

HEALTH PLAN OF SAN JOAQUIN			
Subject: Primary Care Availability Standards			
Department: Medical Management - Quality			Policy #: QA 04
Applies to: MCL, HF, Commercial			Scope: QI, PS
Effective Date: 2/96	Revised Date: 1/07, 06/08	Approved by: <i>Signature on File</i> Medical Director	

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. 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.
- D. HPSJ has established acceptable accessibility standards in accordance with Title 28, section 1300.67.2.1 specified below.
- E. Appointment Availability
 - 1. First Prenatal Appointment
 - a) Appointments for the first prenatal visit for a pregnant member should be available within two (2) weeks of request.
 - 2. Newborn Visits After Discharge From the Hospital
 - a) Infants discharged in less than 48 hours of life after delivery should be seen within 48 hours of discharge.
 - b) Infants discharged in greater than 48 hours of life after delivery should be seen within one month of life.
 - 3. Routine Primary Care Appointments
 - a) Appointment for initial evaluation of non-emergent complaints should be available within 14 days of the request for an

appointment. These visits 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.

4. Preventive Health Appointments
 - a) Appointments for periodic health screening services should be available within 14 days of request for ages 0-24 months and available within six (6) weeks of request for all other age groups.
5. Urgent Care Appointments
 - a) Appointments for evaluation of urgent problems should be available to members within 24 hours of request for an appointment. 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.
6. Emergency Care
 - a) Emergency treatment must be available immediately to all members 24 hours a day.
7. Routine Specialty Referral Appointments
 - a) Routine specialty referral appointments should be available within thirty days of the request.
8. 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) 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.
9. 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.

10. 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 HPSJ Advice Nurse or to the nearest emergency department.
11. 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.
12. Monitoring PCP Accessibility Through Member Complaints
 - a) Access complaints are logged into Health Trio and are tracked for reporting purposes and annual access studies.
 - b) The Customer Service or Provider Services Departments shall assist members with complaints about not being able to access their PCP for an urgent appointment.
13. Corrective Actions

- a) 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.
 - b) The Provider Services Department shall address persistent complaints regarding accessing a specific provider, by requesting a corrective action plan.
 - c) Any provider with three (3) or more access complaints during the past year will be included in the annual access survey.
14. Monitoring of Provider Wait Times
- a) 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
15. 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.
- a) The QI Department is responsible for implementing and monitoring corrective action plans.
 - b) Accessibility to PCP services is continually monitored through member complaints, member satisfaction surveys and annual access studies.

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*

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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			