
	POLICIES AND PROCEDURES
Policy #: HS 3.44	Lead Department: Health Services
Title: Accessibility	
Original Date: February 1996	Last Revision Date: June 2009
Approved by: Barbara Flynn, RN	
Applies to: All Lines of Business	

Policy Objective: Timely enrollee access to health care, delivered in an appropriate, cost effective setting, will be ensured through a monitoring process using acceptable performance standards.

I. Access Indicators

A. Appointment availability

1. **Routine Appointments:** Primary non-emergent appointments should be available within two (2) weeks of request for an appointment. These appointments will be made directly with staff at the primary care site. These visits are described as care appropriate at a primary care level for evaluation and treatment of non-acute problems for new or established patients. Follow-up care for established patients will be accommodated as medically appropriate.
2. **Physical Examinations:** Appointments for routine physical examinations should be available within six (6) weeks of request. These appointments will be made directly with staff at the primary care site. If possible, special consideration should be given to members who require a physical examination as part of their employment.
3. **Urgent Care:** Medically indicated urgent appointments should be available to enrollees the same day or within 24 hours of call for an appointment. The request for services will be evaluated and the urgency assessed to determine the nature of the medical problem and the need for urgent treatment. Contingent on the nature of the medical problem, the enrollee should be triaged to the most appropriate care site.
4. **Emergency Care:** Medically necessary emergency treatment will be provided immediately to all health plan members. Emergency care is available 24 hours, 7 days per week. A PCP or designee shall be available twenty-four (24) hours a day, seven (7) days a week to respond to a hospital emergency room Practitioner regarding members who have been assessed to have emergent or non-emergent conditions. Notice informing Emergency Departments of the 24-hour availability of a PCP with instructions on how to contact the PCP are sent to Emergency Departments on a periodic basis.
5. **First Prenatal Visit:** The first prenatal visit must be scheduled within two weeks of member's request.

	POLICIES AND PROCEDURES
Policy #: HS 3.44	Lead Department: Health Services
Title: Accessibility	
Original Date: February 1996	Last Revision Date: June 2009
Approved by: Barbara Flynn, RN	
Applies to: All Lines of Business	

6. Specialty Care: Specialty care will be provided within the plan service area whenever possible. If a medically necessary specialty service is unavailable within the service area, plan staff will coordinate specialty care outside of the service area and/or network.
7. Routine Specialty Care: As with Specialty Care, care will be provided within the service area whenever possible. If the service is not available within the service area, plan staff will coordinate care outside of the service area or network. Time frames for accessing such care may vary dependent upon condition and diagnosis, but routine specialty care should be available within six weeks of the request.

B. Waiting Time To See A Provider


Enrollee waiting time in the office to see an Alliance provider for scheduled appointments should not routinely exceed 45 minutes. PCPs and other providers of office-based services will be requested to monitor waiting times and to adhere to this standard.

C. Telephone Wait Times to Schedule Appointments

Enrollee waiting time on the telephone to schedule appointments at primary care sites should average no longer than 3-5 minutes, whenever possible.

D. Telephone Wait Times to Speak to Providers and Provider Response Time

The waiting time on the telephone to speak to a provider or his/her clinical designee may vary depending on the nature of the call. This assumes a normal range of inquiries that range from simple non-medical questions and prescription refills to guidance on urgent medical conditions. The office staff should triage each call and evaluate the necessity of interrupting providers already busy with scheduled patients or otherwise occupied. Requests for routine appointments may be handled by non-clerical office staff. Should a member identify a current medical problem or crises, the call will be directed to a member of the clinical office staff. Whenever possible, the office staff should respond to the enrollees inquiry immediately and directly. This allows patients who are currently being seen in the office to receive care in an undisrupted manner. Response

	POLICIES AND PROCEDURES
Policy #: HS 3.44	Lead Department: Health Services
Title: Accessibility	
Original Date: February 1996	Last Revision Date: June 2009
Approved by: Barbara Flynn, RN	
Applies to: All Lines of Business	


time to return calls may also vary due to momentary demands on the provider. The return of phone calls should be prioritized, with urgent medical questions or problems addressed as soon as possible. Routine or administrative questions should be answered within eight hours or, in the case of a call received after hours, the next business day. Again, urgent medical situations should be attended to in an appropriate time frame and be consistent with standards of care in the community.

II. *Appointment Scheduling*


- A. Primary Care Sites are contractually obligated to provide the Plan with their office hours, staffing and any on-call or coverage arrangements. Office hours and an emergency 24-hour number will also be clearly displayed in the provider’s office. Each primary care site will be responsible for implementing an appointment scheduling system. This system should be designed to give highest priority to accessibility to care. While each site has its own unique characteristics, which will affect the type of appointment scheduling system that is utilized, the following guidelines shall be considered as minimum standards when designing an appointment system.
1. There should be an adequate telephone system to handle the enrollee volume. Ideally, at least two lines should be available for each provider with a roll over mechanism to shift incoming calls to a non-busy line.

 2. Appointment scheduling may be handwritten or electronically stored. In either case, appointment intervals should be scheduled based upon the type of service to be given, i.e., 15- minute block for routine or follow-up appointment, 30 minutes for a pelvic exam, and 45-60 minutes for a complete physical examination. Appointments should be available for scheduling patients who need to be seen at fixed intervals, such as those on anticoagulant therapy or for visits with the same physician at fixed intervals. Appointments should also be coordinated for patients visits among different physicians on the same day. Some flexibility should be built into the system to allow for urgent walk-in appointments.

Reminder notices should be sent to the member for regularly scheduled routine appointments, failed scheduled appointments and for procedures needing completion prior to the next scheduled visit.

	POLICIES AND PROCEDURES
Policy #: HS 3.44	Lead Department: Health Services
Title: Accessibility	
Original Date: February 1996	Last Revision Date: June 2009
Approved by: Barbara Flynn, RN	
Applies to: All Lines of Business	

3. At each site, the physician(s) will be responsible for ensuring back-up coverage during the physician's absence or during emergency calls to the hospital, ER, etc. on a 24 hour basis.
4. When there is a need to cancel or reschedule patient appointments due to unforeseen circumstances, consideration should be given to the severity of illness and enrollee needs. If possible, patients should be "worked in" to an associate physicians schedule, or given the opportunity to wait until their physician returns from the emergency call. Routine appointments should be re-scheduled for the next available appointment slot.
5. Any special needs of Alliance members should be considered when scheduling appointments, i.e., scheduling a wheelchair-bound patient 15 minutes before normal office hours begin to allow staff to be free to assist the patient, or scheduling a patient needing language translation at a time when office staff are available to assist with this need.
6. Each primary care site should develop a mechanism for patient notification, both for preventive care appointments (immunizations, mammograms, etc.) and for patient recall in the case of a failed scheduled appointment for a condition which requires treatment, abnormal diagnostic test results, or for scheduling of procedures which must be scheduled prior to the next visit (i.e., GI series before return appointment).
7. Each patient chart should include member information needed to facilitate both appointment scheduling and patient recall. This information should include:
 - a) Member first and last names with correct spelling
 - b) Patient address
 - c) Medi-Cal number
 - e) Alternate name, nickname or alias
 - f) Telephone number
 - g) Emergency contact person
 - h) Special language and/or access needs, if any

 <p>LA AVANZA • THE ALLIANCE CENTRAL CALIFORNIA ALLIANCE FOR HEALTH</p>	POLICIES AND PROCEDURES
Policy #: HS 3.44	Lead Department: Health Services
Title: Accessibility	
Original Date: February 1996	Last Revision Date: June 2009
Approved by: Barbara Flynn, RN	
Applies to: All Lines of Business	

At each office visit, the patient will be asked if any of the above information has changed since the last visit, and the change documented in the record accordingly.

8. The accessibility to care at the site should be monitored by the staff. This includes tracking of wait times to obtain appointments, telephone waiting times, and waiting time to be seen by the physician after check-in with the receptionist. Patient comments and/or complaints about accessibility should be recognized as a valuable tool for determining patient perception of the accessibility of care.

References: CCR Title 28 Section 1300.67.2
Medi-Cal Contract Exhibit A, Attachment 9
Access and Availability

Review Date	Revised Date	Approved By
October 2008	October 2008	Barbara Flynn, RN
June 2009	June 2009	Barbara Flynn, RN