereotypes and generate an incredibly powerful attitudinal barrier — *the greatest obstacle facing individuals with disabilities*. A disability is, first and foremost, a medical diagnosis, and when we define people by their diagnoses, we devalue and disrespect them as individuals. Do you want to be known primarily by your psoriasis, gynecological history or the warts on your behind? Using medical diagnoses incorrectly — as a measure of a person's abilities or potential — *can ruin people's lives*.

Embrace a new paradigm: "Disability is a natural part of the human experience…" (*U.S. Developmental Disabilities/Bill of Rights Act*). Yes, disability is natural, and it can be redefined as a "body part that works differently." A person with spina bifida has legs that work differently, as a person with Down syndrome learns differently, and so forth. People can no more be *defined* by their medical diagnoses than others can be defined by their gender, ethnicity, religion, or other traits!

A diagnosis may also be used as a *sociopolitical passport* for services, entitlements, or legal protections. Thus, the *only places* where the use of a diagnosis is relevant are the medical, educational, legal, or similar settings.

People First Language puts the person before the disability, and describes what a person *has*, not who a person *is*. Are you "cancerous" or do you have cancer? Is a person "handicapped/disabled" or does she "have a disability"? Using a diagnosis as a defining characteristic reflects prejudice, and also robs the person of the opportunity to define himself.

Let's reframe "problems" into "needs." Instead of, "He has behavior problems," we can say, "He needs behavior supports." Instead of, "She has reading problems," we can say, "She needs large print." "Low-functioning" or "high-functioning" are pejorative and harmful. Machines "function;" people live! And let's eliminate the "special needs" descriptor – it generates pity and low expectations!

A person's self-image is tied to the words used about him. People First language reflects good manners, not "political correctness," and it was started by individuals who said, "We are not our disabilities!" We can create a new paradigm of disability and change the world in the process. Using People First Language is right – *just do it, now!*

The difference between the right word and the almost right word is the difference between lightning and the lightning bug.
— Mark Twain

A Few Examples of People First Language

Say:	Instead of:
Children/Adults with disabilities.	Handicapped, disabled, special needs.
He has a cognitive disability.	He's mentally retarded.
She has autism.	She's autistic.
He has Down syndrome.	He's Down's/mongoloid.
She has a learning disability.	She's learning disabled.
He has a physical disability.	He's a quadriplegic/crippled.
She uses a wheelchair.	She's confined to/wheelchair bound.
He receives special ed services.	He's in special ed; a special ed kid.
People without disabilities.	Normal or healthy people.
Communicates with her eyes/device/etc.	Is non-verbal.
Congenital disability/Brain injury.	Birth defect/Brain damaged.
Accessible parking, hotel room, etc.	Handicapped parking, hotel room, etc.

New Enrollee Initial Health Assessments (IHAs)

HPSM complies fully with the California state mandate requiring that all new members receive an Initial Health Assessment (IHA) within 120 days of enrolling with HPSM. The California Department of Health Care Services (DHCS) expects 100% participation from all providers.

The IHA is a comprehensive assessment that documents each patient's health history and current physical/mental health status. The components of a complete IHA consist of the following:

- Comprehensive history (which includes history of present illness, past medical history, social history and review of organ systems)
- Preventive services
- Comprehensive physical and mental status exam
- Diagnoses and plan of care
- Individual Health Education Behavioral Assessment (IHEBA) — also known as the Staying Healthy Assessment (SHA) — for each appropriate age group
    - Please note that the IHA is ***not*** complete without the SHA: DHCS provides links to SHA questionnaires by age group and language at **www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx**

Any forms used to satisfy these requirements need to be reviewed and signed by the provider, and copies scanned into the medical record

Why completing IHAs is important

Performing IHAs in a timely manner provides vital baseline information about a new patient's health. This enables you to prescribe effective interventions and track patient progress over time. That is why HPSM rewards providers for conducting high-quality IHAs through our Pay for Performance (P4P) program.

Depending on your participation in P4P, you may be eligible for bonus payments. Learn about your options at **www.hpsm.org/provider/p4p-quality-initative**.

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Visit our NEW website!
www.hpsm.org

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