



SECTION 10



ACCESS AND APPOINTMENT STANDARDS

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Timely Access Regulations

State regulations require plans to assure timely access for its commercial member plans regulated under the Department of Managed Health Care (DMHC) effective January 17, 2011.

Chinese Community Health Plan (CCHP), Chinese Community Health Care Association Medical Group (CCHCA) and Chinese Hospital, and have worked collaboratively to respond to this need. Timely access involves physician offices being able to offer appointments within certain time frames. If your office is unable to provide an appointment within the time frame, you could refer the patient to the Chinese Hospital clinics for a one-time appointment. Please note that the waiting time in an office for scheduled appointments should not exceed 15 minutes. Please review “CCHP Appointment and Availability Standards” on the following page for a description of standards for different types of medical appointments. CCHP conducts appointment access surveys, provider satisfaction surveys, and member satisfaction surveys to identify trends or problems.

Nurse Advice Line

Timely access also requires that 24-hour a day seven day a week triage and screening services be available. The primary care physician office should be the primary responder. After hours, physicians also should indicate on their answering lines what time frame a patient may expect a response. For CCHP, if the physician is not available, a nurse advice line staffed by Chinese Hospital is available to respond to the member and offer advice. **The service is not a backup after hours service for physicians. In addition, it is not intended to replace or substitute for the services of the Primary Care Physician** but respond to calls from members needing to talk with a qualified medical professional on general health education information or seeking medical care advice in a medical situation.

CCHP’s nurse advice line (1-888-243-8310) provides for a licensed health care professional to be available to assist members by phone 24 hours a day, seven days a week. Although the timely access standards are technically not applicable to the senior plans, the nurse advice line will respond to any member who calls. The function of the nurse advice line is to determine the severity of the caller’s complaint using a series of algorithms nationally vetted, then offer recommendations or health information based on assessment and established protocols. The nurse advice line will send a record of the call to the PCP.





After Hours Instructions

Chinese Community Health Plan's contracted medical group, Chinese Community Health Care Association, requires that each physician office's automated message or answering service will provide appropriate emergency instructions and will have a healthcare professional available to return patient calls within 4 hours for situations where the patient perceives their issue as urgent. Every after-hours caller is expected to receive emergency instructions, whether a line is answered live or by recording. Callers with an emergency are expected to be told to hang up and dial 911, or to go to the nearest emergency room. After receiving emergency instructions, callers with non-emergency situations that cannot wait until the next business day should receive one of the following options:

1. When speaking to a person:
 - Stay on the line to be connected to the doctor on call,
 - Leave a name and number and a physician or qualified healthcare professional will call you back within 4 hours,
 - Reach the doctor at another number, or

2. When reaching a recording:
 - Leave a message and have their call returned that same evening or day within 4 hours of receipt for situations where the patient perceives their issue as urgent,
 - Call an alternate phone or pager number to contact the physician on call.



Appointment and Availability Standards

All applicable contracted physicians and providers are responsible for complying with the following standards:

COMMERCIAL NON-EMERGENT MEDICAL APPOINTMENT ACCESS STANDARDS	
Appointment Type	Must Offer Appointment Within
Non-urgent Care appointments for Primary Care (PCP)	10 Business Days of the request
Non-urgent Care appointments with Specialist physicians (SCP)	15 Business Days of the request
Urgent Care appointments that do not require prior authorization (PCP)	48 hours of request
Urgent Care appointments that require prior authorization	96 hours of request
Non-urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	15 Business Days of the request
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 15 minutes

BEHAVIORAL HEALTH EMERGENT STANDARDS AND NON-EMERGENT APPOINTMENT ACCESS STANDARDS	
Appointment Type	Must Offer Appointment Within
Non-urgent appointments with a physician mental health care provider	10 business days of request
Non-Urgent Care appointments with a non-physician mental health care provider	10 business days of request
Urgent Care appointments	48 hours of request
Access to Care for Non-Life Threatening Emergency	6 hours
Access to Life-Threatening Emergency Care	Immediately
Access to Follow Up Care After Hospitalization for Mental Illness	Must Provide Both: 1 follow-up encounter with a mental health provider within 7 calendar days after discharge Plus 1 follow-up encounter with a mental health provider within 30 calendar days after discharge.



Exceptions to Appointment and Availability Standards

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 relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.



Definitions: Timely Access Regulations

1. "Advanced access" means 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. "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" [as defined by H&S Code Section 1323(e)(1)].
3. "Appointment waiting time" means 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 or medical group (if delegated) and completing any other condition or requirement of the plan or its contracting providers.
4. "Health care service plan" or "specialized health care service plan" means either of the following:
 - (1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.
 - (2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.
5. "Mental Health Care Provider (MHCP)" includes Medical Doctors and Doctors of Osteopathy with specialties in addictionology or psychiatry, clinicians licensed by the state for the independent practice of psychology (California requires a PhD in psychology to be licensed for independent practice), and Master's Level Clinicians: counselors, therapists, social workers, licensed professional examiners and nurses who are licensed or certified to practice independently according to state laws in their practice location. Marriage and Family Therapists and Licensed



Clinical Social Workers are licensed or certified to practice independently in California.

6. “Provider” means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services [as defined by H&S Code Section 1345(i)].
7. “Provider Group” means a medical group, independent practice association, or any other similar organization (as defined by Section 1373.65(g) of the Act).
8. “Preventive care” means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.
9. “Specialist” is defined as a residency-trained, board-certified or board-eligible licensed practitioner who completed advanced training in a field recognized by the American Board of Medical Specialists (ABMS) or the American Osteopathic Association (AOA).
10. “Triage” or “screening” means 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.
11. “Triage or screening waiting time” means 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.

“Urgent care” means 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 health or could jeopardize the enrollee’s ability to regain maximum function (consistent with subsection (h)(2) of Section 1367.01 of the Act).