MH Access Times

Access to Services Journal 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 MH care provider – within 10 business days from request
        - Non-urgent with specialist physicians (psychiatry) – within 15 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 our 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 ASJ 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 the Access to Services Journal (ASJ).
  - There is an access times report available on-demand in CCBH 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.

- **Why does this guidance conflict with past guidance?**
  - Local policy decisions changed to align with State requirements to ensure compliance.
  - For example, previously the guidance was for only documenting clients who were offered an appointment and excluded clients requesting information. This has changed; all contacts must be documented, including clients who do not make an appointment.
  - Note: CCBH field for 1st, 2nd, 3rd available appointments include "offered" language due to past understanding of the requirements. The verbiage is expected to be revised in the new Millennium system. Going forward this field will be referenced as "available" without the "offered" language.

- **Why are the response types changing?**
  - Emergent – No longer included in access times standards.
  - Discharge from IP 72 hours – Programs are required to assess clients discharged from IP within 72 hours for urgent or non-urgent services and document access times data in the ASJ based on the results of that assessment for urgent or non-urgent. NOTE: The reporting requirement for DC from IP 72 hours shall be indicated using the "9-Other Psych Hosp" in the "referred from" field.

- **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 two different services (psychiatric and routine services) on the same time back-to-back. Does this need to be documented as one journal entry or two?**
  - The access time limits for both are different, therefore both need to be documented as separate entries.

- **If an existing client requests a new service (such as psychiatric services), does this need to be documented in the ASJ?**
  - 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.

- **We do walk-in only; do access time requirements apply?**
  - Yes, first available appointment is the first date a client is told to attend walk in clinic; 2nd and 3rd

available are the next available walk-in days.

- If the individual attends on a walk-in day and is not seen and asked to return, that is no longer your first available appointment; first available is now the day a client is told to return for the next walk-in clinic time. This also means the 2nd and 3rd available dates initially identified are no longer correct and are now the dates of the following available walk-in days.
- The expectation is that programs shall correct access time dates until the client is seen for services in order to report correct dates.

- **We receive a high volume of referrals and were previously advised to only document referrals once contact with the client/family happens or once client/family agrees to the referral; why is the guidance now different?**
  - Clarification by the State includes confirmation that access times shall include all referrals, regardless of if a client or family is aware or accepts the referral, and that the referral date is the initial request for services.
  - BHS will additionally be tracking time from referral date to request for service date, if they are not the same date, to review referral processing time and time it's taking to reach referred individuals.
  - *Client/family is aware of referral:*
    - Initial contact date = Referral received date
      - Referral is received on 4/1/23 and client is aware of the referral.
      - Referral from date = 4/1/23
      - 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
  - *Client/family unaware of referral:*
    - Step A: Initial contact date = Referral received date
      - Identify next available dates based on the date the referral was received. These dates will be used if no contact is made by the client/family (see Step C below).
        - Available dates should be reassessed once contact is made with the client/family (see Step B below).
    - Step B: Revised Initial contact date = Date of initial contact with client after referral received
      - Referral is received on 4/1/23; client is not aware; program makes several attempts to contact the client and successfully contacts client on 4/15/23.
      - Referral from date = 4/1/23
      - Revised Initial contact date = 4/15/23
      - Revised 1st, 2nd, 3rd available dates based on program availability on 4/15 when the program made contact with the client. Revised dates = which are 4/16, 4/17, 4/18.
      - 1st accepted appointment = 4/18
    - Step C: Initial contact date for no contact with client/family = Referral received date
      - Use dates identified upon receiving the referral.
   - See example above for how to document the dates based on referral

received date.

- **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 on internal logs that later get submitted to QI Matters.
    - 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?**
    - Programs can use the ASJ Excel template to assist with data collection to ensure all required information is collected before entering into ASJ. If programs develop their own templates, programs shall ensure templates includes all fields in the ASJ template.
    - 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 Cerner/ASJ; see steps outlined below.

1. Open the Access to Services Journal
    a. Select the Systems Button→ Menu→ ATP→ Access to Services Journal
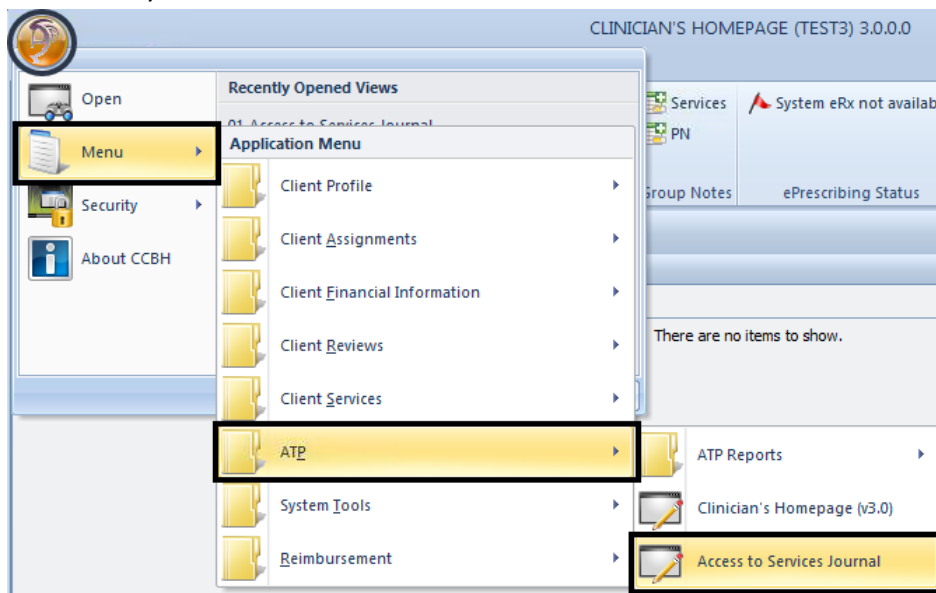
2. Enter the date of contact, time (original date/time from the contact log), and unit/subunit. *Note: the date and time will pre-populate to the date and time that the ASJ was launched and will require an adjustment.*

3. Enter Contact Type (the method by which the program was contacted), Contact Reason, and Response Type (the urgency).

Contact Type	Telephone	T
Contact Reason	Mental Health	M
Response Type	Routine	R

4. Click on the magnifying glass.

Client		0	☐ Name Not Provided
First		Middle	Last
DOB	/ /	Age	Gender

5. Click the "All" radio button and search for the client; use the filter settings if helpful. If the client is in CCBH, select the client and click "OK."

Clients Lookup

Sort Name	Case Number	S	E	DOB	SSN	Primary Unit	Primary Sunt	Ext Case #	SAI
000CLIENT, TEST		M	9	05/26/1992		9900	9901		16346
00BLANKET, ELECTRIC		M	9	10/02/1956		9900	9901		17361
00CELEBRATED, CALM		M	9	10/11/1988		9900	9901		16404
00CERTAIN, CHAMP		M	9	10/05/1988		9900	9901		16453
00CLASSICALY, CLEAN		M	9	12/15/1944		9900	9901		16442
00CLIENT, DOCTORS		F	1	01/01/1975		9900	9901		16515
00CLIENT, SAMPLE		U	1	05/05/1985		9900	9901		2277
00CROSSING, DEER		M	6	10/10/2014			0		
00FABULOUSLY, FAIR		M	9	10/15/1988		9900	9901		7832

○ Active   ○ Inactive   ● All

[Filters] [Alias]   [Find] [OK] [Cancel]

First Name Match: [ ]
Ethnicity: [ ]
Primary Unit: [ ]
Primary SubUnit: [ ]   ○ Male   ○ Female   ● All
SAI: [ ]
From Age: [0]   Thru Age: [0]   [Refresh] [Clear]

6. Add client information. *Note: Never use the **Name Not Provided** check box; never type a client's name via free text. A case number must always be present.*
   a. **If the client is in CCBH**, review prepopulated demographic information; update if necessary; complete blank fields.
   b. **If the client is not in CCBH,** add client's name/DOB to obtain case number; input the case number in the "Client" field and press tab; complete any blank fields.

Client	000CLIENT, TEST	☐ Name Not Provided
First	TEST	Middle	Last	000CLIENT
DOB	05/26/1992	Age	27	Gender	Male	M
Phone	999 999-9999	Alt. Phone	
Race	Chinese	D	Pref. Language	Unknown / Not Reported	U
Ethnicity	Unknown	9	Benefit Type	Medi-Cal	MC

7. Select Add in the service container.

MH Access Times

8. Enter type of service, available dates and scheduled appointment dates and save the data.
    a. Service - Click on the magnifying glass and select the service
        i. Service Code 10 - Assessment - Psychosocial is used for Mental Health Services.
        ii. Service Code 11 - Medication Evaluation is used for Psychiatric Services.
        iii. Service Code 30 - Individual Psychotherapy is used for the first treatment service, which is defined as the first appointment after medical necessity is determined.
    b. 1st, 2nd, 3rd Available Appointments – these are the dates available for upcoming appointments at your program.
        i. 2nd Available Appointments – the data is required despite the field not being system required. Note: date must be after 1st Available date
        ii. 3rd Available Appointments – the data is required despite the field not being system required. Note: date must be after 2nd Available/Offered date
    c. Appointment scheduled – 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.

9. Enter Disposition and Referred information.
    a. Disposition
        i. **Made Appointment** - Client was offered/scheduled an appointment.
        ii. **Declined Appointment (Specify)** - Client was offered but did not schedule an appointment; call was terminated or client left before referrals were offered.
        iii. **Referred Out - Location** - Client offered but did not schedule an appointment due to physical distance; client prefer to receive services closer to their locaton.
        iv. **Referred Out - Required Other Services** - Client offered but did not schedule an appointment due to not meeting level of care requirements. (example: client is an adult and the program serves youth).
        v. **Referred Out - Wait Too Long** - Client offered but did not schedule an appointment because due to wanting quicker access to services elsewhere

      vi. **Referred Out - Other (Specify)** - Client was referred out for a reason not listed; specify the reason in the Notes box.

  b. Referred To and Date – Required when disposition is "Referred Out".

  c. Referred From and Date – Referred from information and date are required. Date may be the same as initial contact date but should reflect the actual date a referral was received.

    i. Note: For DC IP 72 Hours, select option "9-Other Psych Hosp".

10. Notes

  a. If the first available appointment is beyond the access time limit/standard, document the reason why a warm handoff did not happen.

11. Click Final Approve. No signature/password is necessary.