BCBSM
Physician Group Incentive Program

Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor Domains of Function

Interpretive Guidelines

2015-2016
V1.0

5.0 Extended Access

Goal: All patients have timely access to health services that are patient-centered and culturally sensitive and are delivered in the most appropriate and least intensive setting based on the patient's needs

Applicable to PCPs and specialists.

5.1
Patients have 24-hour access to a clinical decision-maker by phone, and clinical decision-maker has a feedback loop within 24 hours or next business day to the patient's PCMH

PCP and Specialist Guidelines:

a. Clinical decision-maker must be an M.D., D.O., P.A., or N.P. If not M.D. or D.O., clinical-decision maker must have ability to contact supervising M.D. or D.O. on an immediate basis if needed
    i. Clinical decision-maker may be, but is not required to be, the patient's primary care provider
b. Clinical decision-maker has the ability to direct the patient regarding self-care or to an appropriate level of care.
    i. When reason for patient contact is not relevant to provider's domain of care, provider will ensure that patient is able to contact PCP or other relevant provider
c. Clinical decision-maker communicates all clinically relevant information via phone conversation directly to patient's primary physician, by email, by automated notification in an EMR system, or by faxing directly to primary physician regarding the interaction within 24 hours (or next business day) of the interaction
d. For after-hour calls, clinical decision-maker responds to patient inquiry in a timely manner (generally 15-30 minutes, and no later than 60 minutes after initial patient inquiry)
    i. For urgent calls, clinical decision-maker responds to patient inquiry in a timely manner (generally 15-30 minutes, and no later than 60 minutes after initial patient inquiry)
    ii. For non-urgent calls during office hours, patients may be given response by phone before end of business day, or offered appointments in a timeframe appropriate to their health care needs

5.2
Clinical decision-maker accesses and updates patient's EMR or registry info during the phone call

PCP and Specialist Guidelines:

a. Clinical decision-maker (as defined in 5.1) must routinely have access to and update patient's EMR or registry information during all calls
    i. Occasional technical problems, such as failure of internet service in rural areas, may occur and would not constitute failure to meet the requirements of 5.2 as long as access to the EMR or registry is typically and routinely available
b. In circumstances where the patient is personally well known to clinician or the condition is

non-urgent and easily managed, the clinician may not always need to access the EMR or registry during the call, and may update the record after the call

5.3
Provider has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs during at least 8 after-hours per week and, if different from the PCMH office, after-hours provider has a feedback loop within 24 hours or next business day to the patient's PCMH

PCP Guidelines:

a. After-hours is defined as office visit availability during weekday evening (e.g., 5-8 pm) and/or early morning hours (e.g., 7-9 am) and/or weekend hours (e.g., Saturday 9-12), sufficient to reduce patients' use of ED for non-ED care
b. After-hours provider may be at Practice Unit site or may be in a physically separate location (e.g., an urgent care location or a separate physician office) as long as it is within 30 minutes travel time of the PCMH
    i. Services provided by the after-hours provider must be billable as an office visit or an urgent care visit, not as an ER visit
c. If after-hours provider is different from Practice Unit (e.g., they are an urgent care center or a physician who shares on-call responsibilities), there must be an established arrangement for after-hours coverage, and the after-hours provider must be able to provide feedback regarding care encounter to the patient's Practice Unit within 24 hours or on the next business day
d. Practice Units may team with other practice units/physicians to provide after-hours urgent care
e. Patient referral to specialists, high tech imaging, and inpatient admissions recommended by urgent care providers should be made by or coordinated with PCP

Specialist Guidelines:

a. Feedback from urgent care center is only required when the care provided to the patient is relevant to the condition being managed by the specialist
    i. For patients who do not reside within the specialist's geographic vicinity, establishment of a feedback loop may not always be possible
b. After-hours is defined as office visit availability during weekday evening (e.g., 5-8 pm) and/or early morning hours (e.g., 7-9 am) and/or weekend hours (e.g., Saturday 9-12), sufficient to reduce patients' use of ED for non-ED care
c. After-hours provider may be at Practice Unit site or may be in a physically separate location (e.g., an urgent care location or a separate physician office) as long as it is within 30 minutes travel time of the PCMH
    i. Services provided by the after-hours provider must be billable as an office visit or an urgent care visit, not as an ER visit
d. If after-hours provider is different from Practice Unit (e.g., they are an urgent care center or a physician who shares on-call responsibilities), there must be an established arrangement for after-hours coverage, and the after-hours provider must be able to provide feedback regarding care encounter to the patient's Practice Unit within 24 hours or on the next business day

e. Practice Units may team with other practice units/physicians to provide after-hours urgent care
f. Patient referral to specialists, high tech imaging, and inpatient admissions recommended by urgent care providers should be made by or coordinated with PCP

5.4
A systematic approach is in place to ensure that all patients are fully informed about after-hours care availability and location, at the PCMH site as well as other after-hours care sites, including urgent care facilities, if applicable

PCP and Specialist Guidelines:

a. Providers should ensure patients know how to contact them during after-hours, and should ensure patients are aware of location of urgent care centers, when applicable
b. Where PCPs and specialists are in the same medical neighborhood, they should be aware of urgent care centers commonly used by care partners
    i. Specialists are encouraged to work with the PCP community to identify appropriate urgent care sites with whom they share clinical information

5.5
Practice Unit has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs (as defined under 5.3) during at least 12 after-hours per week

PCP and Specialist Guidelines:

a. Reference 5.3

5.6
Non-ED after-hours provider for urgent care accesses and updates the patient's EMR or patient's registry record during the visit

PCP and Specialist Guidelines:

a. Reference 5.3 for definition of non-ED after-hours provider for urgent care needs
b. Clinical decision-maker must routinely have access to and update patient's EMR or registry information during all visits
    i. Occasional technical problems, such as failure of internet service in rural areas, may occur and would not constitute failure to meet the requirements of 5.6 as long as access to the EMR or registry is typically and routinely available

5.7

Advanced access scheduling is in place: for PCPs, at least 30% of appointments are reserved for same-day appointments for acute and routine care (i.e., any elective non-acute/urgent need, including physical exams and planned chronic care services, for established patients); for specialists, tiered access is in place

PCP Guidelines:

a. 30% of the day's appointments should be available at the start of business for same-day appointments for both acute and routine care needs
    i. In unusual, extenuating circumstances (such as a solo practice in a rural or urban under-served area), practice units may meet the requirements of capability 5.7 by having a routine, systematic procedure that practice unit clinicians remain after-hours as necessary to see the majority of patients requesting routine or acute care
b. Written policy for advanced access is available
    i. Patients are aware of policy and do not feel that they must self-screen to avoid imposing on practice unit staff
c. Patients can be accommodated throughout the day (not only during lunch or after-hours)
d. Patients are seen on a timely basis with no excessive waiting time
e. Patients can be seen by PAs/NPs or by any physician in practice
f. **If practice does not have an approach to scheduling that closely follows the structure and process of formal open access scheduling consistent with the sources cited herein, then they must have documented policy and procedures demonstrating that the practice's advanced access approach has the attributes referenced at the following sites:**
    i. **http://www.aafp.org/fpm/20000900/45same.html**
    ii. Reference Institute for Healthcare Improvement articles at **http://www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/IH** for information on implementing advanced access

Specialist Guidelines:

a. Specialists must establish tiered access system to address needs of sub-acute, chronic, and routine patients
    i. Same day appointments available for urgent patients
    ii. Appointments within 1-3 weeks available for sub-acute patients
b. Written policy for advanced access is available
    i. Patients are aware of policy and do not feel that they must self-screen to avoid imposing on practice unit staff

5.8
Advanced access scheduling is in place reserving at least 50% of appointments for same-day appointment for acute and routine care (i.e., any elective non-acute/urgent need, including physical exams and planned chronic care services, for established patients)
[Applicable to PCPs only]

PCP Guidelines:

a. 50% of the day's appointments should be available at the start of the business day for same-day appointments for acute and routine patient needs
b. Reference 5.7

5.9
Practice unit has telephonic or other access to interpreter(s) for all languages common to practice's established patients.

PCP and Specialist Guidelines:

a. Languages common to practice are defined as languages identified as primary by at least 5% of the established patient population
b. Language services may consist of third-party interpretation services or multi-lingual staff
c. Asking a friend or family member to interpret does not meet the intent of this capability

5.10
Patient education materials and patient forms are available in languages common to practice's established patients

PCP and Specialist Guidelines:

a. Languages common to practice are defined as languages identified as primary by at least 5% of the established patient population
b. Not applicable to practices where English is the primary language for 95% or more of the practice's established patient population