POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Evaluation of the Accessibility of Services
PAGE: 1 of 33	**REPLACES DOCUMENT:**
APPROVED DATE: 09/11	**RETIRED:**
EFFECTIVE DATE: 01/12;12/15	**REVIEWED/REVISED:** 09/13; 11/13; 1/14; 9/14; 9/15; 9/16, 9/17, 9/18; 4/20
PRODUCTS: Medicaid	**REFERENCE NUMBER:** LA.QI.05

SCOPE:
Louisiana Healthcare Connections (Plan) Quality Improvement, Provider Consultant, and Member Services Departments

PURPOSE:
To outline and define the mechanism utilized to monitor member access to primary care services, specialty services, and member services.

POLICY:
The Plan Provider Consultant department measures access to practitioner services at least annually. The Plan Member Services department measures telephone access to the member services department at least monthly The Quality Improvement Committee (QIC), or designated subcommittee, will analyze the data and make recommendations to address deficiencies in member access to practitioners or member services. Results are reported and reviewed by the QIC.

PROCEDURE:

A. Medical Appointment Access Standards

1. Plan will establish quantifiable and measurable standards for appointment access.

Appointment Type	**Access Standard**
PCPs – routine, non-urgent or preventative visits	6 weeks
PCPs – non-urgent sick care	72 hours or sooner if medical condition deteriorates into an urgent or emergent condition
PCPs – urgent care	24 hours
Emergent or emergency visit	Immediately upon presentation
Walk-In- non urgent needs	Should be seen if possible or scheduled for an appointment consistent with written scheduling procedures
Specialist	Within one (1) month of referral or as clinically indicated
Lab and X-ray services (usual and customary)	Not to exceed 3 weeks for regular appt. and 48 hours

	for urgent care or as clinically indicated
Direct Contact	Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times

Pregnant Women

Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetable from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing member or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy.

Initial prenatal visits for newly enrolled pregnant women within their first trimester	Within fourteen (14) days
Initial prenatal visits for newly enrolled pregnant women within the second trimester	Within seven (7) days
Initial prenatal visits for newly enrolled pregnant women within the third trimester	Within three (3) days
High risk pregnancies	Within three (3) days of identification of high risk by Louisiana Healthcare Connections or maternity care provider, or immediately if an emergency exists.

Behavioral Health Services

Emergent, crisis or emergency behavioral health services	Within one (1) hour of the request
Urgent behavioral healthcare	Within 48 hours of the request
Behavioral healthcare, routine, non-urgent	Within 10 business days/ 14 calendar days of the referral
Follow-up to Emergency Department visits	In accordance with ER attending provider discharge instructions.
In Office Waiting Time	Not to exceed 45 Minutes

In Office Waiting Time- If provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment time.	

2. Information regarding appointment access and waiting time standards are communicated via member/provider handbook and/or other written communication to members, network providers, and other groups as specified by the Plan.

3. At least annually, Plan analyzes appointment accessibility including routine, urgent and after-hours care against the standards it has defined.

24-Hour Access:

Louisiana Healthcare Connections PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to members as needed twenty-four (24) hours a day, three hundred sixty-five (365) days a year as follows:

• A provider's office phone must be answered during normal business hours

• During after-hours, a provider must have arrangements for:

1. Access to a covering physician,
2. Triage service, or
3. A voice message that provides a second phone number that is answered.
4. Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish speaking members.

Examples of Unacceptable After-Hours Coverage include, but are not limited to:

• The Provider's office telephone number is only answered during office hours;

• Returning after-hours calls outside thirty minutes.

The selected method of twenty-four (24) hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever

possible, PCP, specialty physician, or covering medical professional must return the call within thirty (30) minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

4. Data sources may include but are not limited to:
   a. Applicable results of the HEDIS/CAHPS survey. Survey questions applicable to assessing access to practitioner services include:
      - % of members who reported that they "always" or "usually" got regular or routine care as soon as they wanted it (satisfaction with timeliness)
      - % of members who reported that they "always" or "usually" got urgent appointments as soon as they wanted them (satisfaction with timeliness)

   b. Member complaints/grievances about access to specific practitioners, groups or geographic areas. On an annual basis, the Member Services Department will compile a report of all access-related issues documented during the prior 12-month period.

   c. Site specific surveys/audits regarding access to PCP offices. The Plan's Provider Consultants and/or Clinical Quality Improvement Department will conduct random access audits for PCP services using a standard audit methodology/tool.
      (a) Audits may be performed telephonically or onsite over the course of the year.
      (b) The sample of practitioners included in the audit must treat at least 50% of Plan total membership.
      (c) Providers must meet 90% compliance of the State defined standards noted above.
      (d) If minimum compliance is not met, the provider, network, or group will be asked to comply with a 2 step written Performance Improvement Plan (PIP)/ Corrective Action Plan.
      (e) Louisiana Healthcare Connections will send a letter notifying the practice they are not compliant and educate them on the acceptable After Hours coverage response. The practice will be responsible for making adjustments to become compliant with this LDH requirement (See attachment (E)

(f) Louisiana Healthcare Connections will monitor the implementation of the PIP. If after allowing the practice one (1)month to demonstrate a change and compliance is still not achieved, the following process will be followed: (See attachment F)

i. Louisiana Healthcare Connections will send a second letter to the practice indicating they are still not in compliance and ask that the practice complete and submit a Corrective Action Plan (CAP) within 2 weeks.(see attachment (G)) Another audit will be performed within the next quarter to document improvement.

ii. If the provider remains non-compliant after a second audit, the case will be brought to the Quality Improvement Committee for review and recommended next steps for corrective action.

B. Member Services Telephone Access Standards

1. The Plan collects and performs analysis to measure performance against defined telephone access standards as follows:
   - Ninety-five percent (95%) of all calls answered within 30 seconds. Calls are directed to an automatic call pickup system with IVR options
   - Less than one percent (1%) of calls receive a busy signal
   - Call abandonment rate less than or equal to five percent < (5%)
   - Average speed of answer less than 30 seconds

- Average hold time less than three (3) minutes. Hold time, or wait time, for the purposes of this RFP includes 1) the time a caller spends waiting for a customer service representative to assist them after the caller has navigated the IVR system and requested a live person; and 2) the measure of time when a customer service representative places a caller on hold. Results are reported to the QIC at least annually and are included in the annual QI Program Evaluation.

C. Analysis and Improvement

1. The assessment is reported to the QIC at the individual practitioner, physician network, and/or medical group levels and/or as an aggregate as appropriate by provider type at least annually, although interim quarterly reports may also be reported to the QIC.

2. The QIC, or designated subcommittee, will review the information for opportunities for improvement. Analysis of data must include practice-specific and Plan-wide comparison of results against the standard and analysis of the causes of any deficiencies (if appropriate) that must go beyond data display or simple reporting of results. (Attachment A)

3. Interventions will be developed where indicated. Examples of interventions include:
   - Expanding the network
   - Working with individual practices to improve their scheduling systems
   - Targeting a specific specialty or geographic area for special recruitment efforts

4. Effectiveness of interventions are measured and reported at least annually in the QI Program evaluation.

5. The audit and evaluation documents will be maintained in the Quality Improvement Department in a secure area. Access will be limited to those individuals outlined in the Quality Improvement Program Description

REFERENCES:
LA.MSPS.22 - Member Services Calls/Hotline
Current NCQA Health Plan Standards and Guidelines
LA CCN-P Contract – Section 7 Provider Network Standards

ATTACHMENTS:
Attachment A - Practitioner and Telephone Access Analysis Template- EXAMPLE
Attachment B - Access/Availability PMP Performance Audit Tool - EXAMPLE
Attachment C - Availability & Access Scripted Survey Questions – EXAMPLE
Attachment D- Primary Care Provider Response Time Survey Letter-EXAMPLE
Attachment E- Follow Up Second Letter-EXAMPLE
Attachment F- Corrective Action Plan (CAP) Template-EXAMPLE

DEFINITIONS:

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Primary Care Practitioner (PCP): a Family Practitioner, General Practitioner, Internist, OB/GYN (as required by State contract), Pediatrician or Nurse Practitioner meeting Plan guidelines.

REVISION	DATE
No changes	9/13
Updated references to NCQA 2013 Health Plan Standards and Guidelines	11/13
Inserted after-hours standard definition Under Procedure Section A	11/13
Changed 90% to 80% compliance goal; changed to a 2 step PIP/CAP plan; changed attachments to show as examples and not samples	1/14
Changed provider audit percentage to 90% compliance.	9/14
Changed Provider Relations to Provider Consultant. Changed frequency of Member Services telephone access to monthly. Defined QIC. Added to Procedure A Appointment type grid: Walk-In non Urgent Needs Lab and X-ray services (usual and customary) Family Planning Behavioral Health Services section In office waiting times Added 4C – e regarding non-compliant letters Change 4C – h to 1 month and referenced attachment Changed 4C – i to reference CAP Changed 4C – j to reference non-compliant instead of a % Added to section B 1 – IVR and less than 1% receive busy signal Defined hold and wait times Added attachments Updated NCQA date reference	9/15
Changed Provider Consultant to Louisiana Healthcare Connections Changed DHH to LDH Updated Attachment G Signature from Joseph Tidwell to Lacee Allen	9/16
Deleted Family Planning from Service Type Changed Behavioral Health, Routine, Non Urgent within 10 days instead of 14 days Removed Answering Service for During After Hours arrangements Removed Recordings from Unacceptable devices for After Hour arrangements	9/17
Added Direct Contact Information – per RFP 7.2.1.12 Added Maternity Care information – per RFP 7.2.1.7	9/18

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Attachment B – Updated Attachment C – Removed [Access/Availability Specialist Audit Tool] Attachment D – Updated Attachment E – Updated Attachment F – Updated Updates behavioral health routine standard to match RFP 7.2.1.4	
~~Updates behavioral health routine standard to match RFP 7.2.1.4~~ **Updated Attachment A** **Updated CAP letters**	4/20

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer GRC, Centene's P&P management software, is considered equivalent to a physical signature.

Sr. Manager, Provider Network Performance: ____Electronic Signature on File

VP, Network Development:_____ Electronic Signature on File_____

(Name of the Health Plan)

Practitioner and Telephone Access Analysis

(From date) to (To date)

Introduction

Consumers value timely access to medical care and telephone inquiries. (name of health plan) monitors primary care and behavioral health practitioner appointment and after hours accessibility annually against its standards, and initiates actions as needed to improve. Customer service and behavioral health telephone triage access also are monitored on a regular basis, and actions initiated when needed to improve performance. This report describes the monitoring methodology, results, analysis, and action.

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Instructions

This template is organized into three sections:

- PCP appointment access
- Behavioral health appointment access
- Customer service and behavioral health triage telephone access.

To ensure a smooth flow for the reader, each section summarizes measurement methods, results, analysis, actions, and committee reporting. If desired, you can remove any section and make it a free-standing document. Or, you can maintain all access analysis in a single document.

Throughout this template, text in parentheses indicates information that must be replaced, such as (name of health plan), or an action you must take to complete the report. As you work through writing the report, be sure to address all instances of text in parentheses.

If your organization delegates behavioral health to a NCQA-accredited MBHO, you will receive auto-credit for the behavioral health requirements and do not need to include behavioral health information in this report.

This report uses sample language to illustrate report preparation. Modify the sample language to reflect your organization's process.

Section I: Primary Care Physician Appointment Access

Standards and Methodology

(Name of health plan) monitors primary care physician (PCP) appointment accessibility and after hours access to ensure members have access to medical care 24 hours a day, 7 days a week.

Table 1 lists the primary care physician standards, measurement method, and measurement frequency for each aspect of performance that is monitored.

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Instructions

Use the table below to outline your primary care appointment and after hours standards, measurement methods and frequency.

- The types of primary care appointment types that must be monitored are listed in column 1 (including PCP after hours access). Modify the entries in this column to match your organization's appointment types and categories.
- List your organization's accessibility standard and performance goal for each appointment type in column 2. This column is pre-populated with the most common standards used to meet NCQA's requirements, but other options exist that also meet the requirements. Please refer to the examples in the current NCQA *Standards and Guidelines* for acceptable methods to express these standards. If you have any questions about your organization's standards or performance goals, please discuss with your Tashidy consultant. Modify the entries in this column to match your organization's standards and performance goals for each appointment type.
- List the measurement method for each standard in column 3. This column is pre-populated with the most common methods used to meet NCQA's requirements, but other options exist that also meet the requirements. Note that NCQA requires the measurement method to align with the standards. That means if you are using CAHPS survey questions to assess PCP appointment access, then your standard must be expressed using the same variables as the CAHPS questions. Please refer to the examples in the current NCQA *Standards and Guidelines* for acceptable methods to express these standards.
  If your measurement method involves sampling for any of the access measures, indicate that in the appropriate cell and describe the sample criteria and process in a paragraph below the table. Please note that NCQA requires that samples for the PCP measures must include PCPs that treat at least 50% of the organization's members. If you have any questions about your organization's measurement methods, please discuss with your Tashidy consultant. Modify the entries in this column to match your organization's measurement methods for each appointment type.
- List the measurement frequency in column 4. NCQA requires at least annual measurement. If your organization performs the analysis more often than annually, discuss with the consultant whether it is necessary for you to report all the measurement periods to NCQA.

Table 1: Standards and Measurement Methods by Appointment Type

Appointment Type	Standard and Performance Goal	Measurement Method	Measurement Frequency
Primary care routine appointments	(XX)% of members report they always or usually obtained urgent appointments as soon as they wanted it (CAHPS question 20) and Rate of member complaints about appointment access is less than 0.(X) per 1000 members	CAHPS member satisfaction survey ~~Complaint analysis~~**Secret shopper outreach calls**	Annually Annually
Primary care urgent appointments	(XX)% of members report they always or usually obtained regular or routine care as soon as they wanted it (CAHPS question 19) and ~~Rate of member complaints about appointment access is less than 0.(X) per 1000 members~~	CAHPS member satisfaction survey ~~Complaint analysis~~ **Secret shopper outreach calls**	Annually Annually

Table 1: Standards and Measurement Methods by Appointment Type

Appointment Type	Standard and Performance Goal	Measurement Method	Measurement Frequency
Primary care after hours care	xx~~100~~% of PCP offices have an after hours access mechanism that meets health plan standards	Calls to PCP offices after hours	Annually

Results

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Instructions

Use table 2 to summarize your monitoring results, and begin analysis by indicating whether the goal is met.

- Copy the appointment types from column 1 in Table 1 to column 1 in Table 2.
- Copy the organization's standard from column 2 in Table 1 to column 2 in Table 2.
- In column 3, report your plan-wide monitoring results for each measure.
- In column 4, insert a Yes if results met or exceed the goal and a No if results are less than the performance goal. NCQA expects the organization to implement actions if the goal is not met.

All rows are filled in to illustrate how to complete the table. Modify this information to accurately reflect your organization's process.

Table 2: Measurement Results and Comparison to Performance Goal by Appointment Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
Primary care routine appointments	(XX)% of members report they always or usually obtained regular or routine care as soon as they wanted it (CAHPS question 19) and Rate of member complaints about appointment access is less than 0.(X) per 1000 members	62% of members reported they always or usually obtained regular or routine care as soon as they wanted it 0.08 access complaints per 1000 members	No Yes
Primary care urgent appointments	(XX)% of members report they always or usually obtained urgent appointments as soon as they wanted it (CAHPS question 20) and Rate of member complaints about appointment access is less than 0.(X) per 1000 members		
Primary care after hours care	100% of PCP offices have an after hours access mechanism that meets health plan standards		

Analysis

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Instructions

Write a narrative summary of the quantitative analysis which includes:

- Comparing results to the performance goal
- Trending results over measurement periods
- Summarizing the results of any drill down analysis performed

A sample quantitative analysis appears below. Modify the sample to reflect your results and analysis.

CAHPS survey results showed that routine appointment access did not meet the performance goal, while urgent appointment access did. (XX)% of CAHPS respondents reported that they waited between 0 to 14 days to obtain an appointment for non-urgent care, with (XX)% reporting they obtained an appointment the same day, while (X)% waited 1 day, (X)% waited 2-3 days, (X)% waited 4-7 days, and (X)% waited 8-14 days. (XX)% of members reported they waited more than (name of health plan)'s standard for routine appointment access is within 10 business days. (X)% waited 15-30 days, and (X)% waited 31 days or longer. Although the member complaint rate was within our performance goal threshold, the CAHPS results demonstrate members are not able to consistently obtain a routine appointment within a timeframe that meets their expectations. Barrier analysis on this topic is discussed later in this report.

X% of PCP offices did not have an acceptable method of providing after hours access for members. The table below details the areas in which PCP offices did not meet health plan standards.

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Instructions

Create or modify table 3 to report detailed results of your after hours access monitoring. At a minimum, include the following:

- The criteria used to assess after hours access
- The number and percent of PCP offices that were compliant (or non-complaint) with each criterion
- Any comments or discussion of results, especially explanations of why the criterion was not met. For example, you might indicate: The phone number for two PCP offices was disconnected, in three other offices the phone was not answered when called after hours.

Table 3 After Hours Access Detailed Results

Criteria	# & % Compliant	Comments

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Instructions

If all results met the performance goal, NCQA allows the organization to conclude there are no improvement opportunities, and to repeat monitoring the next year.

If this situation applies to your organization, cut the paragraph below and paste it into the body of the report. Delete all other content from this section of the report EXCEPT the committee reporting information at the end. Finalize the report and submit it to the committee for approval. Fill out the committee report section after committee review, and the report is done!

Because all results met the performance goal we concluded there are no opportunities to improve PCP access at this time. (name of health plan) will continue monitoring PCP access on an annual basis.

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Instructions

Next, summarize the results of your barrier analysis to identify the root causes driving performance for any measure that did not meet the performance goal. Specify:

- Participants in the barrier analysis.
- Methods used to conduct the barrier analysis, i.e., brainstorming, process flow diagrams, fish bone diagrams, focus groups or interviews with members or practitioners, etc.
- Opportunities identified as a result of barrier analysis.

A sample barrier analysis summary appears below. Modify the sample to reflect your barriers and opportunities. Delete the sample text from the first two rows of the table and replace it with your organization's information.

A group of internal staff completed the initial barrier analysis. Participants included a QI analyst, and two provider relations representatives. The group brainstormed the following potential barriers and opportunities for improvement:

Table 4 Barrier Analysis Results

Barrier	Opportunity	Selected for Improvement?
~~Members expect to be able to obtain a routine appointment in less time that the doctor's office offers one~~	~~Establish incentive program for physician offices to move to open access scheduling~~	Yes
~~Some PCP offices are not aware their after hours access mechanism is not functioning~~	~~Inform the office of the failure and request a corrective action plan~~	Yes

Action

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Instructions

If your results did not meet the performance goal, NCQA expects organizations to initiate actions for improvement. Describe the actions implemented to reduce or remove the barriers to improvement. Use a table format similar to the one used in the QIA form, as illustrated below.

- List the month and year the action was implemented in column 1.
- Describe the action in column 2. Be specific, for example, Communicated new incentive program design and requirements to all PCP offices via letter.
- Copy the barrier the action addressed from column 1 in Table 4 to column 3 in Table 5.

Table 5 Planned Actions

Date Initiated	Action Implemented	Barriers Addressed

Reporting

Delete this table before finalizing the report

Instructions:

Use this next section to summarize reporting to QI committees. The intent of this section is to facilitate retrieval of information from QI committee minutes when needed, and reduce or eliminate the need to attach meeting minutes to the web-based Survey Tool.

Sample text is included in row 1. Delete the sample text and insert information based on your organization's committee reporting.

This QI activity was reported to the following QI committees:

Table 6 Committee Reporting

Committee Name	Meeting Date	Committee Actions or Recommendations
~~Quality Improvement Committee~~	~~January 13, 2006~~	~~Reviewed monitoring results, analysis, and proposed actions. Approved action plan.~~

Section II: Behavioral Health Appointment Access

(Name of health plan) monitors behavioral health appointment access to determine whether members can receive timely appointments based on severity of illness.

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Instructions

Use the table below to outline your behavioral health appointment standards, measurement methods and frequency.

- The types of behavioral health appointment types that must be monitored are listed in column 1. Modify the entries in this column to match your organization's appointment types and categories.
- List your organization's accessibility standard and performance goal for each appointment type in column 2. NCQA specifies the minimum requirements for behavioral health appointments; these are pre-loaded into the table along with recommended performance goals. Modify the entries in this column to match your organization's performance goals for each appointment type. If you have any questions about your organization's standards or performance goals, please discuss with your Tashidy consultant.
- List the measurement method for each standard in column 3. This column is pre-populated with the most common methods used to meet NCQA's requirements, but other options exist that also meet the requirements. Note that NCQA requires the measurement method to align with the standards. Please refer to the examples in the current NCQA *Standards and Guidelines* for acceptable methods to express these standards.
  If your measurement method involves sampling for any of the access measures, indicate that in the appropriate cell and describe the sample criteria and process in a paragraph below the table. Please note that NCQA requires that samples for the behavioral health appointment measures must include practitioners that treat at least 50% of the organization's members. If you have any questions about your organization's measurement methods, please discuss with your Tashidy consultant. Modify the entries in this column to match your organization's measurement methods for each appointment type.
- List the measurement frequency in column 4. NCQA requires at least annual measurement. If your organization performs the analysis more often than annually, discuss with the consultant whether it is necessary for you to report all the measurement periods to NCQA.

Table 7: Behavioral Health Standards and Measurement Methods by Appointment Type			
Appointment Type	**Standard and Performance Goal**	**Measurement Method**	**Measurement Frequency**
Behavioral health routine appointments	(X)% of members with routine needs obtain an appointment within 10 business days	Analysis of case management records which document date member requested routine care appointment and date claim reports member received care	Ongoing data tracking, report and analyze quarterly
Behavioral health urgent appointments	xx~~97~~% of members with urgent needs obtain an appointment within 48 hours	Analysis of case management records which document date member assessed with urgent care needs and date of appointment	Ongoing data tracking, report and analyze quarterly
Behavioral health non-life threatening emergency appointments	xx~~99~~% of members with non-life threatening emergent needs obtain an appointment within 6 hours	Analysis of case management records which document date and time member assessed with emergent care needs and date and time of appointment	Ongoing data tracking, report and analyze quarterly

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Instructions

Since administrative data is more likely to be used for the behavioral health access measures, you may be reporting and analyzing the data more frequently than once a year. Table 8 is formatted to display quarterly results and an aggregate annual rate. Modify the table layout as needed to fit your data.

- Column 1 lists each of the required behavioral health appointment access categories.
- Insert the quarterly results for each appointment category into columns 2-5 respectively.
- Insert the annual results for each appointment category into column 6.
- In column 7, insert a Yes if results met or exceed the goal and a No if results are less than the performance goal. NCQA expects the organization to implement actions if the goal is not met.

Be sure to report both the raw rate (XX/XX) and the percentage when reporting the data. The raw rate provides context to the reported percentages; 50% of 121 is very different than 50% of 10. All rows are filled in to illustrate how to complete the table. Modify this information to accurately reflect your organization's process.

Table 8 Behavioral Health Appointment Access Monitoring Results

Behav. Health Appt Type	Qtr 1	Qtr 2	Qtr 3	Qtr 4	200X Total	Goal Met? Yes or No
Routine	XX/XX 79%	XX/XX 74%	XX/XX 72%	XX/XX 69%	XX/XX 73.5%	Yes
Urgent	XX/XX 99%	XX/XX 100%	XX/XX 98%	XX/XX 97%	XX/XX 98.5%	Yes

Table 8 Behavioral Health Appointment Access Monitoring Results

Behav. Health Appt Type	Qtr 1	Qtr 2	Qtr 3	Qtr 4	200X Total	Goal Met? Yes or No
Non-life threatening emergent	XX/XX 100%	XX/XX 99%	XX/XX 98%	XX/XX 97%	XX/XX 98.5%	No

Routine and urgent behavioral health appointment access met the goal, while non-life threatening emergent appointments did not. The majority of members with non-life threatening emergent behavioral health needs go directly to the emergency room; in 200X, only (XX) contacted the health plan with a non-life threatening emergent behavioral need. (name of health plan) intentionally sets a very high performance goal for this aspect of access, given the potential ramifications if members with emergent needs are not seen timely. However, some members with emergent needs simply refuse an appointment within the 6 hour window, preferring to wait until their usual therapist is available. Case managers utilize their judgment about whether to honor this request based on the member interaction during the assessment of member needs. Upon analyzing the cases in which members did not obtain emergent care within the 6-hour window, we found no opportunity to improve case manager practice or internal procedures. We will continue to monitor this closely and analyze each non-compliant case to identify any actionable opportunities.

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Instructions

If all results met the performance goal, NCQA allows the organization to conclude there are no improvement opportunities, and to repeat monitoring the next year.

If this situation applies to your organization, cut the paragraph below and paste it into the body of the report. Delete all other content from this section of the report EXCEPT the committee reporting information at the end. Finalize the report and submit it to the committee for approval. Fill out the committee report section after committee review, and the report is done!

Because all results met the performance goal we concluded there are no opportunities to improve behavioral health appointment access at this time. (name of health plan) will continue monitoring behavioral health appointment access on an annual basis.

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Instructions

Next, summarize the results of your barrier analysis to identify the root causes driving performance for any measure that did not meet the performance goal. Specify:

- Participants in the barrier analysis.
- Methods used to conduct the barrier analysis, i.e., brainstorming, process flow diagrams, fish bone diagrams, focus groups or interviews with members or practitioners, etc.
- Opportunities identified as a result of barrier analysis.

A sample barrier analysis summary appears below. Modify the sample to reflect your barriers and opportunities. Delete the sample text from the first row of the table and replace it with your organization's information.

A group of internal staff completed the initial barrier analysis. Participants included the behavioral health clinical director, a QI analyst, and two provider relations representatives. The group brainstormed the following potential barriers and opportunities for improvement:

Table 9 Barrier Analysis Results

Barrier	Opportunity	Selected for Improvement?
~~Some members with a non-life threatening behavioral need prefer to wait for an appointment with their established therapist~~	~~Case managers assess safety of this request, and approve request if deemed safe, otherwise intervene~~	Yes

Action

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Instructions

If your results did not meet the performance goal, NCQA expects organizations to initiate actions for improvement. Describe the actions implemented to reduce or remove the barriers to improvement. Use a table format similar to the one used in the QIA form, as illustrated below.

- List the month and year the action was implemented in column 1.
- Describe the action in column 2. Be specific, for example, Clinical director reviews all non-life threatening emergent cases that do not meet goal on a monthly basis to ensure case managers use sound judgment when granting member requests to defer appointments to see a therapist with whom they have an established relationship.
- Copy the barrier the action addressed from column 1 in Table 9 to column 3 in Table 10.

Table 10 Planned Actions

Date Initiated	Action Implemented	Barriers Addressed

Reporting

Delete this table before finalizing the report

Instructions:

Use this next section to summarize reporting to QI committees. The intent of this section is to facilitate retrieval of information from QI committee minutes when needed, and reduce or eliminate the need to attach meeting minutes to the web-based Survey Tool.

Sample text is included in row 1. Delete the sample text and insert information based on your organization's committee reporting.

This QI activity was reported to the following QI committees:

Table 11 Committee Reporting

Committee Name	Meeting Date	Committee Actions or Recommendations
~~Quality Improvement Committee~~	~~January 13, 2006~~	~~Reviewed monitoring results, analysis, and proposed actions. Approved action plan.~~

Table 11 Committee Reporting

Committee Name	Meeting Date	Committee Actions or Recommendations

Section III Customer Service and Behavioral Health Triage Telephone Access

(Name of health plan) monitors telephone access to customer service and behavioral health triage lines to assure members can access assistance when they need it.

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Instructions

Use the table below to outline your telephone accessibility standards.

- Column 1 lists the functional areas for which NCQA requires telephone accessibility monitoring. You may add other functional areas to this table if you wish to report that data here as well, but do not delete the current entries that relate to NCQA requirements. Modify the entries in this column to match your organization's names for these functional areas. If your organization contracts with a NCQA-accredited MBHO you do not have to report the behavioral health results and can delete that row from the table and subsequent portions of this section of the report.
- Column 2 lists the performance goal and standard for average speed of answer. This column is pre-populated with the most common industry standards. Modify the entries in this column to match your organization's customer service standards and performance goals. NCQA specifies the minimum requirements for behavioral health telephone triage; these are pre-loaded into the table. Enter your organization's performance goals where indicated by text in parentheses. If you do not enter a performance goal, then NCQA is likely to assume that the goal is 100% compliance.
- Column 4 is labeled Organization Standard and allows you to enter an organizational standard not required by NCQA if desired. Insert the metric name, for example, Blockage rate in the table heading, and the standard and performance goal in the respective rows. If there are no other organizational standards, you may delete this column. To do so, highlight the table heading row that begins with the left column heading Functional Area. Open the Table drop down menu, and select Split table. Delete the far right column, adjust column widths so the entire table matches the table heading width, and rejoin the heading to the table.
- The last row of the table describes the measurement method used for this data. If your organization uses something other than your telephone system's automatic call distribution software to derive these statistics, please discuss how to summarize the measurement methods used with your Tashidy consultant.

If you have any questions about your organization's standards or performance goals, please discuss with your Tashidy consultant.

Table 12 Telephone Access Standards

	Goals for Performance Metrics		
Functional Area	**Avg. Speed to Answer**	**Abandonment Rate**	**(Organizational Standard)**
Customer Service	XX% within 30 seconds or less	Less than 5% over 12 calendar months	(Specify your organization's standard)
Behavioral Health Access Line	XX% within 30 seconds or less	Less than 5% over 12 calendar months	(Specify your organization's standard)

Measurement method: automatic call distribution software

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Instructions

Use table 13 to summarize your telephone access monitoring results, and begin analysis by indicating whether the goal is met.

- Column 1 lists the metrics for each functional area. If you added additional functional areas to table 2, add those here as well.
- Insert the quarterly results for each metric into columns 2-5 respectively.
- Insert the annual results for each metric into column 6.
- In column 7, insert a Yes if results met or exceed the goal and a No if results are less than the performance goal. NCQA expects the organization to implement actions if the goal is not met.

The first two rows are filled in to illustrate how to complete the table. Modify this information to accurately reflect your organization's process, and complete the remainder of the table.

Because some people prefer to see numbers and others prefer pictures, if available, insert charts below table 13 that show the results for these monitors over a 12-month (or longer) period. It is easier to see how data fluctuated from month to month in graphic form. Graphs are less important if the results met goal and were fairly stable over time.

Table 13 Telephone Access Monitoring Results

Metric	Qtr 1	Qtr 2	Qtr 3	Qtr 4	200X Total	Goal Met? Yes or No
Cust. Svc ASA in 30 sec.	54%	82%	79%	65%	70%	No
Cust. Svc Abd. Rate	8%	4.8%	6.3%	7.1%	6.55%	No
BH Access ASA in 30 sec.						
BH Access Abd. Rate						

(Insert graph of telephone access results here if available)

Neither of the customer service telephone access measures met the performance goal, although both of the behavioral health access line measures met the performance goal. Review of the monthly customer service telephone access results demonstrate that goals were met only two months of the year, in May and June. The remainder of the year performance was below goal, with the largest gaps in the first and fourth quarter of the year. Barriers to improvement and actions are discussed below.

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Instructions

If all results met the performance goal, NCQA allows the organization to conclude there are no improvement opportunities, and to repeat monitoring the next year.

If this situation applies to your organization, cut the paragraph below and paste it into the body of the report. Delete all other content from this section of the report EXCEPT the committee reporting information at the end. Finalize the report and submit it to the committee for approval. Fill out the committee report section after committee review, and the report is done!

Because all results met the performance goal we concluded there are no opportunities to improve (customer service and/or behavioral health triage) telephone access at this time. (name of health plan) will continue monitoring telephone access on a quarterly basis.

Delete this box before finalizing the document

Instructions

Next, summarize the results of your barrier analysis to identify the root causes driving performance for any measure that did not meet the performance goal. Specify:

- Participants in the barrier analysis.
- Methods used to conduct the barrier analysis, i.e., brainstorming, process flow diagrams, fish bone diagrams, focus groups or interviews with members or practitioners, etc.
- Opportunities identified as a result of barrier analysis.

A sample barrier analysis summary appears below. Modify the sample to reflect your barriers and opportunities. Delete the sample text from the first two rows of the table and replace it with your organization's information.

A group of internal staff completed the initial barrier analysis. Participants included the customer service call center manager, the call center trainer and a QI analyst. They brainstormed the following potential barriers and opportunities for improvement:

Table 14 Barrier Analysis Results

Barrier	Opportunity	Selected for Improvement?
CSR staff turnover leading to inadequate phone coverage in first and fourth quarters	• Recruit and train new staff to assure adequate staffing • Develop a career ladder to retain trained CSRs	Yes No
Implementation of new contact management system increased talk time and adversely impacted performance	• Analyze quality monitoring results to identify areas where CSRs find it challenging to access information and develop training exercises to build skills	Yes

Action

Delete this box before finalizing the document

Instructions

If your results did not meet the performance goal, NCQA expects organizations to initiate actions for improvement. Describe the actions implemented to reduce or remove the barriers to improvement. Use a table format similar to the one used in the QIA form, as illustrated below.

- List the month and year the action was implemented in column 1.
- Describe the action in column 2. Be specific, for example, Recruited 7 new CSRs in January, and 11 in October.
- Copy the barrier the action addressed from column 1 in Table 14 to column 3 in Table 15.

Table 15 Planned Actions

Date Initiated	Action Implemented	Barriers Addressed

Reporting

Delete this table before finalizing the report

Instructions:

Use this next section to summarize reporting to QI committees. The intent of this section is to facilitate retrieval of information from QI committee minutes when needed, and reduce or eliminate the need to attach meeting minutes to the web-based Survey Tool.

Sample text is included in row 1. Delete the sample text and insert information based on your organization's committee reporting.

This QI activity was reported to the following QI committees:

Table 16 Committee Reporting

Committee Name	Meeting Date	Committee Actions or Recommendations
Quality Improvement Committee	January 13, 2006	Reviewed monitoring results, analysis, and proposed actions. Approved action plan.

Access/Availability PMP Performance Audit Tool

Group Practice Name: **Group TIN:**	**Type; FP, OB, IM, Peds:** **Membership Panel:**	**Date of Contact:**		
Address:	**Region:**	**County:**		
Name of Contact:	**Phone Number:**	**PC Name:**		
INDICATOR **Accessibility Survey Measurements for PMP**	**OMPP Standard** **Total score = ≥80%**	**Points** **Next three available**		
1. Next available appointments for Routine, non-urgent and preventative care?	Within 6 weeks			
2. Next available appointments for non-urgent sick (including walk in)?	Within 72 hours or sooner			
3. Next available appointment for Urgent Care?	Within 24 hours			
4. Next available appointment for Emergency care?	Within 24 hrs			
5. What is the in-office wait time for scheduled appointment?	Not to exceed 45 minutes – If more than 90 minutes, members shall be offered new appointment			
6. Next available appointments for initial prenatal visits, 1st trimester?	Within 14 days			
7. Next available appointments for initial prenatal visits, 2nd trimester?	Within 7 days			
8. Next available appointments for initial prenatal visits, 3rd trimester?	Within 3 days			
9. Next available appointments for high risk pregnancies?	Within 3 days of identification of high risk by Louisiana Healthcare Connections or maternity care provider, or immediately if an emergency exists			
10. Next available appointments for routine, non-urgent, behavioral health care?	Within 10 days			
11. Next available appointments for urgent behavioral health care?	Within 48 hours			
12. Next available appointment for emergency behavioral health care?	Within 1 hour			
13. Wait time for referral to Specialty Care Provider?	Within 1 month of referral or as clinically indicated			
14. Wait time for lab and X-Ray services (usual and customary)?	Within 3 weeks for regular and 48 hours for urgent care or as Clinically indicated			

Availability & Access Scripted Survey Questions

PCP/Office Name: _____

Date of Survey:_____ Time/Place of Survey_____

Office Address _____Office Phone#: _____

Plan Employee Conducting Survey: _____

Question	Response/Outcome			Meets Standard Y/N
1. What are the next three available appointments for routine, non-urgent or preventative visits? (6wks)				
2. What are the next three available appointments for non-urgent sick care? (72 hrs)				
3. What are the next three available appointments for urgent care? (24 hrs)				
4. What is the next available appointment for Emergent care? (Immediately)				
5. What are the next three available appointments for non-urgent, routine, behavioral health care? (14 Days)				
6. What are the next three available appointments for urgent behavioral health care? (48 hrs)				
7. What is the next available appointment for emergent behavioral health care? (1 hr)				
8. What are the next three available appointments for initial prenatal visits, 1st trimester?(14 days)				
9. What are the next three available appointments for initial prenatal visits, 2nd trimester?(7 days)				
10. What are the next three available appointments for initial prenatal visits, 3rd trimester?(3 days)				
11. What are the next three available appointments for high risk pregnancies? (3 days)				
12. How long is wait time in office? (< or = to 45 minutes)				
13. How long is wait time for referral to Specialty Care Provider? (1 month of referral)				
14. How long is wait time for lab and x-ray services? (3 weeks, 48 hrs for urgent, as clinically indicated)				

TELEPHONE ACCESS – After Hours done by Nurse Wise		
•Call answered by a designated provider, a nurse, or a member of the PCP office staff?		
•Answering service –return call within 30 minutes?		
• Recording directing pt to call another # to reach PMP (or designee)?		
• Transferred after hours to another location where someone will answer the phone & contact the PMP who will return call within 30 minutes?		
• Recording directing members to local ER regardless of concern?		

<<date>>

«Practice Name »
ATTN: Practice Manager
«Add1», «Add2»
«City», «State» «Zip»

Attachment E- RE: Primary Care Provider Response Time Survey

GROUP Medicaid ID:

Dear Practice Manager:

Louisiana Healthcare Connections recently conducted a telephone survey in order to ensure our network providers are meeting the response time required by the Healthy Louisiana Medicaid contract. As outlined in the Louisiana Healthcare Connections Provider Manual, Healthy Louisiana-contracted PCP practices are required to provide access to medical advice and care for enrolled members 24 hours per day, 7 days per week. There must be prompt, defined as within thirty (30) minutes, access to a designated medical professional who is able to provide medical advice, consultation and authorization for service when appropriate. Furthermore, PCPs must have at least one telephone line that is answered by office staff during regular office hours.

Your practice was called on «Date » at «time » and was determined to be noncompliant with this requirement.

As required by our contract as a Healthy Louisiana Medicaid health plan, we will continue to monitor our contracted providers in order to ensure compliance with state appointment accessibility standards. Practices determined to be non-compliant with this requirement will be provided an opportunity to make adjustments to become compliant with this state requirement. If your practice remains out of compliance after a second audit, the case will be sent to the Quality Improvement Committee for review and recommended next steps for corrective actions.

Below is additional information on requirements for the handling of after-hour calls. These standards are also described in our Provider Manual in the 24-Hour Access Section.

Examples of Acceptable PCP After-Hours Coverage:

- The PCP's office telephone is answered after-hours by an answering service. All calls answered by an answering service must be returned within 30 minutes.
- The PCP's office telephone is answered after normal business hours by a recording directing the member to call another number to reach the PCP or another provider designated by the PCP who can return the call within 30 minutes.

8585 Archives Avenue, Suite 310 | Baton Rouge, LA 70809 | 866.595.8133 [T] | 866.700.6765 [F] | www.LouisianaHealthConnect.com

- The PCP's office telephone is transferred after office hours to another location where someone will be able to contact the PCP or another designated medical practitioner who can return the call within 30 minutes.

Examples of Unacceptable PCP After-Hours Coverage:

- The office telephone is only answered during office hours.
- The office telephone is answered after-hours by a recording that tells patients to leave a message.
- The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed 7 days a week.
- A clinician returning after-hours calls outside of the 30 minutes.

As a reminder, please note that Nurse Advice is a 24/7 nurse hotline is available to our members. This nurse line is staffed by Registered Nurses and is available 24 hours a day, seven days a week. These nurses will help your patients – our members - determine where to go to receive the most appropriate level of care and to answer our members' healthcare questions. Please encourage Louisiana Healthcare Connections members to call **1-866-595-8133 (TTY:711)** any time, day or night.

If you have any questions or concerns about this issue, please feel free to contact me or your assigned Provider Consultant.

Sincerely,

Joseph Tidwell
VP Provider Network and Contracting

jotidwell@louisianahealthconnect.com

Date

Name
Company (if applicable)
Address
City, State, zip code

Dear <<name>>:

Louisiana Healthcare Connections conducts random call audits of our network providers to check appointment availability, as required by our contract. We recently called your office a second time to review if you meet the appointment availability standards as described in our Provider Manual.

At the time of our calls, you did not meet the requirements of your contract, which are;

Examples of Acceptable PCP After-Hours Coverage:

- The PCP's office telephone is answered after hours by an answering service. All calls answered by an answering service must be returned within 30 minutes.
- The PCP's office telephone is answered after normal business hours by a recording directing the member to call another number to reach the PCP or another provider designated by the PCP who can return the call within 30 minutes.
- The PCP's office telephone is transferred after office hours to another location where someone will be able to contact the PCP or another designated medical practitioner who can return the call within 30 minutes.

To address this issue, Louisiana Healthcare Connections asks that you submit the attached Corrective Action Plan (CAP) to us within two weeks of receipt of this letter. Please describe the internal processes you have changed/will change to meet this section of your contract. The CAP offers some suggestions, but you may edit these to meet your needs. Once your interventions are in place, Louisiana Healthcare Connections will conduct another call to verify that you meet after-hours availability standards. We will notify you of our findings after that call.

If you have any questions or concerns about this issue, please contact your Provider Consultant, «PSR name » at «PSR phone» or via email at «PSR email address ». Your prompt attention to this matter is appreciated.

Sincerely,

Joseph Tidwell
VP Provider Network and Contracting

jotidwell@louisianahealthconnect.com

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Corrective Action Plan (CAP) Template:

Organization / Individual Name:

Date of CAP:

Check if Applicable	Issue	Action	Person Assigned	Outcome
	Staff not aware of contractual obligations	Train all staff regarding urgent and routine appointment availability		
	Staff needs re-education regarding scheduling of routine and urgent appointment availability	Train all staff regarding urgent and routine appointment availability		
	Revision of schedules to accommodate urgent appointments	Extend schedules as needed at the beginning or end of the day or over the lunch hour to accommodate a request for an urgent appointment within 24 hours		
	Revision of schedules to accommodate routine appointments	Establish a visit schedule with existing patients at the first visit to accommodate their needs for routine appointments		
	Develop plan for 24/7 provider coverage	Establish a plan to have a provider available to respond to members call afterhours within 30 min		

«Practice Name »
ATTN: Practice Manager
«Add1», «Add2»
«City», «State» «Zip»

Attachment E- RE: Primary Care Provider Response Time Survey

GROUP Medicaid ID:

Dear Practice Manager:

Our company recently conducted a telephone survey in order to ensure that network providers were meeting the response time required by the Healthy Louisiana Plan. As is outlined in our LHCC Provider Manual, Healthy Louisiana contracted PCP practices are required to provide access to medical advice and care for enrolled members 24 hours per day, 7 days per week. There must be prompt, within thirty (30) minutes, access to a designated medical **professional**~~practitioner~~ who is able to provide medical advice, consultation, and authorization for service when appropriate. Furthermore, PCPs must have at least one telephone line that is answered by office staff during regular office hours.

Your practice was called on «Date » at «time » and we were able to verify that your practice was noncompliant with this requirement.

We will continue to monitor our contracted providers in order to ensure compliance with this Healthy Louisiana Plan requirement. Practices that are out of compliance with this requirement will be given an opportunity to make adjustments to become compliant with this LDH requirement. If your practice remains out of compliance after a second audit, the case will be brought to the Quality Improvement Committee for review and recommended next steps for corrective actions.

Below is additional information on requirements of how after-hour calls should be handled by your practice. These details are indicated in our Provider Manual under the 24-Hour Access Section.

Examples of Acceptable PCP After-Hours Coverage:

- The PCP's office telephone is answered after-hours by an answering service. All calls answered by an answering service must be returned within 30 minutes.
- The PCP's office telephone is answered after normal business hours by a recording directing the member to call another number to reach the PCP or another provider designated by the PCP, who can return the call within 30 minutes.
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- The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed 7 days a week.
- A clinician returning after-hours calls outside of the 30 minutes.

Nurse Advice is a 24/7 nurse hotline is available to your members. This nurse line is staffed by registered nurses and is available 24 hours a day, seven days a week and they will help your members determine if they need the ER (Emergency Room), an Urgent Care Clinic or you, their Primary Care Provider. The nurses are available to answer your LHCC members' health care questions. Please encourage your LHCC member to call **1-866-595-8133 (TDD/TTY 1-877-285-4514)** any time, day or night.

If you have any questions or concerns about this issue, please contact myself or your assigned LHCC Provider Consultant.

Sincerely,

Joseph Tidwell
VP Provider Network and Contracting
Louisiana Healthcare Connections
3854 American Way, Ste B
Baton Rouge, LA 70816
jotidwell@louisianahealthconnect.com
~~Akiko Toussant Barrow~~
~~Director, Provider Network~~
~~Louisiana Healthcare Connections~~
~~3854 American Way, Ste B~~
~~Baton Rouge, LA 70816~~
~~Phone number 225.439.1028~~
~~AkBarrow@centene.com/ www.louisianahealthconnect.com~~

Month, Day, Year

Name
Company (if applicable)
Address
City, State, zip code

Dear <<name>>:
LHCC conducts random call audits of our Network Providers to check appointment availability, as required by our contract. We recently called your office a second time to ascertain if you meet the appointment availability standards as listed in your Provider Manual.
At the time of our calls, you did not meet the requirements of your contract, which are as follows;

Examples of Acceptable PCP After-Hours Coverage:

- The PCP's office telephone is answered after-hours by an answering service. All calls answered by an answering service must be returned within 30 minutes.
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To address this issue, LHCC asks that you submit the attached Corrective Action Plan (CAP) to us within two weeks of receipt of this letter. In the CAP, please address what internal processes you have changed / will change to meet this section of your contract. The CAP has some suggestions, but you should edit to meet your needs. Once your interventions are in place, LHCC will place another call to assure that you meet after hours availability standards. You will be notified after that call as to our findings.

If you have any questions or concerns about this issue, please contact your LHCC Provider Consultant, «PSR name » at «PSR phone» or via email at «PSR email address ».Your prompt attention to this matter is appreciated.

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Corrective Action Plan (CAP) Template:

Organization / Individual Name:

Date of CAP:

Check if Applicable	Issue	Action	Person Assigned	Outcome
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	Revision of schedules to accommodate urgent appointments	Extend schedules as needed at the beginning or end of the day or over the lunch hour to accommodate a request for an urgent appointment within 24 hours		
	Revision of schedules to accommodate routine appointments	Establish a visit schedule with existing patients at the first visit to accommodate their needs for routine appointments		
	Develop plan for 24/7 provider coverage	Establish a plan to have a provider available to respond to members call afterhours within 30 min		