KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Accessibility Standards				POLICY #: 4.30-P	
DEPARTMENT: Provider Relations					
Effective Date: 01/1996	Review/Revised Date: 09/15/2017	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Doug A. Hayward
Chief Executive Officer — Date 9/15/17

Chief Medical Officer — Date 9/14/17

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Administrative Director of Health Services — Date 9/18/17

Director of Provider Relations — Date 9/6/17

POLICY:
Kern Health Systems (KHS) monitors the accessibility of contracted providers to members to obtain covered services and implements corrective measures when necessary.

Contracted providers are made aware of and accountable for these accessibility standards. This policy will be included in the *KHS Provider Manual*. Provider contracts contain provisions pertaining to member access to medical care, the monitoring of the standards, and KHS right to implement actions to provide sufficient health care access.

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

- California Code of Regulations Title 28 §1300.67.2.2 (i.e., Geographic Accessibility Standards)
- California Code of Regulations Title 28 §1300.67.2.2 (i.e., California's Timely Access Standards)

DEFINITIONS:

1.0 ADVANCED ACCESS:
The provision, by an individual provider, or by the medical group or independent practice association to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.

2.0 ANCILLARY SERVICE:
Includes but is not limited to providers of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, and home-health service providers.

3.0 APPOINTMENT WAITING TIME:
The time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan and completing any other condition or requirement of the plan or its contracting providers.

4.0 PREVENTIVE CARE:
Health care provided for prevention and early detection of disease, illness, injury or other health condition.

5.0 TELEMEDICINE:
The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications (real-time or near real-time two-way transfer of medical data and information). Neither a telephone conversation nor an electronic mail message between a health care practitioner and enrollee constitutes telemedicine for the purposes of this policy and procedure.

6.0 TRIAGE OR SCREENING:
The assessment of an enrollee'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 enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

7.0 TRIAGE OR SCREENING WAITING TIME:

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 enrollee who may need care.

8.0 URGENT CARE:

Health Care for a condition which requires prompt attention when the enrollee's condition is such that the enrollee 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 enrollee's life or other health or could jeopardize the enrollee's ability to regain maximum function.

PROCEDURES:

1.0 SCOPE

These standards apply to contracted providers.

2.0 RESPONSIBILITY

KHS has ultimate responsibility for facilitating timely access to covered health care services. The monitoring of these standards has been delegated to the KHS Provider Relations Department. The Director of Provider Relations, 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.

Limited English Proficient (LEP) and hearing impaired members will be provided equal access to health services in accordance with *KHS Policy and Procedure 11.01-E Cultural and Linguistic Services*.

3.0 STANDARDS

Contracted providers are held to the following accessibility standards concerning their patient facilities and provision of care to members:

3.1 Facility Characteristics

The facility must be clean, adequately-lighted, 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. The seating shall be adequately constructed to support patients of varying physical stature. The waiting area's proximity to the reception areas should be arranged to allow visual and 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

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

3.1.3 Restrooms

Restrooms must be equipped to accommodate patients with and without a disability. The restrooms must be close to waiting and treatment areas.

3.1.4 Treatment Areas

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

3.1.5 Barriers

Patient areas must be free of barriers that would restrict access to person with or without a disability. This includes the provision of ramps and elevators to access patient care areas and drinking water.

3.1.6 Disability Accommodations

Contracted providers are required to comply with the Americans with Disabilities Act (ADA). Questions regarding the ADA can be directed to Region IX - Disability and Business Technical Center at 1-800-949-4232 or www.PACDBTAC.org.

3.2 Staffing

Contracted providers must be staffed with personnel who possess the ability to assist 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 point 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 public or private transportation.

3.5 Driving Time/Miles

KHS maintains a network of Primary Care Providers and Hospitals located within thirty (30) minutes or ten (miles) of a Member's residence. For geographic service areas *(zip codes)* found to not meet the above standard, KHS shall maintain alternative access standards, to be filed and approved with the DHCS and DMHC.

3.6 Appointment Waiting Time and Scheduling:

The "appointment waiting time" means the time from the initial request for health care services by a Member or the Member's treating provider to the earliest date offered for the appointment for services inclusive of the time for obtaining authorization from the plan, and completing any other condition or requirement of the plan or its contracting providers. KHS shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition. Members must be offered appointments within the following

timeframes:

Type of Appointment	Time Standard
Urgent care appointment for services that do not require prior authorization[1]	Within 48 hours of a request
Urgent appointment for services that require prior authorization	Within 96 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of a request
Pediatric CHDP Physicals	Within 2 weeks upon request
First pre-natal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

EXCEPTIONS:

Preventive Care Services and Periodic Follow Up Care:
Preventive care services and periodic follow up care, including but not limited to, 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 treating licensed health care provider acting within the scope of his or her practice.

Advance Access:
A primary care provider may demonstrate compliance with the primary care time-elapsed access standards established herein through implementation of standards, processes and systems providing advance access to primary care appointments as defined herein.

Appointment Rescheduling:
When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.

Extending Appointment Waiting Time:
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 Member's medical record that a longer waiting time will not have a detrimental impact on the Member's health.

Telemedicine:
To the extent that telemedicine services are appropriately provided as defined per Section 2290.5(a) of the Business & Professions Code, these services shall be considered in determining compliance with the access standards hereby established. Prior to the delivery of health care via telemedicine, the provider must obtain verbal and written informed consent from the enrollee or the enrollee's legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the enrollee or the enrollee's legal representative verbally and in writing:

1. The enrollee or the enrollee's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the enrollee or the enrollee's legal representative would otherwise be entitled.

2. A description of the potential risks, consequences, and benefits of telemedicine.

3. All existing confidentiality protections apply.

4. All existing laws regarding enrollee access to medical information and copies of medical records apply.

5. Dissemination of any enrollee identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the enrollee.

   A enrollee of the enrollee's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the enrollee or the enrollee's legal representative understands the written information provided and that

this information has been discussed with the health care practitioner, or his or her designee. The written consent statement signed by the enrollee or the enrollee's legal representative shall become part of the enrollee's medical record.

3.7 Shortage of Providers

To ensure timely access to covered health care services as required in this policy, where there is a shortage of one or more types of providers, providers are required to refer members to available and accessible contracted providers in neighboring service areas consistent with patterns or practice for obtaining health care services in a timely manner appropriate for the member's health needs. Furthermore, providers shall arrange for the provision of specialty services from specialists outside the provider's contracted network if unavailable within the network, when medically necessary for the member's condition. This requirement does not prohibit a plan from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

3.8 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
Mental Health Services		1 hour	1 hour
Ancillary Providers		1 hour	1 hour

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

3.9 Facility Hours

A. Emergency Care - 24 hours per day, 7 days per week

B. After Hours Urgent and Emergency Care - Primary and specialty care providers must provide or arrange afterhours access for treatment of urgent and emergency conditions by telephone and/or personal contact.

C. Each contracted provider shall offer their KHS Medi-Cal members hours of operation that are no less than the hours of operation offered by the contracted provider to other patients or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal beneficiaries.

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

3.10 Telephone Accessibility

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

Nature of Telephone Call	Response Time
Emergency medical or Kern County Mental Health Crisis Unit	Member should be instructed to call 9-1-1 or 661-868-8000
Urgent medical	30 Minutes
Non-urgent medical	By close of following business day
Non-Urgent Mental Health	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 or service must be made available after normal business hours with direction in non-emergency and emergency situations.

Contracted providers must answer or design phone systems that answer phone calls within six 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.

KHS provides or arranges for the provision of 24/7 triage screening services by telephone. KHS ensures that telephone triage or screening are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. KHS provides triage or screening services through medical advice lines pursuant to section 1348.8 of the Health & Safety Code. Refer to KHS Policy 3.15-I 24-hour Telephone Triage Service.

4.0 MONITORING

The Provider Relations Department shall use the following sources to study and assure compliance with access standards:

A. Appointment Availability Survey Program
B. Access grievances/1000 member months
C. Member Services Call Center Data

D. Member Satisfaction Survey
E. Annual Provider Satisfaction Survey

4.1 Appointment Availability Survey Program

The Appointment Availability Survey Program assists with monitoring accessibility of care and quality of customer service. Calls are made to contracted primary care, mental health and specialist providers to assess their level of customer service and access compliance. The program also provides intervention and early feedback that identifies and facilitates resolution of access problems and prevents some member complaints.

The Plan will review and evaluate on a quarterly basis the accessibility, availability and continuity of care of PCP's, Specialists, and Mental Health Providers through the *member grievance process, After Hours Access Survey* and *quarterly DMHC reporting.*

4.1.1 Method and Frequency

Calls will be placed to contracted PCPs, mental health providers and specialists during regular business hours on an annual basis. Methodology for this survey will be based on the annually defined DMHC Survey Methodology. The Provider Appointment Availability Survey will be conducted annually.

The monitoring of PCP afterhours access is performed by the contracted telephone triage service by completing a telephone survey. The Afterhours Access Survey results are reported to KHS quarterly.

4.1.2 Documentation and Monitoring

The results of each call are recorded by the KHS contracted telephone triage service. The report is forwarded to the Provider Relations Supervisor. The rate of compliance is calculated using the DMHC model provider appointment availability survey method.

Any contracted provider found to be out of compliance with an 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 with the afterhours access standards will be issued a letter notifying the provider of non-compliance along with a copy of the access policy, and included in the following quarter's Afterhours Access Survey. Any providers found to be out of compliance a second time, may be issued a Corrective Action Plan (CAP) as described in *KHS Policy and Procedure #10.10–P: Corrective Action Plans.* The Provider Relations Supervisor notifies the Member Services Director of any contracted provider that was issued a CAP.

4.2 Member Satisfaction Survey

KHS conducts a *Member Satisfaction Survey.* The survey includes questions to determine member satisfaction with access to care and quality of care. The survey will include the following CAHPS questions for the annual member survey to assess member perception and satisfaction of accessing timely

health care under KHS: CAHPS Q4, Q6, Q23, Q25a, Q27, and Q27a. The survey will also include a question to assess member perception and satisfaction of accessing 24-hour telephone triage service under KHS. KHS informs contracted providers of the survey results. CAPs are issued in accordance with *KHS Policy and Procedure #10.10–P: Corrective Action Plans*.

4.3 Access to Specialists[8]

Access to specialty providers is monitored through the Appointment Availability Survey Program, the member grievance process, and reporting from the Utilization Management (UM) Department.

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

4.4 Provider Satisfaction Survey.

KHS will use modified talking points and methodology from the Industry Collaborative Effort (ICE) Provider Satisfaction Survey in conducting an annual survey of its contracting providers' experience in accessing health care for members under KHS.

4.5 Full-time equivalent (FTE) Provider to Member Ratios

On an annual basis, KHS will monitor that its provider network capacity satisfies the following full-time equivalent provider to member ratios:

1) Primary Care Physicians 1:2,000
2) Total Physicians 1:1,200

Full-time equivalency shall be determined by percentage of members assigned to the two Medi-Cal managed care plans in Kern County. For example, if KHS has 80% of the Medi-Cal managed care members in Kern County, the PCP FTE assumption to calculate the PCP to member ratio will be 80% FTE of all PCPs in the network.

Due to a maximum member assignment of 1,000 (See policy 5.06-P *Assignment of Primary Care Providers)* Mid-level providers serving in the Primary Care capacity will be counted as .5 of a PCP FTE, prior to percentage calculation.

5.0 REPORTING

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

Reported To	Report	Due Date	Requirements and Format

Reported To	Report	Due Date	Requirements and Format
QI/UM Committee Executive Staff and QI/UM Committee	Annual Provider Appointment Availability Survey Results	Annually	

ATTACHMENTS:

- Attachment A – *Telephone Advice Protocol*

REFERENCE:

Revision 2017-08: Revised the methodology for the calculation of FTE as directed by DMHC, approved by DMHC and DHCS. Section 4.0 Monitoring updated to remove ICE vendor and to update FTE ratio. FTE ratio removed from policy 5.06 section 2.4. Revision **2015-07:** Section 4.0 Monitoring updated by Provider Relations to reflect current processes. Attachments B and F reflect attachments referenced within the policy. **Revision 2014-11:** References to mental health services included to expand services to members. Requested by DMHC May 6, 2014, eFiling 20140831. **2014-03:** Policy revised to comply with DMHC model provider appointment availability survey methodology. **Revision 2014-03:** Revisions provided to comply with the 1115 SPD Waiver Survey by the Provider Relations Supervisor. **Revision 2011-08:** Policy underwent major revisions due to Timely Access Standards. Revised by COO Becky Davenport and approved by DMHC 3-19-12 and DHCS 12/5/11.

Attachment A

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.