Timely Access to Care Training

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2020
Agenda

- Welcome & Introductions
- Training Updates
- COVID-19 Updates
- Importance & Drivers
- Monitoring & Evaluation
- Survey Process: Preparation & Resources
- Best Practices
- Non-Compliance
- Conclusion & Questions
Training Scope

Training is intended for Plan contracted PPGs, Primary care, Specialty care, Ancillary care providers and provider office staff.

Overview and importance of providing timely access to care for health plan members and important COVID-19 updates.

Methods used to monitor and evaluate timely access to care.

Provide adequate resources and best practices to improve timely access to care for health plan members.
COVID-19 AND IMPORTANT ACCESS TO CARE UPDATES
Telehealth

Health Net, California Health & Wellness and CalViva Health’s coverage for members telehealth services are temporarily expanded to comply with regulatory requirements.

Telehealth services may be used to determine the medical necessity for a member to see a provider in person or go to an emergency room or urgent care center.

Telehealth services will be reimbursed when deemed medically appropriate.
Changes in Hours of Operation

For office closures, reduced office hours, or providing Telehealth consultations only, the following steps need to be taken:

Contact their Plan provider network regional representative immediately and inform the Plan of the date when the office will be re-opening.

Notify patients who have upcoming appointments about changes to office processes and provide documentation detailing how patients were notified to a designated Plan network representative.

Inform patients about available care options via updated voicemail instructions, leaving messages for patients, putting up posters or making member outreach via mail and/or email.

When rescheduling or postponing an appointment, the referring or treating provider must determine and note in the patient record that a longer waiting time will not have a detrimental impact on the health of the member.
COVID-19 Resources

1. Members wanting to be tested should consult with their provider who may order the test if the provider determines the member meets the testing criteria. Criteria is available at www.covid.ca.gov

2. For Health Net support inquiries and COVID-19 FAQs regarding Access to Care and Cost Share, call toll free line (800) 400-8987

3. For general information, check the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/coronavirus/2019-nCoV
TIMELY ACCESS TO CARE

Importance and Drivers
Why Is Timely Access to Care Important?

Provide members access to comprehensive, quality health care services, *the right care at the right time*

- Improve the member experience and satisfaction with timely access to health care services
- Improve outcomes to the members’ overall health and wellness status.
  - Preventing and Managing disease
- Reducing unnecessary disability and premature death outcomes
- Reducing utilization of avoidable ER, shorter inpatient admissions and other services provided in higher cost settings
- Achieving health equity for all
Timely Access to Care Drivers

Customer Driven
- Anticipate, understand and respond to customer needs and provide resolution for the customer – at member and provider level
- Focus on improving member experience and satisfaction
- Improve provider satisfaction

Compliance Driven
- Monitor and evaluate practitioners and providers to ensure compliance with access and availability standards.
- Fully comply with regulatory and accreditation requirements

Improvement Focus
- Identification of deficiencies and implementation of initiatives to improve access for members
- Promote access and availability of practitioners and providers to our members.
MONITORING & EVALUATION
Evaluation Tools & Data

**SURVEYS**
- Provider Appointment Availability Survey (PAAS)
- Provider After-Hours Availability Survey (PAHAS)
- Provider Office Telephone Access Monitoring
- Consumer Assessment of Health Plan Survey (CAHPS®)
- CG CAHPS® Medicare
- Provider Satisfaction Survey (PSS)
- Patient Assessment Survey (PAS)
- DHCS Timely Access Study (Conducted quarterly by DHCS vendor HSAG)

**NETWORK ADEQUACY**
- Analysis of the Plan’s in-network contracted primary care, specialty care and ancillary network availability of practitioners and providers to assure an adequate number and geographic distribution for health plan membership

**GRIEVANCES**
- Member grievances related to access to care
- Evaluation includes exempt grievance data provided by the Plans Customer Contact Center

**PROVIDER DEMOGRAPHIC DATA**
- Accuracy of provider demographic data available in Plan’s provider search and directories

**SPECIALIST REFERRAL REPORTS**
- Analysis of Specialty referral time to service

**HEALTH PLAN CUSTOMER CONTACT CENTER**
- Health Plan Customer Service metrics and standards to meet member needs
Provider Access to Care and Member Satisfaction Surveys Conducted by The Plan

The following surveys are conducted by the Plan to assess provider compliance with timely access and after-hours standards.

<table>
<thead>
<tr>
<th>Survey</th>
<th>Monitoring</th>
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<tbody>
<tr>
<td>Provider Appointment Availability Survey (PAAS)</td>
<td>Appointment availability for routine and urgent care</td>
</tr>
<tr>
<td>Provider After-Hours Availability Survey (PAHAS)</td>
<td>Appropriate emergency instructions for after-hours care and the Providers’ availability to be reached within 30 minutes of a member’s call for urgent after-hours issues.</td>
</tr>
<tr>
<td>Telephone Access Monitoring</td>
<td>Time to answer the call, and call-back wait time for patients with non-urgent issues.</td>
</tr>
<tr>
<td>Consumer Assessment of Health Plan Survey (CAHPS®) / CG CAHPS® Medicare</td>
<td>Member satisfaction survey asks members to evaluate their experience with their health plan and healthcare received.</td>
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## Timely Access to Care Standards

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Appointment Access Standards</th>
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<tbody>
<tr>
<td><strong>URGENT APPOINTMENTS</strong></td>
<td></td>
</tr>
<tr>
<td>Urgent care appointment with PCP</td>
<td>Within <strong>48 hours</strong> of request</td>
</tr>
<tr>
<td>Urgent care appointment with SCP</td>
<td>Within <strong>96 hours</strong> of request</td>
</tr>
<tr>
<td>Urgent care appointment with non-physician mental health provider</td>
<td>Within <strong>48 hours</strong> of request</td>
</tr>
<tr>
<td><strong>NON-URGENT APPOINTMENTS</strong></td>
<td></td>
</tr>
<tr>
<td>Non-urgent care appointment with PCP</td>
<td>Within <strong>10 business days</strong> of request</td>
</tr>
<tr>
<td>Non-urgent care appointment with SCP</td>
<td>Within <strong>15 business days</strong> of request</td>
</tr>
<tr>
<td>Non-urgent care appointment with non-physician mental health provider</td>
<td>Within <strong>10 business days</strong> of request</td>
</tr>
<tr>
<td>Appointment for Ancillary Services</td>
<td>Within <strong>15 business days</strong> of request</td>
</tr>
<tr>
<td>¹First prenatal visit with PCP or SCP</td>
<td>Within <strong>2 weeks</strong> of request</td>
</tr>
<tr>
<td>¹Well-child visit</td>
<td>Within <strong>10 business days</strong> of request</td>
</tr>
<tr>
<td>¹Wellness visit</td>
<td>Within <strong>30 calendar days</strong> of request</td>
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</tbody>
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¹Well Child & First-Prenatal Visits, and Wellness check standards are specific to DHCS regulations
## Other Timely Access Standards

<table>
<thead>
<tr>
<th><strong>AFTER-HOURS ACCESS</strong></th>
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<tbody>
<tr>
<td><strong>After-hours physician availability</strong></td>
<td><strong>Call back within 30 minutes</strong></td>
</tr>
<tr>
<td><strong>After-hours ER instructions</strong></td>
<td><strong>Appropriate emergency instructions</strong></td>
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<table>
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<tr>
<th><strong>ANSWER TIME &amp; CALL BACK</strong></th>
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<tbody>
<tr>
<td><strong>Telephone access answer time during normal business hours</strong></td>
<td><strong>Answers calls within 60 seconds</strong></td>
</tr>
<tr>
<td><strong>Telephone access call-back for non-urgent issues</strong></td>
<td><strong>Calls patients back within 1 business day</strong></td>
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</tbody>
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<table>
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<tr>
<th><strong>IN-OFFICE WAIT TIME</strong></th>
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<tbody>
<tr>
<td><strong>In-office wait time for scheduled appointments with PCP</strong></td>
<td><strong>Not to exceed 30 minutes</strong></td>
</tr>
<tr>
<td><strong>In-office wait time for scheduled appointments with Specialist</strong></td>
<td><strong>Not to exceed 30 minutes</strong></td>
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Appointment Rescheduling

When it is necessary for a provider or member to reschedule an appointment, the appointment will be:

- Promptly rescheduled in a manner that is appropriate for the member’s health care needs.
- Rescheduled applying the applicable timely access standards to the appointment.
- Rescheduled ensuring continuity of care consistent with applicable professional practice.
Providing After-Hours Access to Care Standards

Health Plan Goal: >90%

Ensure that Members are able to call the provider's office 24-hours-a-day, 7 days a week to talk to a qualified health care professional to obtain input as to the urgency of any health problems.

If a call-back is necessary, it must occur within 30 minutes of receipt of the member call.

PCPs are responsible for ensuring answering service staff do not provide telephone medical advice if they are not a licensed, certified, or registered health care professionals.

Sample Answering Machine/Service Scripts

Hello, you have reached the answering service/centralized triage for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, please stay on the line and I will connect you.

Hello, you have reached the answering service/centralized triage for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, Dr. <Last Name> can assist you. Please <page/call> him/her at <telephone number>. You may expect a call back within 30 minutes.
SURVEY PROCESS

Preparation & Resources
Measurement Year 2020

- **Provider Appointment Availability Survey (PAAS)**
  Initial outreach will be via fax or email. If a provider does not respond to the initial invite or the Plan does not have fax or email details for a provider, the outreach will be completed via telephone.

- **Provider After-Hours Availability Survey (PAHAS)**
  Will be conducted by telephone.

- **Provider Telephone Access Surveys**
  Will be conducted by phone.

*PAAS & PAHAS are conducted annually, typically from August through December 31st.

The Provider Telephone Access Survey is conducted quarterly, with randomly selected providers surveyed once annually.

*For MY 2020 the Plan has joined the health plan shared services survey model*
Survey Response Prep Activities

Ensure appointment scheduling processes are compliant with regulatory standards

Review all timely access standards with all office staff

Ensure understanding of all of the survey questions

Test after-hours protocol: Ensure answering machine message and/or answering service responses comply with regulatory standards

Ensuring answering machine messages or answering service responses are compliant is an easy fix

Ensure appointment scheduler is aware of health plan contracts and participating products i.e. Medi-Cal/Medicare

If same day appointments or walk-ins are available to patients, state this during survey

Ensure that the office staff is aware of Provider Panels being open or closed to new patients

If there are changes to provider demographic information, ensure that the Plan is notified timely

9/22/2020
Provider Updates & Resources

Provider Updates containing information to assist with survey completion, are distributed to PPGs /Providers/IPAs by fax/email prior to the start of the surveys.

Provider Notifications are distributed to all providers which include specific timely access topics and updates as well as tools and tips for attaining compliance.

Timely Access Provider Webinars provided quarterly or as required.
Provider Update

Topics Covered Include

• Timely Access Overview
• Improving After-Hours Access
• Changes in Survey Methodology
• Survey Preparation
• Regulatory Standards
Provider Notification Example

Topics Covered Include

- Standards for Advanced Access
- Appointment types
- Provider types
- Tips on how to provide Advanced Access to Members
Access to Care Best Practices Member Experience

Office staff and providers should treat all patients courteously and with respect while ensuring patients are fully informed.

Offer same-day appointment access (Advanced/Open Access Scheduling).

Shorten time to answer and return patient calls.

Educate patients about urgent care, after-hours protocols & general health-related topics.

Educate patients about the prior authorization, referral and follow-up appointment processes and timelines.

Arrange for interpreter services when appointments are scheduled or rescheduled ensuring maximum member comfort at all appointments. Telephone interpreters are available immediately, in person interpreters need 5 days notice to be present.

Handle patient calls with goal of first call resolution.
Access to Care Best Practices Provider Activities

Provider Activities

- Assist patients by scheduling referrals and follow-up appointments with providers/specialists in a timely manner
- Patient Care/Quality: Understand the impact to e.g. CAHPS performance measures; Patient Portal Utilization
- Ensure that Provider Panels are Opened or Closed appropriately so as not to stifle patient access or provide a low level of care due to a high volume of patients
Access to Care Best Practices PPGs

**PPG**

**Implementation of enhanced patient communication systems for routine and urgent patient needs**
- e.g. Use of online patient portals such as MyChart for appointment scheduling, test result communications, responding to patient inquiries and sending messages to patients

**Telemedicine**
- Extend group services using virtual care delivery models to expand methods for patients to access care with increased ease

**Referral Process**
- Evaluate and address necessary changes to improve process and compliance with regulatory standards

**Provider Data Integrity**
- Ensure accuracy of provider data routinely
- Communicate changes timely to Health Net

**Physician Roster**
- Review of physician roster to confirm adequacy of adult and pediatric specialists

**Call Center Performance Service levels**
- e.g. Service Level - 80% calls answered within 30 seconds; Answer Rate ≥95%; First Call Resolution >80%

**Urgent Care Center Availability/Adequacy**
- • Ensure adequacy of UCCs – location and scope of services
- • Communication to patients
- • Verify contracted urgent care centers: hours of operation, locations, available resources to patients

**Access to Care Grievance Monitoring**
- Drill down to identify trends
NON-COMPLIANCE
Corrective Action Plans (CAPs)

- PPGs and Providers are considered non-compliant if they fail one or more timely access metrics annually. CAPs will be mailed to these Providers or PPGs.

- PPGs and Providers may be required to complete and return an Improvement Plan (IP) within 30 days of CAP receipt.

- PPGs and Providers are encouraged to attend a Timely Access Provider Online Training (1 Webinar) as part of their Improvement Plan.

- Providers may be subject to a telephone audit if non-compliant with timely access standards for 2 years or more in a row.
Topics Covered Include

• Includes information on Timely Appointment Access Standards

• Improvement Plan template to complete for noncompliant metrics
Provider Toolkit

Topics Covered Include

- Health Care Performance Measurement Systems
- Performance Measures:
  - HEDIS Measures
  - CAHPS Survey
  - Pharmacy Measures
- QI Activities
- Timely Appointment Access
- Advanced Access
- Online resources
Non-Compliance Implications

Corrective Action Plans:
- Failure to achieve regulatory standard metrics will result in CAPs being issued by the Plan to low performing providers.

Members Grievances:
- An increase of member grievances related to Provider timely access provision is an indication of inadequate provision of timely access.

Performance Based Incentives:
- Will be impacted as a result of Providers/PPGs/IPA’s not meeting the Plans threshold for regulatory standards.

Contracting:
- Health Plans may terminate provider contracts as a result of repetitive non-compliance.

Potential for Sanctions:
- Regulators may impose CAPs on PPGs/IPAs/Providers when they continually fail to offer adequate timely appointments contributing to the Plan’s non-compliance with regulatory standards and simultaneously impose financial penalties or sanctions on the Plan.
Q&A
It is our pleasure to support you!

Please fill out the survey link that will be sent after the webinar to receive your Certification of Completion.

For any Access to Care related questions please use the following email address Access.Availability.PNM@healthnet.com

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