Provider Access & Availability

Effective Date: 10/19/2017 Draft/Review Date: 10/19/2017

Policy

A. It is the policy of the ACO to follow all CMS guidelines for providing Beneficiaries with access to providers.

Applicability

This policy and procedure applies to all Participants, Providers/Suppliers, and other individuals or entities performing functions or services related to the ACO's activities.

Procedure

A. The ACO will offer Beneficiaries appointments with their Primary Care Physician (PCP) in a timely manner, regardless of the Beneficiary's health condition or status.

B. The ACO will provide Beneficiaries with access to healthcare professionals during hours in which the facility is not open. The individual taking after-hours calls should be qualified to perform triage on the telephone to identify situations that require immediate emergency attention and those that can be scheduled for an appointment when the facilities are open.

C. The ACO will continually monitor Participants to ensure compliance with these standards and, through its Governing Body, will take corrective action if necessary.

D. **Business Hour Availability**

1. The Quality Improvement & Care Coordination (QICC) Subcommittee should work with appropriate clinical and operational staff to design the ACO's care delivery system for open access.
2. Recommended access time frames include:
    a. For preventive care/health maintenance, the Beneficiary should be seen within twenty (20) days.
    b. For routine symptomatic care, the Beneficiary should be seen within a week.
    c. For urgent care, the Beneficiary should be seen within twenty-four (24) hours.
    d. For emergency care, such as chest pain, the Beneficiary should be seen within twenty-four (24) hours.
3. For providers who are listed in directories as bilingual, phone and appointment service must be available in English and other languages stated.
4. **[Best Practice]** The ACO, working with appropriate individuals, should collect data on the following measures:
    a. Delay: Time to the third next available appointment;

b. Supply of appointments;

c. Demand for appointments;

d. Supply used; and,

e. Continuity: The percentage of Beneficiaries with appointments that were seen by their own provider.

5. **[Best Practice]** The ACO should work with appropriate clinical staff to analyze the data and design interventions to reduce the time to the third next available appointment by balancing supply and demand.

E. **After Hours Access**

1. The ACO advises Beneficiaries in writing at the offices and on the telephone answering system how they may reach a healthcare professional when the office is closed. This same information will be posted at the facility entrance and visible after hours.

2. **[GUIDANCE]** Options for the after-hours access may include:

   a. Answering Service that will take down the information and page the provider on call;

   b. A recording that either gives the pager number or the provider on call; and/or,

   c. Number for the service that will page the provider on call.

3. **[GUIDANCE]** Unacceptable processes include:

   a. A recording that directs the Beneficiary to proceed to the nearest emergency department if the Beneficiary has a medical emergency; and/or,

   b. A request to call back during normal business hours.

4. **[GUIDANCE]** After hours and on call processes may include:

   a. Beneficiaries will be advised to go to the closest Emergency Room if they are experiencing an emergent condition.

   b. Provider staff members that are qualified to triage client clinical situations will be scheduled to rotate call during times that the facility is not open.

   c. The on-call provider will be provided a pager or designated cell phone to be kept accessible and functioning during the on-call responsibility.

5. The on-call provider will maintain a record of all calls received. The record will include:

   a. Name of the Beneficiary or representative making the call;

   b. Phone number of the caller;

   c. Name and birth date of the Beneficiary;

   d. Reason(s) for the call;

   e. Assessment/triage findings; and,

f. Disposition of the call encounter.

6. **[Best Practice]** The documentation from the on-call encounter will be entered in the medical record of the Beneficiary on the next day when the office is open. This may be accomplished by a data entry in the Electronic Health Record (EHR) or the notation may be physically attached to the hard copy medical record.
7. **[Best Practice]** On the next day the facility is open, the appropriate individual in the provider office will follow up to check the status of the Beneficiary and to arrange for an appointment as needed. The individual will document the follow-up in the medical record.
8. **[Best Practice]** The ACO will monitor provider access and availability practices annually. Calls will be placed by individuals designated by the Governing Body after office hours, week days and/or weekends, including any holidays that fall during the monitoring period to assess if offices meet the policy. Reports will be provided to the QICC Subcommittee following the monitoring period.

Reporting

A. The Medical Director reports access data to the QICC Subcommittee and the Governing Body on a regular basis.

B. **[Best Practice]** Annual reports on monitoring of compliance to access & availability policy are made to the Quality Improvement Subcommittee. Any issues found are escalated to the Governing Body.

Related Documentation

A. 42 CFR §425.112(b)(2)

B. ACO Terms & Definitions Policy

C. Beneficiary Discharges & Dismissals Policy

D. CAHPS survey

E. Medical Records Policy

F. Medicare Shared Savings Program Quality Measures

G. Privacy & Security of Beneficiary Data Policy

Additional Guidance

N/A