SUD Access Times

Access Times/Contact Log FAQ/Tip Sheet

- **What is access time?**
  - How long a client must wait to get an appointment at your program from the date requested.
  - This means that there are limits on how long clients must wait to get care appointments:
    - Non-urgent with nonphysician SUD care provider – within 10 business days from request
    - Non-urgent with OTP provider – within 3 business days to from request
    - Urgent – within 48 hours from request
  - Regulation: Cal. Health & Safety Code § 1367.03

- **Why do I have to document it?**
  - It is required at the State and Federal level for managed care plans to provide timely access to care.
  - Short wait times to access services is a client right.

- **If a caller is inquiring about program information vs requesting an appointment to access clinical services, do I need to document this contact for access times reporting?**
  - Yes, but only to document an appropriate disposition to indicate an appointment was not offered, not made, or client was referred out.
  - Documenting 1st, 2nd, 3rd available appointment is not required.

- **Why is it problematic if data is inaccurate, entered late, or missing?**
  - Counties are required to submit data to the State showing programs have adequate availability of services for clients seeking care.
  - Inaccurate data affects the programs and county's ability to convey the true story of what clients and programs are experiencing. This in turn affects how the county plans for future program changes.

- **Why isn't the data matching our program's actual availability?**
  - Data entry errors, missing or incomplete data, arbitrary dates selected for next available appointments, or misunderstanding the requirements resulting in collecting the wrong information.

- **How do I figure out my next available appointment dates?**
  - Next available appointment date refers to when your program can provide a clinical contact to assess appropriateness for service and level of care.
  - Programs shall develop processes, tools or use software to assist with tracking and identifying next available appointments.

- **How do I QA my data?**
  - Programs shall develop processes to ensure information collected upon the initial request for services meets the minimum standards for access times reporting.
  - If programs have workflows that include staff having their own template to record client access times, programs shall develop processes to ensure logs are submitted to data entry staff timely and complete.

- Programs shall develop processes to reconcile data collected with data entered into SanWITS contact screen.
- There is an access times report available on-demand in SanWITS for programs to use to monitor compliance internally.

- **My program is a specialty program; do access time requirements apply?**
  - Yes, all programs should fit into one of the requirements outlined above.

- **We use interpreters; is access time based on when interpreters are available?**
  - No, access time is based on available appointments at your program, not when interpreters are available.
  - Interpreter services must be coordinated and provided with scheduled appointments without imposing delay on scheduling the appointment.
  - Regulation: Cal. Health & Safety Code § 1367.03(a)(4)

- **We offer services for different levels of care that have different access times limits (outpatient/res + wm). If an existing client in one level of care is assessed for needing another at our program, do we need to document that?**
  - Yes, the state wants to see that access time for both services separately, even if the client is already active or admitted in the program.
  - Example 1: Client is at a residential program that offers LOC's 3.1, 3.5, and WM 3.2. Client currently receiving services under LOC WM3.2 and is assessed for needing Res 3.5 and will be transitioned to this new LOC. A new contact is needed to record access times for this.
    - Initial contact date = the date the client requested a new LOC
      - Initial contact date = 4/1/23
      - 1st, 2nd, 3rd available dates should be based on program availability on 4/1 when the referral was received, which are 4/2, 4/3, 4/4.
      - 1st accepted appointment = 4/5
    - Service requested = routine

  - Example 2: Client is at an outpatient program that offers OS 1.0, IOS 2.0, and ambulatory WM. Client is currently receiving services under LOC OS 1.0 and is assessed for needing ambulatory WM and will be transitioning into adding this to their care. A new contact is needed to record access times for this.
    - Initial contact date = the date the client requested a new LOC
      - Initial contact date = 4/1/23
      - 1st, 2nd, 3rd available dates should be based on program availability on 4/1 when the referral was received, which are 4/2, 4/3, 4/4.
      - 1st accepted appointment = 4/5
    - Service requested = urgent

- **We receive referrals from schools, community partners, law enforcement; do we need to document this information? What if we don't make contact with the client or they refuse services?**
  - Access times data is required for all referrals, regardless of if a client or family is aware or accepts the referral.
  - Access times for referrals are based on when the referral was received versus when the

program contacted the family or when the family agreed to services.

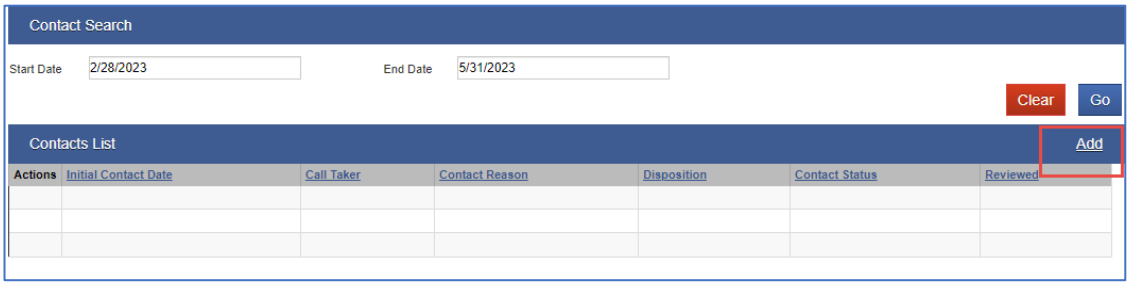
- **Do I have to issue an NOABD for access times?**
  - Yes, when the access time limits cannot be met, you must send the client an NOABD for timely access and document NOABD info in SanWITS. If your program is not documenting NOABD info in SanWITS and is instead documenting the info on another log or tracking log, this needs to be submitted to QI Matters monthly.
  - Lack of NOABD is a client rights issue that can result in a grievance.

- **How do I keep track of or document client access times? Is there a data entry standard?**
  - Access data is key to quality improvement, and BHS is currently evaluating the implementation of consistent data entry standards across the MH and SUD Systems of care.
  - Enter into SanWITS; see steps outlined below.

1. Open the Client Profile (see SanWITS guide for details)
   a. Search – search for existing client records; if a matching record is identified, review existing information to confirm accuracy; update as needed.
   b. Add client – if no existing client records are identified during the search step, add client demographics to create client profile. Minimum requirements include:
      i. Current first and last name
      ii. Birth first and last name
      iii. SSN – enter 99902 if unable to obtain
      iv. DOB
      v. Gender
      vi. Primary Race/Ethnicity
      vii. Disabilities – 99900 if unable to obtain
      viii. Preferred Language

2. Client Profile -> Contacts (see SanWITS guide for details)
   a. Add new record for every referral and/or client contact until the client is admitted into the program.

3. Contact List
   a. Add new Contact



4. Contact Profile (see SanWITS guide for details)
   a. Initial contact Date/Stop Date – Document the date of the initial contact; this includes date an initial referral is received.

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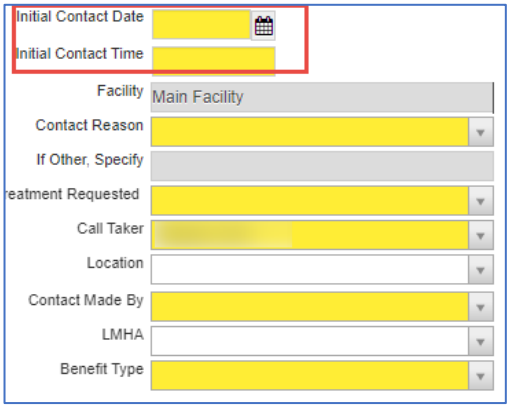
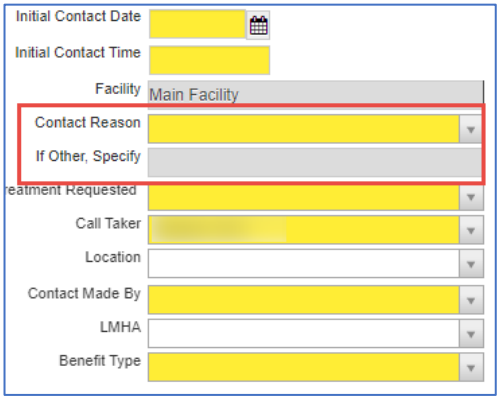
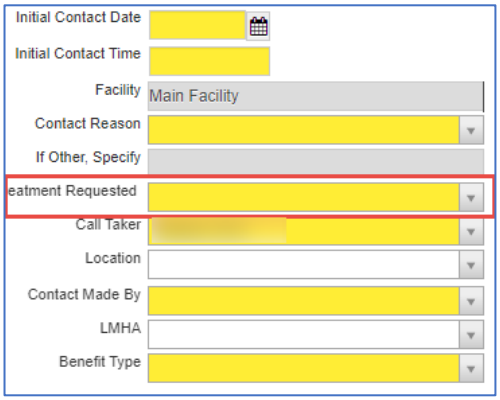
b. Start Time/Stop Time – Document the start/stop time of the contact.



c. Contact reason – Identify the reason for call. Note: WM is always going to be "urgent".
   i. Routine
   ii. Urgent
   iii. Information
   iv. Other – if "other" selected, indicate in the field below



d. Treatment Requested – Document the treatment requested using choices listed below. This is used to calculate compliance based on associated time limits by LOC.
   i. OTP
   ii. Outpatient
   iii. Residential
   iv. WM



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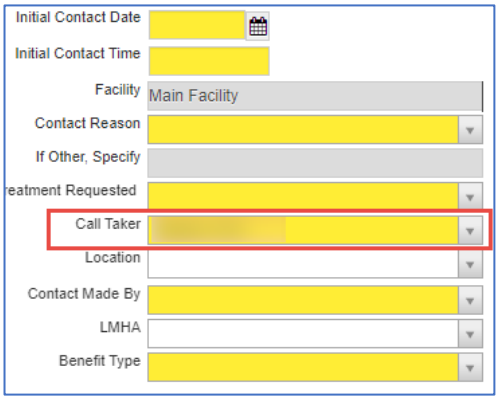
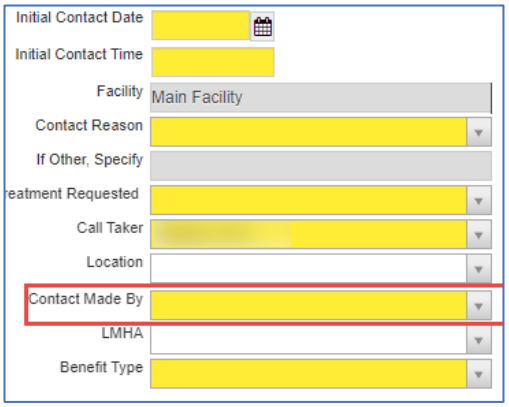
e. Call Taker – This field prepopulates to staff logged into SanWITS; update to reflect correct information.



f. Contact made by
   i. Self
   ii. Family member
   iii. Justice System
   iv. Other SUD Provider
   v. Primary Health Care provider
   vi. MH Provider
   vii. MCP
   viii. Other



g. Benefit Type
   i. Medi-Cal
   ii. Medicare
   iii. Medi-Cal/Medicare
   iv. No Insurance
   v. Other/Private Insurance
   vi. Tricare
   vii. Veterans Admin
   viii. Unknown

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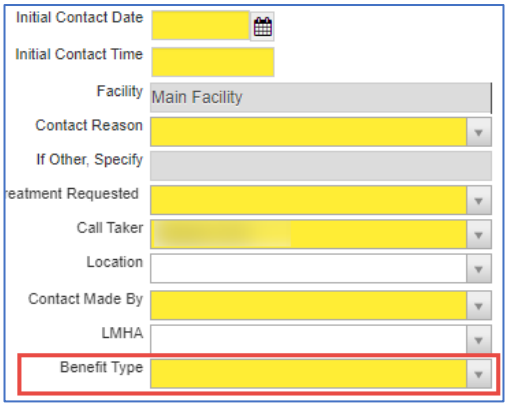
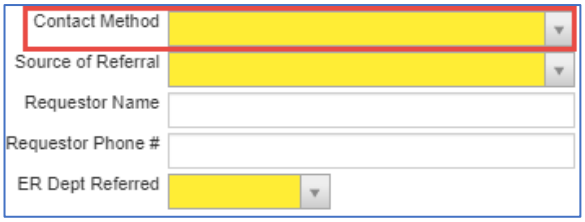
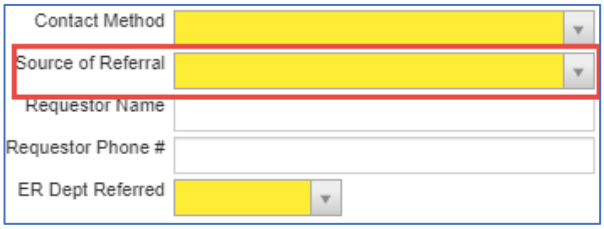


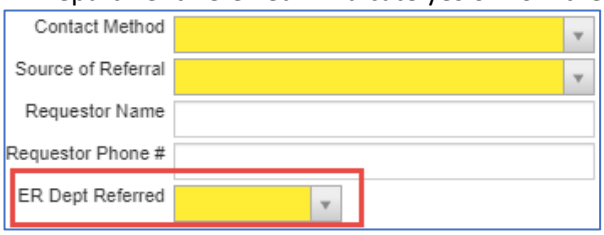
h. Contact Method – Document method of contact/referral using choices listed below:
   i. Electronic
   ii. Phone
   iii. Walk-in



i. Source of Referral – Document the source of the referral using choices listed below:
   i. Individual, including self-referral
   ii. AOD Program
   iii. MCP – MH Provider
   iv. MCP – PCP
   v. Other Health Care Provider
   vi. School/Educational
   vii. Employer/EAP
   viii. 12 Step Mutual Aid
   ix. Probation or Parole



j. ER Department Referred – Indicate yes or no if the referral is coming from ER Department



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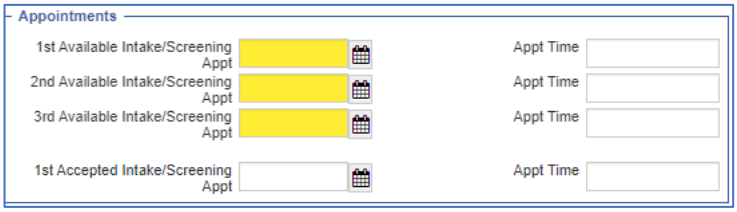
5. Appointments
    a. 1st, 2nd, 3rd Available Appointment - these are the dates available for upcoming appointments at your program
        i. 2nd Available - date must be after 1st Available/Offered date
        ii. 3rd Available - date must be after 2nd Available/Offered date
    b. 1st Accepted Appointment – If the client accepted an appointment date, enter the date. If client does not schedule or accept an appointment date, the field should be blank.
    c. NOTE: field indicates "intake/screening" appointment, but screening should occur prior to an intake; 1st, 2nd, 3rd available appointments are when your program can provide a clinical contact to assess appropriateness for service and level of care.



6. Disposition
    a. Made an appointment - Client was offered/scheduled an appointment.
    b. No appointment made
    c. Declined appointment
    d. Ref out to another LOC
    e. Ref out for non-SUD services
    f. Ref to Private Insurance Carrier
    g. Ref to SMH Services
    h. Refer to MCP – PCP
    i. Refer to MCP – MH Provider

7. Click Save + Finish