


<b>HEALTH PLAN OF SAN JOAQUIN</b>		
<b>Subject: Appointment Availability and Access Standards</b>		
<b>Department:</b> Medical Management - Quality		<b>Policy #:</b> QA 04
<b>Applies to:</b> MCL, HF, Commercial		<b>Scope:</b> QI, PS, CS
<b>Effective Date:</b> 2/96	<b>Revised Date:</b> 1/07, 06/08; 10/08; 10/10; 4/11; 5/11	<b>Approved by:</b>    Medical Director

### **DEFINITIONS**

- A. "Appointment waiting time" means the time from the initial request for health care services by an member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or medical group (if delegated) and completing any other condition or requirement of the plan or its contracting providers.
- B. "Preventive care" means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.
- C. Routine Primary Care appointments are described as scheduled visits for purpose of follow-up or monitoring of non-urgent problems or chronic medical conditions for new or established patients. Follow-up visits should be accommodated as medically appropriate.
- D. "Triage" or "screening" means the assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an member who may need care, for the purpose of determining the urgency of the member's need for care.
- E. "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an member who may need care.
- F. "Urgent care" means health care for a condition which requires prompt attention when the member's condition is such that the member faces an imminent and serious threat to his or her health, including but not limited to, potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process

would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function (consistent with subsection (h)(2) of Section 1367.01 of the Act). If the office staff cannot schedule the visit within 24-hours, a physician, mid-level clinician, or a registered nurse must evaluate the member's complaint, determine the most appropriate place for care, and refer the member for care accordingly

### **POLICY**

- A.** Health Plan of San Joaquin (HPSJ) shall maintain a network of Primary Care Providers (PCPs) which are located within thirty (30) minutes or ten (10) miles of a Member's residence unless HPSJ has a DHCS approved alternative time and distance standard.
- B.** Each HPSJ member will have a primary care provider (PCP) who is available and physically present at the service site during posted office hours. Office hours must be sufficient to ensure access to the member upon request by the member or when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of vacation, illness, or other unforeseen circumstances.
- C.** Providers will maintain office hours for HPSJ members that are no less than those office hours maintained for other commercial or Medi-Cal FFS patients.
- D.** Provider offices that employ mid-level practitioners, such as nurse practitioners (NP), physician assistants (PA) and certified nurse midwives (CNM) and are credentialed by HPSJ, will adhere to the same access standards as described below.
- E.** Services requiring prior authorization will be completed in a manner that assures the provision of covered health care services to members in a timely manner appropriate for the member's condition and in compliance with the requirements of the time-elapsd access standards. (HPSJ P&P UM01 – Authorization Referral Process).
- F.** Interpreter services required by Section 1367.04 of the California Health & Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. (HPSJ P&P C&L 03 – Access to Interpreter Services).
- G.** HPSJ has established acceptable accessibility standards in accordance with Title 28, section 1300.67.2.2, and the DHCS Contract, Exhibit A, Att. 9. as specified below.

### **Non-Emergent Appointment Access Standards – Medical Healthy Families, AIM, Network+**

<b>Appointment Type</b>	<b>Time-Elapsed Standard</b>
Non-urgent appointments for Primary Care (PCP)	Must offer the appointment within 10 Business Days of the request
Non-urgent appointments with Specialist physicians	Must offer the appointment within 15 Business Days of the request
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within 48 hours of request
Urgent Care appointments that require prior authorization	Must offer the appointment within 96 hours of request
Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 Business Days of the request

### **Non-Emergent Appointment Access Standards –Medi-Cal**

<b>Access Measure</b>	<b>Time-Elapsed Standard</b>
Access to PCP or designee	24 hours a day, 7 days a week
Non-urgent appointments (PCP Regular and Routine) Excludes physicals and wellness checks	Must offer the appointment within 7 business days of request
Adult physical exams and wellness checks	Must offer the appointment within 4 weeks of request
Non-urgent appointments with Specialist physicians (Regular and Routine)	Must offer the appointment within 15 business days of request
PCP Urgent Care appointments that do not require prior authorization (Includes appointment with any physician, Nurse Practitioner, Physician’s Assistant in office)	Must offer the appointment within 24 hours of request
Specialist Urgent Care appointments that require prior authorization	Not to exceed 96 hours of request for an appointment
First Prenatal Visit	Must offer the appointment within 14 calendar days of request
Newborn Visits after discharge from the hospital	<ul style="list-style-type: none"> <li>• Within 48 hours for infants discharged in less than 48 hours of life after delivery</li> <li>• Within 30 days from the date of birth if the infant was discharged more than 48 hours of life after delivery</li> </ul>
Child physical exam and wellness checks	Must offer the appointment within 14

<b>Access Measure</b>	<b>Time-Elapsed Standard</b>
with PCP	calendar days of request
Non-urgent appointments for ancillary services ( diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 business days of request
Initial Health Assessment (members age 18 months and older)	Must be completed within 120 calendar days of enrollment
Initial Health Assessment (Members age 18 months and younger)	Must be completed within 60 calendar days of enrollment

**Emergent & Non-Emergent Appointment Access Standards – Behavioral Health**

\* Note: These time-elapsed standards follow the more stringent accreditation agency criterion

<b>Appointment Type</b>	<b>Time-Elapsed Standard</b>
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 15 business days of request
Non-Urgent Care appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Urgent Care appointments	Must offer the appointment within 48 hours of request
Access to Care for Non-Life Threatening Emergency	Within 6 hours
Access to Life- Threatening Emergency Care	Immediately
Access to Follow Up Care After Hospitalization for mental illness	Must Provide Both: One follow-up encounter with a mental health provider within 7 calendar days after discharge Plus One follow-up encounter with a mental health provider within 30 calendar days after discharge

E. Provider Availability and Appointment Scheduling and Wait Time

1. PCP Office Hours

- a) PCP practices must be open and staffed by an appropriately licensed clinician(s), medical doctor (MD), physician assistant, nurse practitioner or certified nurse midwife, who is available to members for a minimum of 20 hours per week. When a PCP has two office sites less than ten (10) miles apart and sees members at either site, open hours at one site may be combined with open hours at the alternate site for the purpose of meeting this requirement.
2. Follow-up on Missed and Canceled Appointments
    - a) The provider must have a system in place to follow-up on missed and canceled appointments.
    - b) When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of this policy.
    - c) The Customer Services Department, upon request of the provider, shall contact members who miss two or more consecutive appointments or three appointments in a six-month period.
3. Extending Appointment Waiting Time
    - a) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.
4. PCP After Business Hours
    - a) It is expected that the answering service contact the practitioner or designee with 30-minutes for urgent questions. The practitioner on call for the practice is expected to call the answering service within 30-minutes of contact by the answering service. The practitioner on-call is required to call the member back within 60-minutes for probable urgent problems and within four (4) hours for probable non-urgent matters. If the answering service is unable to reach the on-call practitioner, or the designated back-up practitioner, the answering service either will refer the member to the 24/7 HPSJ

Advice Nurse for triage and screening, or to the nearest emergency department (HPSJ P&P MM01 – 24/7 Nurse Advice Line).

5. Waiting Times

- a) Member waiting time in the office to see a provider for a scheduled appointment should not exceed 45-minutes unless the provider is unexpectedly delayed.
- b) Telephone waiting time to schedule primary care site appointments should be no longer than five (5) minutes.
- c) Telephone waiting time to speak to a provider, or a clinical designee, may vary depending on the nature of the call. This accounts for a normal range of inquiries that include simple non-medical questions and prescription refills to guidance on urgent medical conditions.
- d) Office staff with medical training (i.e., medical assistant) may screen each call, and if the member has a medical problem, refer the call to the RN, mid-level clinician or physician for triage, as per the office triage protocols.
- e) During business hours, routine or administrative questions should be answered within eight hours or, in the case of a call received after hours, the next business day.
- f) Urgent medical condition questions should be answered within 30 minutes during office hours.
- g) During normal business hours, the waiting time to speak to a Plan Customer Service Representative will be 30 seconds (Average Speed of Answer), and will never exceed 10 minutes.
  - Average Speed of Answer is monitored by the Director of Customer Service, and is reported monthly to the Executive Team, and annually to the Commission.

F. Monitoring Accessibility

1. Provider office hours are tracked by Provider Services and are maintained in the Provider Directory.
2. Access studies are completed annually as described in section H.
3. Access complaints are logged into the health information database, and are tracked for reporting purposes and annual access studies. The Customer Service or Provider Services Departments shall assist members with complaints about not being able to access their PCP for an urgent appointment.

4. When a case-specific access issue is identified, the Case Manager discusses the issue with the Medical Director, and a determination is made regarding timeliness of need using medical necessity criteria/guidelines. Additional resources are sought to meet timely medical needs, including referring members to contracted providers outside of the HPSJ service area.

#### G. Corrective Actions

- i. When a member telephones HPSJ with problems accessing a provider, “secret shopper” telephone calls may be placed by Provider Services staff to substantiate the complaint, or a letter may be sent reminding the provider of the standardized wait times.
- ii. The Provider Services Department shall address persistent complaints regarding accessing a specific provider, by requesting a corrective action plan.
- iii. Any provider with three (3) or more access complaints during the past year will be included in the annual access survey.

#### H. Monitoring of Provider Wait Times

- i. The Quality Improvement (QI) Department conducts routine access surveys on 50% of PCPs who have greater than 500 members, a 5% random selection of all other PCPs, and any provider that has had 3 or more access complaints during the year. If a provider is selected for the access study, the following studies are utilized:
  - On-site evaluation of the provider’s wait room times and appointment scheduling system
  - After hour telephone calls to evaluate provider availability
  - Provider Telephone Wait Time Call Log
  - Provider telephone calls to evaluate appointment scheduling for both urgent and non-urgent health care requests
- b) As access surveys are completed, findings are reviewed and corrective action plans may be requested for deficiencies. Results of the access studies are reported to the Quality Improvement Utilization Management Committee for review, recommendations, and approval.
- ii. The QI Department is responsible for implementing and monitoring corrective action plans.
- iii. Accessibility to PCP services is continually monitored through member complaints, member and provider satisfaction surveys and

annual access studies, are reviewed and evaluated on no less than a quarterly basis.

- iv. For identified systematic specialty access issues, Provider Contracting and Medical Management work together to seek additional resources on which to focus contracting efforts.

**REFERENCE**

- A. DHCS Contract, Exhibit A, Attachment 9
- B. Title 22, CCR, Section 53853(a)
- C. Title 28, Section 1300.67.2.1
- D. HPSJ P&P QA 04b - *Missed Appointments and Patient Recall*
- E. HPSJ P&P QA 22 - *Initial Health Assessments*
- F. HPSJ P&P SOS 002 - *Pediatric Preventive Health*
- G. HPSJ P&P SOS 003 - *Adult Preventive Health*
- H. HPSJ P&P QA 28 - *Mid-Level Practitioners*
- I. HPSJ P&P UM01 – Authorization Referral Process
- J. HPSJ P&P C&L 03 – Access to Interpreter Services
- K. HPSJ P&P MM01 – 24/7 Nurse Advice Line

Created by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date
2/1/96	S.Steely 8/23/04	Ssteely 7/6/05	S. Steely 9/15/05	M.Jordan RN 4/2006	N. Raymond 1/31/07
	LOrtega 6/08	Reviewed by J. Scott 9/08	DTrinchera 10/10	N.Raymond 4/11	

***DHCS Contract Deliverables/SPD***

<b><i>Contract Reference</i></b>	<b><i>Date of Approval</i></b>	<b><i>DHCS Unit</i></b>
6.I	5/6/11	LI
9.B	8/17/11	LI