blue california
Promise Health Plan

Access to Care: Best Practices 2023

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys measure patient experience for all health plans and products. Employer groups, the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (for Medicare) and the Department of Health Care Services (for Medi-Cal) rely on the results of those surveys to improve patient experience.

It is important to remember that patients' responses to CAHPS surveys capture their perception of their experience and what occurred during the visit, or a follow-up visit that your team performed while providing care.

We're providing this document that your practice can use for achieving the best possible outcomes in Getting Needed Care and Getting Care Quickly, rooted in best practice and industry standards.

Patient experience questions in the CAHPS survey:

Getting Needed Care

- In the last 6 months, how easy was it to get care, tests or treatment needed?
- In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

Getting Care Quickly

- In the last 6 months, how often did you get an appointment for a checkup or routine care as soon as you needed?
- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

DHCS and NCQA publish these standards for access to care:

• Routine – 10 business days • Preventive – 30 calendar days • Urgent/Care Right Away – within 48 hours of request • Specialty non-urgent – 15 business days • Specialty – urgent – within 48 hours of request if no authorization is needed/96 hours if authorization is needed.	While these are the required standards, DHCS measures the patient's perception of access.

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Best Practices

Getting Needed Care

CAHPS question: In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

Best Practices at Medical Group Level:

- Monitor phone line hold-time and improve, if possible. This can help reduce abandonment rate, repeat callers, and missed appointments.
- Make it easy to cancel unnecessary appointments. Supply a phone tree for patients to schedule or cancel appointments.
- Allow patients to schedule appointments online.
- Survey patients at the PCP and specialty level, rather than the group level. This may help you to identify any issues that are clinician specific.
- Ask labs, radiology, and other vendors to provide members with surveys that ask how easy it was to use their services. Provide survey results on a regular basis to the medical group.

Best Practices at Clinic / Provider Level:

- Enhance patient scheduling by having the office manager monitor the providers' appointment schedule daily for potential access problems, including checking third next available appointment availability and same-day open slots availability.
- Ask the office staff to schedule each patient's next appointment before the patient leaves the office. Each week, the office manager may want to perform a quick random audit to confirm that the front office staff has done this.

CAHPS question: In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

Best Practices at Medical Group Level:

- Survey specialists' patients. This will allow the group to know when certain specialists have more barriers than others.
- Perform regular office surveys to assess availability of specialist appointments—especially with high-volume specialists. The surveys do not have to be a blind survey. Ask for third next available appointments.
- Review time and distance associated with current specialty network providers. Are there long commute times to the nearest specialist for some patients within your service area?
- Review prior authorization lists and perform analyses to find those that are seldom denied, especially those with higher volumes, and consider dropping those from requiring prior authorization.

Best Practices at PCP Clinic / Provider Level:

- Confirm that the specialist is accepting new patients before making a referral.
- Schedule a patient's specialist appointment at the end of visit.
- Ensure staff is trained and knows which referrals need Blue Shield Promise's authorization and those that do not need Blue Shield Promise's authorization.
- When needed, submit prior authorization requests immediately.
- When referring a patient, consider providing a document to the patient which sets expectations and lets the patient know whom to call if they have questions or concerns.
- Establish a referral coordinator, with a dedicated phone number, for patients, or use a phone tree with an option to reach the referral coordinator.
- Establish a process where a referral coordinator contacts patients within 24 hours after they receive a referral.
- Return messages from patients within two (2) hours.

Best Practices at Specialist Clinic / Provider Level:

- When a patient cancels an appointment at the last minute, contact other patients who may be able to fill the appointment.

Getting Care Quickly

CAHPS question: **In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?**

Best Practices at Medical Group Level:

- Survey primary care physicians' (PCPs) patients. Profile PCPs about their performance. Provide a financial incentive for improved access.
- Monitor access with third next available appointment. Quarterly is a good frequency.
- Understand and address missed appointments. These impact routine care availability and frustrate clinic staff.
- Standardize appointment types and durations, limiting provider schedule preferences.
- Develop open access schedules.

Best Practices at Clinic / Provider Level

- Set patients' expectations when they call for an appointment. For example, you might say "Our standard scheduling time for this type of appointment is 10 business days. We're able to schedule you in eight (8) days. Would you like this appointment?"
- Offer alternatives to patients if they cannot see their PCP as soon as needed.
    - Alternate provider (same office or nearby)
    - Mid-level provider (nurse practitioner or physician assistant, for example)
    - Weekend or evening appointments
    - Walk-in clinic
    - Contracted urgent care center
    - Telehealth
- Call or send appointment reminders, including texting, 24 hours prior to patient office visits. Call patients scheduled for longer appointments, to avoid losing a 30-plus minute slot.
- Offer to schedule follow-up appointments as part of a patient's discharge process.

CAPHS question: **In the last 6 months, when you needed care right away, how often did you get an appointment as soon as you needed?**

Best Practices at Medical Group Level:

- Communicate care options to your patients via posters, email, newsletters, etc.
- Monitor access to next available appointments. Monthly monitoring is a good frequency.
- Create frozen / reserved slots for urgent appointments.
- Staff clinics with mid-level providers to handle same-day appointments.
- Develop open access schedules.
- Develop process and procedures to utilize late cancelations for wait list patients.
- Develop a call center script and train patient services representatives to offer alternatives such as mid-level providers, alternate providers, urgent care, or walk-in clinics.

Best Practices at Clinic / Provider Level:

- Utilize mid-level providers for same-day access.
- Train and monitor patient services representatives to offer alternatives such as mid-level providers, alternate providers, urgent care, or walk in clinics.
- When a patient cancels an appointment at the last minute, contact other patients who may be able to fill the appointment.

CAPHS question: **In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?**

There is a high correlation between the patient's telephone experience and their overall satisfaction with the clinic and provider. When a message is not returned in a timely manner, patients may feel they are not important, or the doctor or clinic does not care about them.

Best Practices at Medical Group or Clinic / Provider Level:

- Develop written call-back guidelines and standards.
- Consider batch scheduling. For example, schedule three 20-minute slots for visits and one 20-minute slot for indirect care. Primary care has a 5:1 ratio of indirect to direct care activities. Don't put off indirect work to the end of the day.
- Set a same-day call-back cut-off time, e.g., messages left after 4 p.m. will be returned the next morning by 10 a.m. Advertise the cut-off time as often as possible with every patient. Setting expectations is the key.
- Assign each message to a staff member for follow-up.
- Track and communicate message return compliance. Ensure that the call-back commitment window can be consistently achieved by your team.
- Call the patient back on the same day, even if an answer or resolution to the patient's inquiry has not been realized. Let the patient know you and your team are working on getting the information they need.
- Reduce message volumes
    - Perform a telephone traffic study. Log every call and the reason for the call, for one to two weeks.
    - Channel your calls based on the traffic study. For example, 1) Appointments, 2) Referral inquiries, 3) Pharmacy, 4) Test results, 5) Questions for clinical team, etc.
    - Fix the root cause of high-volume calls. For example, enhance expectations and instructions for referrals, ensure that every patient has a visit summary, that test results are communicated every time, and patients are educated about calling their pharmacy, etc.
- Encourage the use of a patient portal (if it is available).