TABLE OF CONTENTS

SECTION 7: PROVIDER–MEMBER RELATIONSHIP

MEMBER RIGHTS AND RESPONSIBILITIES

Health Plan Members have specific rights and responsibilities outlined under Title 22, California Code of Regulations Section 72527 and in the *Medi-Cal Combined Evidence of Coverage and Disclosure Form* for the appropriate year. This information can be found via the following link Health Plan Evidence of Coverage Section 7 and can also be found on Health Plan's website, www.hpsj.com/rights-responsibilities/.

In addition, Health Plan recognizes the specific needs of Members and strives to maintain a mutually respectful relationship. Under the plan's rights and responsibilities statement, for Providers and practice staff, this means Members must:

- Be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of their Protected Health Information (PHI) and Private Information (PI)
- Be provided with information about the plan, its practitioners and Providers, all services available to members, and member rights and responsibilities.
- Be able to choose a primary care doctor within Health Plan's network unless the PCP is unavailable or is not accepting new patients
- Participate in decision making with Providers regarding their own health care, including the right to refuse treatment
- Be able to have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Be able to submit grievances, either verbally or in writing, about the organization, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination
- Be able to request an Appeal of an Adverse Benefit Determination within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and how to continue benefits during the appeal process through the State Fair Hearing, when applicable
- Be able to request a State Fair Hearing, including information on the circumstances under which an expedited State Fair Hearing is available
- Receive no-cost interpretation services and written translation of critical informing materials in their preferred threshold language, including oral interpretation and American Sign Language (ASL)
- Be able to have a valid Advance Directive in place, and an explanation of what an Advance Directive is
- Be able to disenroll from Health Plan and change to another health plan in the county upon request
- Be able to access minor consent services
- Get no-cost written member informing materials in other formats (such as braille, large-size print no smaller than 20-point font, audio, and accessible electronic formats) upon

request and 45 CFR sections 84.52(d), 92.202, and 438.10.

- Be free from any form or restraint or seclusion used as means of coercion, discipline, convenience or retaliation.
- Have access to and get copies of their medical records, and request that they be amended or corrected, as specified in 45 code of federal regulations §164.524 and 164.526.

  Make recommendations regarding these member rights and responsibilities.
- Have freedom to exercise these Member rights without retaliation or any adverse conduct by Health Plan, their Providers or the State.
- Have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, and sexually transmitted infection services from Provider of their choice without referral or Prior Authorization, inside or outside of the network. Also, to have Emergency Services provided in or outside Health Plan's network pursuant to the federal law.
- Have a responsibility to supply information, to the extent possible, that the organization and its practitioners and Providers need in order to provide care.
- Have a responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- Have a responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

ADVANCE DIRECTIVES

Health Plan recognizes the Members' rights to formulate Advance Directives, including the right to be informed of State law in respect to Advance Directives and receive information regarding any changes to that law.

Health Plan notifies Members of their right to formulate an Advance Directive at the time of initial enrollment and annually thereafter through the Combined Evidence of Coverage and Disclosure Form. PCPs and Specialists providing care should assist adult Members over eighteen (18) years of age and older in receiving additional information and understanding their right to execute Advance Directives. Below are key actions that should be taken to assist Members.

- At Member's first PCP visit, office staff should ask if they have executed an Advanced Directive and the Member's response should be documented in the medical record.
- If the Member has executed an Advance Directive, a copy should be included as a part of the Member's medical record.
- Providers should discuss the potential medical situations with the Member and any designees named in the Advanced Directive. This discussion should be documented in the medical record.
- If possible, a copy of the Advance Directive should be placed in the Member's chart.

ROLE OF PRIMARY CARE PROVIDERS (PCPs)

The PCP is the central relationship that all Health Plan Members are encouraged to develop to ensure personal attention, quality care, and efficient services. When Health Plan assigns a Member to a selected PCP, it is with the expectation that the PCP will provide most of the Covered Services. It is the PCP's responsibility to coordinate the services of specialists and ancillary Providers or coordinate with Health Plan if out-of-network services are required.

Participating PCPs are contracted to either perform a number of key activities, or to coordinate them. These include, but are not limited to, the following activities:

- Provide appropriate medical care within their scope of practice for Members, including preventive care, acute care, and care for chronic conditions
- Coordinate necessary health assessments as required by Health Plan or other regulatory agencies
- Provide referrals to other Providers for Covered Services outside of the PCP scope of practice and follow Health Plan guidelines for out-of-network services
- Maintain continuity of Member's care through coordination and follow up with other Providers as well as Health Plan when appropriate
- Ensure that care is provided in a safe, culturally responsive, and timely manner
- Provide Members with educational information on maintaining healthy lifestyles and preventing serious illness
- Provide screenings, health assessments, and other activities in accordance with Health Plan policies, DHCS requirements, and other public health initiatives
- Conduct behavioral health screenings based upon a Provider assessment to determine whether a Member requires behavioral health or substance abuse services and refer for services, if needed (for more information, please see Section 15 on Behavioral Health)
- Meet and maintain the access standards as outlined in this section under "Timely Access to Care"
- Cooperate with Health Plan's Case Management and Quality programs
- Maintain complete and accurate medical records for Members in a confidential manner,

including documentation of all services and referrals provided to Members by the PCP, Specialists, and any ancillary Providers.

- May establish new patient relationships via synchronous video Telehealth visits.
- May establish new patient relationships via audio-only synchronous interaction only when one or more of the following criteria applies:

    a. The visit is related to sensitive services in accordance with California Civil Code Section 56.06(n).
    b. The Member requests an audio-only modality.
    c. The Member attests they do not have access to video.

- FQHCs, including Tribal FQHCs, and RHCs may establish new patient relationships through an asynchronous store and forward modality, as defined in BPC section 2290.5(a), if the visit meets all the following conditions:

    a. The Member is physically present at a Provider's site, or at an intermittent site of the Provider, at the time the Covered Service is performed.
    b. The individual who creates the patient's Medical Records at the originating site is an employee or Subcontractor of the Provider, or other person lawfully authorized by the Provider to create a patient Medical Record.
    c. The Provider determines that the billing Provider can meet the applicable standard of care.
    d. A Member who receives Covered Services via Telehealth must otherwise be eligible to receive in-person services from that Provider.

ROLE OF NON-PHYSICIAN MEDICAL PRACTITIONERS (NPMPs)

Non-Physician Medical Practitioners (NPMPs) provide a wide variety of medical care depending upon their licensure, certification, and experience. This category includes physician assistants (PAs), nurse practitioners (NPs), and certified nurse midwives (CNMs). To provide Covered Services to Members, these Providers must be credentialed by Health Plan.

Consistent with Health Plan and Medi-Cal guidelines, NPMPs must perform services under the general supervision of a Provider. The supervising Providers must be available to the NPMP either in person or through electronic means to provide:

- Supervision as required by State professional licensing laws
- Necessary instruction in patient management
- Consultation
- Referral to Specialists or other licensed professionals

Supervision Limits of NPMPs

In accordance with Medi-Cal regulations, an individual physician may not supervise more than four (4) PAs (full-time equivalents). While there is no limit on the number of NPs or CNMs that a single physician may supervise, if the NPs or CNMs order drugs or devices, a single physician cannot supervise more than four (4). Supervising Providers are required to develop and document a system of collaboration and supervision with each NPMP they supervise. This document must be kept on file at the Provider's office and available for review by either Health Plan or DHCS.

Member Awareness of Care from NPMPs

Providers who employ or use the services of NPMPs must ensure that Members are clearly informed that their services may be provided by NPMPs.

ROLE OF SPECIALISTS

While the PCP provides the central relationship with the Member, the role of the specialist is also important to ensure appropriate care is provided for any given medical need. For this reason, it is important that Health Plan specialists communicate frequently with PCPs in coordinating care and maintain adequate documentation of care provided.

Specifically, specialists should:

- Provide all appropriate services within their scope of practice
- Follow Health Plan referral and authorization guidelines in coordinating services with other Providers
- Provide the PCP with consult reports and other appropriate records
- Be available for, or provide, on-call coverage through another source twenty-four (24) hours a day for the management of Member care
- Maintain the confidentiality of medical information
- Cooperate with Health Plan's Case Management and Quality Programs
- Meet and maintain the Access Standards as outlined in this Section 7 under "Timely Access to Care"
- Maintain complete and accurate medical records for Members in a confidential manner, including documentation of all services and referrals provided to the Member

SUPPORTING MEMBERS IN SELF CARE

Providing quality health care to Health Plan Members includes supporting Members not only in remaining compliant with their medication and treatment protocols, but also supporting them in making important changes in their health behaviors. This includes providing information and education to prevent disease and illness.

SECTION 7: PROVIDER–MEMBER RELATIONSHIP

PCPs are expected to engage frequently with Members to encourage preventive strategies such as improving diets, exercising, taking medications appropriately, and actively managing complex health conditions. Providers should ensure that clinicians and staff communicate with Members about health choices and preventative actions.

Health Education Services

Health education services are covered services and are available to Members at no cost. These services are designed to assist and support Providers in promoting self-management and healthy behaviors for Members. The Health Education Department is part of Health Plan's Medical Management Department. The Health Education Department is dedicated to the promotion and empowerment of healthy lifestyles. The goal is to help Members be engaged and informed so they can be active participants in their care and in the care of their children. Many of the services provided below are provided in English, Spanish and Chinese (the threshold languages for Health Plan).

Health Plan's Health Education Department –

1. Ensures that the health education services are provided directly by Health Plan or through subcontracts or formal agreements with other Providers specializing in health education services.
2. Conducts targeted outreach to promote optimal program use and participation by Members, and ensures these programs are available and accessible upon self-referral or referral by contracted medical Providers. All programs are available to Members at no charge.
3. Distributes appropriate health education notices and information through, but not limited to:
    a. Member handbook
    b. FOCUS YOUR HEALTH, the Member newsletter (quarterly)
    c. Special mailings
    d. Provider offices
    e. Community outreach activities
4. Provides Members' access to an Audio Library, available through the Advice Nurse/Physician Line
5. Health Plan's multidisciplinary health education program includes intervention such as:
    a. Self-care techniques and/or self-care publications
    b. Public service announcements (PSAs) to reinforce healthy behaviors
    c. Billboards (outdoor advertising) identifying health risks/healthy behaviors, etc.
    d. Health/patient education materials (development and distribution)
    e. Advice Nurse information and audio library promotions
    f. Participation in community organizations promoting healthy behaviors
    g. Community health education program development and referral

h. Outreach to target populations, utilizing community-based organizations, the faith communities, neighborhood groups, etc.
i. Trainings/seminars for Provider staff to support their work with Health Plan patients
j. Authorization for nutrition consultation based on medical necessity

6. Health Plan provides health education through health promotion activities including, but not limited to:

a. Participating in community coalitions and meetings to understand the needs of our members in organic settings.
b. Finding, planning, facilitating, and/or participating in community events (e.g., health fairs, annual Black Family Day, Health Plan Walks for Health, etc.)

Health Education Materials

Health Plan has health education materials available at no cost to Providers and Members. These materials are provided at no cost to Providers and Members.

Topics include, but are not limited to:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Parenting
- Colds & flu
- Chronic disease or health conditions
- Prenatal care and unintended pregnancy
- Prevention of sexually transmitted diseases
- Alcohol and drug use
- Comprehensive tobacco cessation
- Nutrition
- Physical activity
- Congestive heart failure
- Pregnancy

New materials are developed as needed. We welcome suggestions for additional health education materials; please contact the Provider Services Department at (209) 942-6340.

Other Educational Resources

Health education services are also provided to Members through:

- **HealthReach** – 24-Hour Advice Nurse/Physician Line – In addition to Advice Nurse services, HealthReach has an audio library with over 1500 health topics recorded in English and Spanish; if necessary, the Advice Nurse can connect Health Plan Member with a

physician

- **Your Health Matters**, a quarterly newsletter that is mailed to Health Plan Members which includes health education and local resources
- **Community Events & Health Fairs** – Health Plan participates in health fairs and community events to promote personal health awareness and preventive health care to Members and the community

SOCIAL SERVICES SUPPORT FOR MEMBERS

Health Plan Social Work Services team conducts Member needs assessments to help Members obtain necessary services that could positively impact their overall health care efforts. Based on findings from the assessment, this team will help coordinate necessary services. These services could include, but are not limited to:

- Payee Information
- Food Resources (i.e., food banks)
- Mental Health Resources
- Support Group Information
- Transportation (i.e., Dial-A-Ride)
- Housing/Shelter Resources
- In-Home Support Services (IHSS)
- Substance Abuse Resources
- Maternal Child/Adolescent Health resources and education

For questions or information about care management, disease management, social services, or community resources, please call (209) 942-6320 or (888) 936-7526.

PARTICIPATION IN COMMUNITY INITIATIVES

Health Plan participates in a variety of workgroups and coalitions that convene to identify and develop health education interventions on important health issues.

PROVIDER PANEL CAPACITY

All Health Plan Providers are considered open to serve new and established Members unless there is written notice on file of any panel capacity limitations. Since the goal is to maintain maximum access for Members, capacity limitations and/or restrictions are discouraged unless necessary.

Health Plan is responsible for monitoring PCP availability and capacity on an annual basis as required by DHCS and State regulations. Availability ratio standards for PCPs and Non-Physician Medical Practitioners (Ns) are defined below:

- PCPs 1:2,000 Members
- NPMP’ss 1:1,000 Members

PCPs have an enrollment limit of 2,000 Members. Health Plan’s policies are in accordance with

these standards. All Participating PCPs are encouraged to accept a minimum potential enrollment of 200 Members.

If there is a change in panel capacity, Providers must provide written notice to the Provider Services Department via fax (209) 461-2565, or by mail to 7751 S. Manthey Road, French Camp, CA 95231-9802.

OPEN AND CLOSED PANEL STATUS

PCPs are expected to maintain an "open" status for Health Plan Members consistent with their availability to patients of other health care plans and programs. PCPs must notify Health Plan within five (5) business days of closing their practice(s) to new Members. This five (5) business day notice also applies to reopening a practice that has been previously closed.

If a Provider is contacted by a Member or potential Member and the Provider is officially "closed" to new Members, it is important that Members or potential Members be directed to contact Health Plan so that they can be assisted in obtaining another Provider, and if necessary, correct any errors in the Provider Directory.

TIMELY ACCESS TO CARE

Under California law, Health Plan is obligated to provide or arrange for timely access to care. Contracted Providers must follow the limits on how long members wait to get health care appointments.

Contracted Providers or members can contact Health Plan to obtain assistance if they are unable to obtain a timely referral to appropriate Providers by calling the Customer Service Department at (209) 942-6320 or (888) 936-PLAN (7526).

You may also call the DMHC Help Center at (888) 466-2219 TDD (877) 688-9891 or at www.HealthHelp.ca.gov for assistance.

If Health Plan is not able to help with a timely referral, you or the member may file a complaint. *See additional information at www.hpsj.com/grievances-appeals.*

PCPs should be located within ten (10) miles or thirty (30) minutes from the Member's residence, when applicable.

PROVIDER TYPE	TIME or DISTANCE
Primary Care (Adult and Pediatric)	10 Miles or 30 Minutes
Obstetrics/Gynecology (OB/GYN) (acting as a PCP)	10 Miles or 30 Minutes

Specialists and other Providers should be within the applicable miles or minutes below from the

Member's residence.

Specialty Care (Adult and Pediatric)	30 Miles or 60 Minutes
OB/GYN Specialty Care	30 Miles or 60 Minutes
Hospitals	15 Miles or 30 Minutes
Mental Health (Non-Psychiatry) *Outpatient Services* (Adult and Pediatric)	30 Miles or 60 Minutes
Substance Use Disorder *Outpatient Services*	30 Miles or 60 Minutes
Substance Use Disorder *Opioid Treatment Programs*	30 Miles or 60 Minutes

The proximity standard must be met whether using private or public transportation. Health Plan may approve exceptions to this standard in certain circumstances including, but are not limited to, PCPs located in areas that are underserved or where no medical delivery/transportation system exists.

Timely Access Standards

Health Plan
Telephone Wait Times

ACCESS MEASURE	TIME-ELAPSED STANDARD
Average Speed of Telephone Answer: The maximum length of time for Customer Service Department staff to answer the telephone	≤ 30 seconds
Call Abandonment Rate	≤ 4.99%
Behavioral Health (BH) Telephone Responsiveness: Health Plan does not have a separate BH telephone line.	≤ 30 seconds
Behavioral Health (BH)Telephone Responsiveness: Calls to the BH telephone line go directly to Health Plan contracted BH vendor	≤ 5%

After Hours Calls	**Telephone triage shall be available 24 hours a day, seven days a week. Telephone triage or screening wait time shall not exceed 30 minutes.** **Automated systems:** o Must provide emergency instructions o Offer a reasonable process to contact the PCP, covering physician or other "live" party o If process does not enable the caller to contact the PCP or covering practitioner directly, the "live" party must have access to a practitioner for both urgent and non-urgent calls. **Professional exchange staff:** Must have access to practitioner for both urgent

Health Plan is committed to providing Timely Access to health care for Members. Below are the standards for appointments and wait times for:

- **Call Service Standards**
- **Preventative Care Appointment Standards**
- **Routine Primary Care Appointment Standards (Non-Urgent)**
- **Urgent Care Services Appointment Standards**
- **Specialty Care Practitioner Appointment Standards**

PRIMARY CARE PROVIDER (PCP) and SPECIALIST Telephone Wait Times	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
Telephone answer time during business hours	Not to exceed 10 minutes
Call return time for urgent message or triage time during business hours	30 minutes
Call return for non-emergency and non-urgent messages during business hours	Within 24 hours and no later than the next business day

PRIMARY CARE PROVIDER (PCP) and BEHAVIORAL HEALTH PROVIDER After Hours Access	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
Telephone access after hours	• The phone message or live person must instruct members to dial 911 or go to the nearest emergency room. • The phone message must provide instructions on how to get care. • Triage or return call must be within 30 minutes of the call.

PRIMARY CARE PROVIDER (PCP) Preventive Care Appointment Standards	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
First Prenatal Visit	▪ Within 14 calendar days of request
Newborn Visits after discharge from the Hospital	▪ Within 48 hours for infants discharged in less than 48 hours of life after delivery ▪ Within 30 days from the date of birth if the infant was discharged more than 48 hours of life after delivery
Child physical exam and wellness checks with PCP	Within 14 calendar days of request or in alignment with American Academy of Pediatrics Bright Futures Guidelines.
Initial Health Assessment (Member's aged 18 months and older)	Completed within 120 calendar days of Enrollment
PRIMARY CARE PROVIDER (PCP) **Routine (Non-Urgent) Services**	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
In-Office wait time for scheduled appointment	Not to exceed 45 minutes
Non-urgent appointments (PCP Regular and Routine) Excludes physicals and wellness checks	Within 10 business days of request.*
Non-urgent appointments for ancillary services (diagnosis or treatment of injury, illness, or other health condition)	Within 15 business days of request.*
PRIMARY CARE PROVIDER (PCP) **Urgent Care Services**	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
Urgent Access to PCP or designee	24 hours a day, 7 days a week appointment availability during business hours from 8–5 pm and after hours on call access.
Urgent Care Services (Includes appointment with any physician, Nurse Practitioner, Physician Assistant)	Within 48 hours of request*

SPECIALTY CARE PROVIDERS Urgent and Non-Urgent Appointment Standards	
ACCESS MEASURE	**TIME-ELAPSED STANDARD**
In-Office wait time for scheduled appointment	Not to exceed 60 minutes
Non-urgent Appointments	Within 15 business days of request*
Urgent Care Services (Includes appointment with any physician, Nurse Practitioner, Physician Assistant)	Within 48 hours of request*
Urgent Care Services (Specialist and other) that require prior Authorization	Within 96 hours of request*

BEHAVIORAL HEALTH PROVIDERS Urgent and Non-Urgent Appointment Standards	
APPOINTMENT TYPE	**TIME-ELAPSED STANDARD**
Non-Urgent Care Services with a -NON-Physician Mental Health Provider	Within 10 business days of the request*
Urgent Care Services	Within 48-hours*
Follow-up appointment with non-physician mental health care substance use disorder Provider for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition	10 business days from the prior appointment *
Access to care for non-life-threatening Emergency Services	Within 6 hours
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, and • One follow-up encounter with a mental health Provider within 30 calendar days after discharge
*Substance Use Disorder - Outpatient services	Within 10 business days

*Substance Use Disorder- Opioid Treatment Program *Substance Use Disorder services are the responsibility of the County Mental Health Program	Within 3 business days
LONG-TERM CARE SERVICES AND SUPPORTS (LTSS) Access Standard	
Skilled Nursing Facility and Intermediate Care Facility	Within 7 business days of the request
PREVENTATIVE CARE Non-Urgent/Routine Appointment Standards**	
Preventive Health Services	Within 30 business days of the request

ANCILLARY PROVIDERS Standards	
ACCESSMEASURE	**TIME-ELAPSED STANDARD**
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business day of the request

* The waiting time may be extended if the referring or treating Provider, or the clinician providing triage or screening, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the member's medical record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

** Preventive care services and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treatment Provider acting within the scope of their practice.

PROVIDER REQUEST FOR MEMBER REASSIGNMENT OR DISMISSAL

Providers can file a grievance regarding a Health Plan Member and request member reassignment or dismissal. PCPs must submit a grievance or request for member reassignment in writing and must include the reason(s). The Provider Services Department will forward all requests for PCP reassignment to Customer Service.

Health Plan Providers have the right to request a member reassignment or dismissal. To assist you with this process, here are some best practices to ensure your request in process promptly.

1. A 30-day or more prior notice of dismissal/reassignment letter must be mailed to the member via United States Postal Service mail. The letter must include the following:
    a. Date
    b. Dismissal/Reassignment effective date
    c. Member Name
    d. Health Plan ID Number
    e. Reason for dismissal/reassignment such as:
        i. Disruptive behavior
        ii. Our office will no longer be able to provide you with patient care services due to break down in doctor-patient relationship
        iii. Non-compliance with our office policy regarding multiple missed appointments
2. Please ensure the letter is addressed to the member. If you are dismissing a minor, address letter to parent/legal guardian
3. A copy of the dismissal letter sent addressed to member must be faxed/scanned to Health Plan of San Joaquin
4. A dismissal letter must be received for each member
5. Please remember that you are still required to see the member for up to 30 days or up to the effective date of dismissal, whichever is more, after requesting reassignment or dismissal.

INTERPRETER SERVICES

Health Plan offers qualified interpreter services 24/7 to assist Providers and staff in communicating with Members. These services can be provided in person, over-the-phone, or via video remote interpreting. During regular business hours, bilingual Customer Service Representatives are available by phone, in person, or through a TTY/TDD line for the deaf and hard-of-hearing.

IN-PERSON INTERPRETER SERVICES

To schedule an in-person interpreter for medical appointments, contact the Customer Service Department at (888) 936-PLAN (7526), TTY/TDD 711. This service must be scheduled five (5) business days prior to the scheduled appointment for spoken languages, and ten (10) business days prior for sign language or captioning services.

REMOTE INTERPRETER SERVICES

For interactions where an in-person interpreter is unavailable or the in-person component not required, **Remote Interpreting Services** are available at no cost through phone over-the phone interpretation OPI) and video remote interpreting (VRI) modalities. Health Plan's Cultural and Linguistic Services department assists Providers with establishing these services in their clinics or units as needed. For Providers who do not currently have a dedicated remote interpreting service established, either by themselves or through Health Plan, over-the-phone interpreters may be accessed by calling (877) 959-6462. For interpreter services after 5 p.m. and on weekends, Providers should contact Health Plan's 24/7 Nurse **Advice Line** by calling (800) 655-8294. The call will be handled in a three-way conversation through the over-the-phone service. Video interpreting devices may also be available in your clinic or unit for 24/7, on-demand, spoken and sign language interpreting services. If you are interested in acquiring these services, Provider Relations can connect you with the Cultural and Linguistic Services department at Health Plan for consultation.

ALTERNATIVE FORMAT SELECTION

Alternative format selection (AFS) is a way of communicating with members who are visually impaired. Health Plan provides alternative formats such as Braille, audio CD, large print, and electronic format for easy reading. Health Plan members have the right to request member informing materials in an alternative format at no cost.

If a member selects an electronic format, such as an audio or data CD, the information will be provided encrypted (i.e. password protected). However, the member can request to receive the information unencrypted (not password protected). Unencrypted materials may make the information more vulnerable to loss or misuse. If the member chooses unencrypted materials, they will have to fill out an informed consent before Health Plan can mail the materials.

Providers can call Health Plan's Customer Service Department at 888.936.7526 with Alternative Format Requests or requests for auxiliary aids.

REQUIREMENTS FOR PROVIDERS

Health Plan Contracted Providers are required to determine the needs of their patients and enter AFS at the time of the member's request. AFS requirements can be reported online at https://afs.dhcs.ca.gov/, or by calling the AFS Helpline at 1-833-284-0040.

Health Plan also maintains AFS preferences reported by members and/or received from DHCS. Health Plan will use this data to provide the alternative format requested by the member. Additionally, Health Plan will share AFS data with subcontractors and network Providers as appropriate.

HEALTHREACH 24-HOUR NURSE/PHYSICIAN ADVICE LINE

Health Plan provides a 24/7 advice nurse and physician consult service through **HealthReach**. This service is available to all Members at no cost. Members may call and speak to a registered

nurse or access the audio health library for recorded messages on hundreds of health topics. If the advice nurse concludes a physician contact is needed, she will connect the Member. Contact **HealthReach** at (800) 655-8294.

TRANSPORTATION SERVICES

Health Plan can arrange medical transportation for members who qualify. Non-medical transportation (NMT) is available upon request to members for medically necessary visits.

Call Health Plan's Customer Service Department at 888-936-7526 to determine eligibility and schedule service.

TRIAGE OR SCREEN MEMBERS TO ASSESS URGENCY OF NEED FOR CARE

Appropriately licensed personnel for triaging the health concerns of a Health Plan member includes:

1. **Licensed physician,**
2. **Registered nurse (RN),**
3. **Certified nurse midwife (CNM),**
4. **Nurse practitioner (NP),**
5. **Physician assistant (PA)**, and
6. **Other licensed personnel acting within their scope of practice to screen patients.**

UNLICENSED PERSONNEL ARE NOT ELIGIBLE TO TRIAGE OR SCREEN MEDI-CAL PATIENTS

Unlicensed personnel who process patient phone calls or unscheduled office visits may ask questions on behalf of appropriately licensed health care personnel for the purpose of determining a patient's condition. However, unlicensed personnel shall not use a patient's responses to assess, evaluate, or determine the urgency of the patient's need for care.

Please refer to Provider Alert: Provider Education: Only Licensed Personnel May Triage Medi-Cal Patients (hpsj.com) for examples.