

**KERN HEALTH SYSTEMS
POLICIES AND PROCEDURES**

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RESPONSIBLE DEPARTMENT HEAD:
Provider Relations Manager

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 Provider Relations Manager

POLICY¹:

Kern Health Systems (KHS) will monitor accessibility of all network practitioners/providers and will introduce reasonable corrective measures when necessary.

All contracted practitioners/providers will be made aware of and accountable for Accessibility Standards. This policy and procedure will be included in the *KHS Provider Manual*. All Provider

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contracts shall contain provisions pertaining to members' access to medical care standards, the monitoring of those standards, and the Plan's right to take corrective action.

Accessibility standards will be established in accordance with the following regulatory and contractual requirements:

- California Code of Regulations Title 28 §1300.67.2.1
- 2004 DHS Contract Exhibit A-Attachment 6(9); Exhibit A-Attachment 9(3); Exhibit A-Attachment 10(4)(B)(3)

PURPOSE:

To establish access standards and methods of evaluating Provider compliance with those standards.

PROCEDURE:

1.0 SCOPE

The program shall apply to all Providers, services, and individuals whose activities with KHS have a direct or indirect influence on member access.

2.0 RESPONSIBILITY

Ultimate responsibility for assuring acceptable member access to all levels of medical care, the establishment of standards by which members will have access to care, and Provider compliance with the Plan's minimum standards lies with KHS. The actual monitoring of standards for access to care and day to day activities in this area has been delegated to the KHS Provider Relations Department. The Provider Relations Manager, with assistance from other KHS departments as needed, shall monitor all areas related to members' access to medical care and shall submit related reports as outlined in *Section 5.0- Reporting*.

3.0 STANDARDS

Contract Providers are held to the following accessibility standards.

3.1 Facility Characteristics

The facility must be clean, well lighted, well maintained, and project professionalism and quality of care.

3.1.1 Waiting Area

The waiting area must be of sufficient size to accommodate patients and wheelchairs and other forms of locomotion. The actual seating shall be comfortable and shall be adequately constructed to comfortably support patients of varying physical stature. The waiting area's proximity to the reception areas should be arranged to allow visual as well as verbal contact. Providers must have a plan or process in place to accommodate patients with a contagious condition as described in *KHS Policy and Procedure #2.20-P: Infection Control Program*.

3.1.2 Parking

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Each facility must have access to adequate parking nearby the facility and be free of barriers. Parking must be provided at no charge to KHS members.

3.1.3 Restrooms

All restrooms must be equipped to accommodate able-bodied as well as disabled patients. The restrooms must be in close proximity to waiting as well as treatment areas.

3.1.4 Treatment Areas

All treatment areas must be well equipped and arranged in a manner that provides for patients' privacy, dignity, comfort, and safety. The treatment areas must be within easy reach of the waiting and reception areas.

3.1.5 Barriers

All patient areas must be free of barriers that would restrict access to either able-bodied or disabled persons. This includes the provision of ramps and elevators, when necessary to access patient care areas, and provisions for drinking water.

3.1.6 Handicapped Accommodations²

Practitioners/providers must comply with the Americans with Disabilities Act (ADA).

Specific questions regarding the ADA should be directed to Region IX - Disability and Business Technical Center at 1-800-949-4232 or www.PACDBTAC.org.

3.2 Staffing

All facilities must be staffed with personnel who possess the ability to assist with or have knowledge of how to obtain assistance for patients who have physical impairments or who have difficulty with the English language.

3.3 Location

All regularly used facilities must be within the KHS service area and connected by roads, streets, and freeways that are easily accessible from all points of the KHS service area. Facilities that provide specialized, seldom used services that are not available within the KHS service area must be located as near as possible to the service area and within the reach of members by public and private transportation.

3.4 Transportation

Facilities must have adequate access to common carriers and other forms of public and private transportation.

3.5 Driving Time/Miles

All regularly used facilities must be geographically located not to exceed the following driving times/miles:

- A. Emergency Care- Nearest appropriate facility

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- B. Primary Care, OB/GYN and Pharmacy
 - (i) Metropolitan areas 30 minutes/10 miles³
 - (ii) Rural areas: 60 minutes/40 miles
- C. Secondary Ambulatory and Specialist Services
 - (i) Metropolitan areas 30 minutes/10 miles
 - (ii) Rural areas: 60 minutes/40 miles

3.6 Appointment Scheduling (Minor's rights apply)

Service	Required Care	
	Urgent ⁴	Routine
Primary Care Services	48 hours	4 weeks ⁵
Specialty Care Services	48 hours	6 weeks
Diagnostic Testing	48 hours	4 weeks
Allied Providers	48 hours	3 weeks

Pediatrics – CHDP Physicals within 2 weeks ⁴

OB/GYN - First pre-natal visit must be available within 2 weeks upon request⁵

3.7 Office Waiting Time - Maximum

Service	Required Care	
	Urgent	Routine
Primary Care Services (including OB/GYN)	1 hour	1 hour
Specialty Care Services	1 hour	1 hour
Diagnostic Testing	1 hour	1 hour
Allied Providers	1 hour	1 hour

Physicians are not held to the office waiting time standards for non-emergent non-scheduled walk in patients.

3.8 Facility Hours

- A. Emergency Care - 24 hours per day, 7 days per week⁶
- B. After Hours Urgent and Emergency Care - Primary care and secondary care Providers must provide or arrange for the provision of after hours access to urgent and emergency conditions by telephone and/or personal contact.

Office hours, including after hours availability, should be posted on the outside entrance of the office along with the office phone numbers and 24-Hour phone number.

3.9 Telephone Accessibility ⁷

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Providers and administrative personnel must maintain a high level of telephone accessibility to KHS members. At a minimum, the following response times are required:

<u>Nature of Telephone Call</u>	<u>Response Time</u>
Emergency medical	Member should be instructed to call 9-1-1
Urgent medical	1 hour
Non-urgent medical	By close of following business day
Administrative	By close of following business day

Provider offices must provide procedures to enable patient access to emergency services 24 hours per day, seven days per week. Patients must be able to call the office number for information regarding physician availability, on call provisions, or emergency services. An answering machine/service must be made available after normal business hours with direction in non-emergency as well as emergency situations.

KHS departments and contract Providers must answer or design phone systems that answer phone calls within six (6) rings. Providers should address each telephone call regarding medical advice or issues promptly and efficiently and must ensure that non-medical personnel do not give medical advice. Only PAs, NPs, RNs, and MDs may provide medical advice. A sample policy that providers may incorporate into their own body of policies is included as Attachment A.

4.0 MONITORING

The Provider Relations Manager shall use, but not be limited to the following sources to study and assure compliance with access standards:

- A. Mystery Caller Program
- B. Referral Tracking
- C. Member Service Data
- D. Member Satisfaction Surveys

4.1 Mystery Caller Program

The Mystery Caller Program is used to monitor access and quality of customer service. Calls are made to Providers, to assess their level of customer service, competence, and access compliance. The information received is tracked and trended. The impetus for this program is to provide intervention and early feedback in the service access provision process prior to complaints being filed.

The Mystery Caller(s) remain anonymous.

4.1.1 Frequency and Schedule

The Member Services Department conducts the Mystery Caller Program on all contract PCPs, OB/GYNs, and designated Specialists according to the schedule listed below. Monitoring consists of two phone calls per Provider conducted both

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during regular business hours and after business hours. One phone call is made using the *Mystery Caller – Regular Business Hours* form (See Attachment B). The monitoring of PCP after hours access is performed by the contracted telephone triage service by completing a survey. The survey results are reported to KHS monthly.

Providers with office services are monitored on the following schedule:

- A. First Quarter
 - (i) January - Primary Care Adult A-F
 - (ii) February - Specialty Care A-F
 - (iii) March - Primary Care Child A-F
- B. Second Quarter
 - (i) April - Primary Care Adult G-L
 - (ii) May - Specialty Care G-L
 - (iii) June - Primary Care Child G-L
- C. Third Quarter
 - (i) July - Primary Care Adult M-R
 - (ii) August - Specialty Care M-R
 - (iii) September - Primary Care Child M-R
- D. Fourth Quarter
 - (i) October - Primary Care Adult S-Z
 - (ii) November - Specialty Care S-Z
 - (iii) December - Primary Care Child S-Z

4.1.2 Documentation and Monitoring

The results of each call are recorded on the appropriate *Mystery Caller Form*. Information from the calls is entered into the *Mystery Caller Log* (See Attachment D). The log is forwarded to the Provider Relations Manager.

Any Provider found to be out of compliance with a given access standard will be issued a letter notifying the provider of non-compliance along with a copy of the access policy. Any providers found to be out of compliance and notified of the non-compliance will be included in the following quarter Mystery Survey. Any providers found to be out of compliance a second time, may be issued a Corrective Action Plan (CAP) as outlined in *KHS Policy and Procedure #10.10-P: Corrective Action Plans*. The Provider Relations Manager notifies the Corporate and Member Services Manager of any Providers that were issued a CAP. Those providers are scheduled to be included in the following Mystery Caller Survey.

4.2 Member Satisfaction Survey

Annually, KHS conducts a *Member Satisfaction Survey*. The survey includes questions to determine member satisfaction with access to Providers as well as

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quality of care. (See Attachment F). KHS informs Providers of the survey results. If deemed necessary, CAPs are issued in accordance with *KHS Policy and Procedure #10.10–P: Corrective Action Plans*.

4.3 Access to Specialists⁸

Access to specialty providers is monitored through the Mystery Caller Program, the Grievance Process, and reporting from the Utilization Management (UM) Department.

The UM Department routinely reports information regarding access to specialty providers to the Provider Relations Manager, Medical Director, and CEO. Trends are identified and tracked on a quarterly basis. Information regarding trends and actions taken to increase access to specialty services is reported to the QI/UM Committee as outlined in *Section 5.0 – Reporting*.

5.0 REPORTING

Reporting of access compliance activities is the responsibility of the Provider Relations Manager. Reports are submitted as outlined in the following table.

Reported To	Report	Due Date	Requirements and Format
Executive Staff and QI/UM Committee	<i>Mystery Caller Accessibility Standards Report</i>	Quarterly	Attachment E
Executive Staff and QI/UM Committee	<i>Mystery Caller Report Summary</i>	Quarterly	Attachment F
QI/UM Committee	Information regarding access to specialists	Quarterly	

ATTACHMENTS:

- Attachment A – *Policy and Procedures: Telephone Advice Protocol*
- Attachment B – *Mystery Caller – Regular Business Hours form*
- Attachment C – *Mystery Caller – Regular Business Hours Log*
- Attachment D – *Member Satisfaction Survey*
- Attachment E – *Mystery Caller Accessibility Standards Report*
- Attachment F – *Mystery Caller Report Summary*

¹ **Revision 2006-08:** Routine revision. **Revision 2004-06:** Revised per DHS/DMHC Medical Audit (YEOct03). **Revision 2003-01:** Revised per DHS comment 7/26/02. Additional revision requested by Provider Relations Manager. **Revision 2002-05:** To incorporate suggestions made by DHS audit team. (Medical Review YE 08/31/00). This version is a combination of policies 4.30 – Accessibility Standards and Compliance Procedures (2001-02) and 5.11 – Accessibility Monitoring (2001-08).

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Revised per DHS Comment Letter (01/30/02). **Revision No. 2001-02:** Changes primary care services appointment scheduling guideline from 6 weeks to 4 weeks.

² DHS Contract A-9(10)

³ 2004 DHS A-6(9)

⁴ “seen w/i 48 hours upon request” 2004 DHS A-9(3)(E)

⁵ “Where a request is made for children’s preventive services by the Member, the Member’s parent(s) or guardian or through a referral from the local CHDP program, an appointment shall be made for the Member to be examined within two weeks of the request.” 2004 DHS A-10(4)(B)(3)

⁵ “w/i two weeks upon request” 2004 DHS A-9(3)(B)

⁶ CCR Title 28§1300.67.2(c), 2004 DHS A-9(6)(C).

⁷ 2004 DHS A-9(3)(D)

⁸ Section added to address DHS/DMHC Medical Audit (YE Oct03) Finding 3.1.3

PROVIDER OFFICE POLICY AND PROCEDURES

TELEPHONE ADVICE PROTOCOL

Policy:

This office will address each telephone call requesting advice or medical issues promptly and efficiently.

Procedure:

All telephone calls from patients or patient representatives with requests for advice, problems or medical question will be documented and promptly referred to the physician, mid-level practitioner or RN.

At no time will office personnel other than PAs, NPs, RNs, or the MD provide medical advice. The caller may be placed on hold while the physician is contacted and information may be relayed. IF the physician is unavailable to address the call, the patient may be scheduled an appointment to be seen. A signed advice form shall be maintained in each employee file.

In the event of an emergency, the patient (caller) will be instructed to call **911**.

All prescriptions must be renewed or changed by the provider.

January 23, 2005

Dear Kern Family Health Care Member,

You have been randomly selected to receive our yearly Member Satisfaction Survey. We would appreciate you taking the time to fill out and return the attached survey. Your comments are important to us and will help us to better serve our members.

As a "Thank You" to you for filling out the survey and returning it to us before February 24th, 2006, we will send you a \$10.00 Target gift card.

Please verify that we have the correct address above so we can send you your gift card. If the address is incorrect, please provide the correct address information in the space provided.

Again, thank you for choosing Kern Family Health Care.

Sincerely,

Member Services
Kern Family Health Care



Kern Family Health Care

Member Satisfaction Survey 2005

A DIVISION OF KERN HEALTH SYSTEMS

The Friendly Face

1. Did you choose Kern Family Health Care as your health plan? Yes No

2. If you answered yes above, how did you hear about Kern Family Health Care?
Please **circle** one.
Doctor Friend State/Case Worker TV Radio Other _____

3. If you transferred from another health plan, please circle the plan from which you transferred to KFHC
Blue Cross Health Net State- Fee for Service Other _____

4. Do you feel you understand your KFHC Benefits? Yes No

5. When you have a question about your benefits, how do you get the information you need? Check all that apply.
 Read Member Handbook Call Member Services Other _____

6. When you call KFHC during normal business hours, how long do you usually have to wait on the phone before someone answers?
 Less than 1 Minute 1 - 2 Minutes More than 2 Minutes

7. When you call KFHC, are you happy with the service you receive over the phone? Yes No
If no, why not _____

8. Have you ever called the 24 hr. Advice Nurse? Yes No
If no, skip to question #11

9. When you call the 24-Hour advice nurse after 5 pm or on weekends, how long do you usually have to wait on the phone before someone answers?
 Less than 1 Minute 1 - 2 Minutes More than 2 Minutes

10. When you called the 24-Hour advice nurse, were you happy with the help or advice you received? Yes No

If no, why not _____

11. Are you happy with your Primary Care Provider (PCP)? Yes No

If no, why not _____

12. Are you happy with the staff at your PCP's office? Yes No

If no, why not _____

13. How long do you usually have to wait to see your PCP when you have a scheduled appointment? 10 Minutes 30 Minutes 45 Minutes

1 Hour 1 ½ Hours 2 Hours

14. When you call for a routine appointment with your assigned PCP, how often do you get to see your assigned PCP instead of another provider in the office?

Always Usually Rarely Never

15. Have you ever been referred to a specialist? Yes No

If no, skip to question #19

16. If you answered yes to #15 please list the type of Specialist and if it was it for an urgent or non-urgent matter.

Type _____ Urgent Non-Urgent

17. How soon were you able to get an appointment with the specialist?

Less than one week 1 - 2 Weeks 2 - 3 Weeks
 Over 3 Weeks

18. Did your PCP follow-up and discuss with you the results of your appointment with the specialist? Yes No

19. Have you ever been asked to pay for health care or pharmacy services? Yes No

If Yes, where was it and what were you asked to pay for?

20. Are you disabled?

Yes No

If no, skip to question #21

If you are disabled, have you had any problems being seen by your doctor because of your disability?

Yes No

If yes, please explain what happened. _____

21. Are you happy with your pharmacy?

Yes No

If no, why not _____

What pharmacy do you use? _____

22. Are you happy with the number of pharmacies in the Kern Family Health Care network?

Yes No

If no, why not _____

23. Are you happy with the number of PCPs available in your area?

Yes No

What is your zip code? _____

If no, why not _____

24. Are you happy with Kern Family Health Care as your health plan?

Yes No

If no, why not _____

Please list any "LIKES" and "DISLIKES" about Kern Family Health Care.

LIKES

DISLIKES

ADDITIONAL COMMENTS:

MYSTERY CALLER ACCESSIBILITY STANDARDS REPORT

Quarter Ending: _____

Provider	Date of Deficiency	Type of Deficiency	Corrective Action Taken	Status	Follow-up Findings	Corrective Action Taken	Status

Deficiencies

- A – Answer w/in 6 rings
- RA – Routine Appt
- UC – Urgent Care Appt
- OB – OB Appt
- SP – Specialist Appt
- MA – Medical Advice Given
- AH – After Hours Coverage

Mystery Caller Report Summary

Access Standard	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Current Quarter Compliance	Over All Compliance		
PCP Routine Appt								
PCP Urgent Care Appt								
Specialist Routine Appt								
OB/GYN Appt								
After-Hours Access								

The providers found to be out of compliance with the access standards are sent a letter notifying them of the identified deficiency. In the letter they are told that future mystery calls will be done to ensure their compliance. If the provider fails to comply with the access standards a second time, a Corrective Action Plan (CAP) is required and the provider is called again. If provider fails to implement the CAP, disciplinary action may be imposed.

PCP Routine Appt should be available within 4 weeks

PCP Urgent Care Appointment should be available within 48 hours

Specialist Routine Appointment should be available within 6 weeks

OB/GYN first pre-natal visit should be within 2 week of request

PCPs should be available 24/7