Behavioral Health Department
Alameda County Health

ACBHD Timely Access Data Collection Definitions for FY 24-25

On an annual basis, the Department of Health Care Services (DHCS) issues new requirements and guidance related to Network Adequacy data collection. For services rendered to members in FY 24-25, Timely Access data reporting is required for:

- **Non-Psychiatry Specialty Mental Health Service (SMHS) appointments**: Data collection is required for **new member requests only.** "New members" means:
  - **New**: Medi-Cal and Medi-Cal-eligible members who are new to the Mental Health Plan (MHP)
  - **New Returning:** Medi-Cal and Medi-Cal eligible members who have not received outpatient services in the past 12 months through the MHP.

- **New Psychiatry SMHS appointments:** Data collection is required for all new psychiatry service requests for new or established members.

- **Substance Use Disorder (SUD) appointments:** All Medi-Cal and Medi-Cal-eligible members requesting SUD services, across the continuum of care.

SMHS Service Types/Modalities

- **Non-Psychiatry SMHS:** Mental Health Services (Assessment, Treatment Planning, Therapy, Rehabilitation), Targeted Case Management (TCM), Intensive Care Coordination (ICC), Crisis Intervention, Peer Support Services, Adult Residential Treatment (ART), Crisis Residential Treatment (CRT), Short-Term Residential Treatment Program (STRTP), Intensive Home-Based Services (IHBS), Day Treatment Intensive (DTI), Day Rehabilitation (DR), Therapeutic Behavioral Services (TBS), Therapeutic Foster Care (TFC), Short-Term Residential Treatment Program (STRTP), outpatient Electroconvulsive Therapy (ECT).

- **Psychiatry Services:** Medication support services (prescribing, dispensing, administering) rendered by psychiatrists/physicians (MD, DO), physician assistants (PA), pharmacists (RPH, APH), or licensed nurse types (PMHNP, APN, NPF, NP, CNS).

DMC-ODS Modalities

- **Outpatient:** Early Intervention Services (EIS 0.5), Outpatient (OS 1.0), Intensive Outpatient Services (IOS 2.1), Opioid Treatment Programs (OTP 1), Recovery Support Service (RSS), Standalone SUD services (Peer Support Services, MAT, Care Coordination).

- **Withdrawal Management:** ASAM Level of Care (LOC) 3.2-WM (Residential Withdrawal Management)

- **SUD Residential:** ASAM LOCs 3.1, 3.3, 3.5.

Timely Access Standards

Service Type	Standard
SMHS	
Outpatient Non-Urgent Non-Psychiatric Specialty Mental Health Services (SMHS)	Appointment offered within 10 business days of request for services
Psychiatric Services	Appointment offered within 15 business days of request for services
Non-Urgent Follow-Up Appointments with a Non-physician	Appointment offered within 10 business days of the prior appointment
All SMHS Urgent Appointments	48 hours without prior authorization 96 hours with prior authorization
DMC-ODS	
Outpatient Services – Outpatient Substance Use Disorder	Appointment offered within 10 business days of request for services
Residential Treatment Services	Appointment offered within 10 business days of request for services
Opioid Treatment Program	Appointment offered within 3 business days of request for services
Non-Urgent Follow-Up Appointments with a Non-Physician	Appointment offered within 10 business days of the prior appointment
All Urgent SUD Appointments	48 hours without prior authorization 96 hours with prior authorization

Timely Access Data Collection Definitions

Currently, Timely Access data is captured differently for SUD and SMHS services, however, the required data reporting elements are essentially the same for both groups. The following are definitions for the required data elements:

Referral Source

- This is the person, program, or organization who referred the member to services.
- The ACBHD e-form and Clinician's Gateway (CG) dropdown menus include the DHCS standard referral source response options.

Urgency

- Determination of URGENCY is required for all appointments.
- SMHS requests are considered urgent if at least one of the following is true for the member:
  - Is pregnant or suffering a severe medical condition and at risk of complications if mental health symptoms are not addressed within the next 48-96 hours (i.e. 2-4 days).
  - Appears to be at imminent risk of suicide, homicide, grave disability, significant property destruction, loss of housing, or risk of incarceration in the next 48-96

hours.
- o Indicates they are running out of antipsychotics, mood stabilizers, or benzodiazepines within the next 7 days.
- o There is indication that the member needs urgent mental health services for other reasons.

- SUD requests are considered urgent if at least one of the following is true for the member:
  - o Requires withdrawal management services (ASAM LOC 3.2-WM).
  - o Is pregnant.
  - o Appears to be at imminent risk of overdosing on any substance in the next few hours or days.
  - o Indicates they are running out of any anti-craving medication such as naltrexone, buprenorphine, or methadone.
  - o There is indication that the member needs urgent SUD services for other reasons.

- Additionally, see CA Health & Safety Code 1367.01 (h)(2) for DHCS's definition of urgent services.

Prior Authorization

Applicable for the following services that require county review and approval prior to service delivery:

- **SMHS:** Intensive Home-Based Services (IHBS), Day Treatment Intensive (DTI), Day Rehabilitation (DR), Therapeutic Behavioral Services (TBS), Therapeutic Foster Care (TFC), Short-Term Residential Treatment Program (STRTP), outpatient Electroconvulsive Therapy (ECT).
- **SUD:** SUD Residential: ASAM LOCs 3.1, 3.3, 3.5.

Referred to an Out-of-Network Provider

- If ACBHD is unable to provide necessary services to a member using an in-network provider, the county must allow beneficiaries to access services out-of-network.
- Required only for appointments referred to an out-of-network provider.
- For information about the out-of-network referral process, contact ACCESS (SMHS) or Center Point (SUD).
- See DHCS BHINs 19-024, 21-008 for more information about out-of-network requirements.

Date of First Contact to Request Services

- This is the date a member first requests services from a program, either by contacting the program directly or through a county access point, whichever date is earlier. For example:
  - o A member presents at the program or calls the program requesting services.
  - o A member's legal guardian contacts ACCESS to request services.

- Required for all appointment requests.
- If a referral is made on behalf of a member and with the member's consent, the date of the referral is the DATE OF FIRST CONTACT TO REQUEST SERVICES. A referral that is made without the member or their legal guardian's consent is not considered the DATE OF FIRST CONTACT TO REQUEST SERVICES.

Time of First Contact to Request Services

- This is the time of day of the member's FIRST CONTACT TO REQUEST SERVICES
- Only required for URGENT appointment requests.
- Hours from first contact to request services to first service appointment offer is required when the appointment request is deemed URGENT.

First Service Appointment Offer Date

- This is the first appointment option offered to the member at the program (e.g. an Intake appointment), regardless of whether it is accepted by the member.
- Required for all appointment requests.
- FIRST SERVICE APPOINTMENT OFFER DATE *cannot* be before the DATE OF FIRST CONTACT TO REQUEST SERVICES, or after the FIRST SERVICE APPOINTMENT RENDERED DATE.
- Previously used terminology for this data element includes:
  - Assessment Appointment First/Second/Third Offer Date
  - First/Second/Third Offered Intake/Assessment Appointment

First Service Appointment Offer Time

- This is the actual time of day of the first offered appointment.
- Only required for URGENT appointment requests.

First Service Appointment Rendered Date

- This is the date when the program first provides non-administrative clinical services (assessment, crisis, treatment, etc.). It may or may not be the date the clinician starts or completes the assessment. It may also be different from the first service appointment that was offered to the member.
- Required when the first service appointment is rendered.
- Previously used terminology for this data element includes:
  - Assessment Appointment Accepted Date
  - Assessment Start Date or Intake/Assessment Start Date
  - Assessment End Date or Intake/Assessment End Date
- NOTE: For SUD service requests received through a Portal (e.g. Center Point, Collaborative Court, etc.), providers are required to contact the referring Portal to let them know whether the member attended a first service appointment. If despite multiple

attempts to engage the member, the member did not engage with services, the Portal will document the Closing Reason in the Portal Screener template and the provider is not required to complete a Timeliness Tracking template in CG.

Wait List and Wait List Reason: Was the member delayed access to services beyond the timely access standard?

- A Yes or No response is required for all appointments.
- A Yes response indicates the waiting time for the appointment was extended beyond the standard and requires a reason be provided, with the following options:
  - Member choice: Treatment modality unavailable (e.g. evidence-based practices model, therapy modality, etc.).
  - Member choice: Preferred MHP provider unavailable.
  - Member choice: Preferred service medium unavailable (e.g. requested in-person services in lieu of telehealth).
  - No available provider.
  - Another reason (please specify).

Follow-Up Appointment

- A follow-up appointment is the second service appointment. It may be a continuation of the assessment or a treatment session.
- A Yes or No response is required for all requests except psychiatry.
- A Yes response indicates a follow-up appointment was offered to the member.
- A No response indicates the member was not offered a follow-up appointment.
- If a follow-up appointment was *not* offered, the provider should document a Closure Reason and Date and finalize timeliness tracking.

First Follow-Up Appointment Offer Date

- This is the first appointment option offered to the member, regardless of whether it was accepted.
- The FIRST FOLLOW-UP APPOINTMENT OFFER DATE may be on the same day as the first service date but cannot be before the first service appointment offer and rendered dates.
- Required whenever a first follow-up appointment was offered.
- Previously used terminology for this data element includes:
  - Treatment Appointment First/Second/Third Offer Date
  - First/Second/Third Offered Treatment Appointment

First Follow-Up Appointment Rendered Date

- This is the second service that the member receives, whether an assessment or a treatment session.

- It may be different than the first follow up appointment that the member was offered.
- The FIRST FOLLOW-UP APPOINTMENT RENDERED DATE may be on the same day but cannot be before the first service appointment offer and rendered dates.
- Required whenever a follow-up appointment was rendered.
- If, despite multiple attempts at rescheduling, a FIRST FOLLOW-UP APPOINTMENT was not rendered, the provider should document a Closure Reason and Date and finalize timeliness tracking.
- Previously used terminology for this data element includes:
  - Treatment Start Date

Follow-Up Appointment Wait Time Extended

- A Yes or No response is required for all appointments.
- A Yes response indicates the wait time for a follow-up appointment was extended.
- If the wait time for a follow-up appointment was extended beyond the standard of 10 business days from the prior appointment, a licensed health care provider documents whether the extended waiting time was clinically appropriate.
- See CA Health & Safety Code 1367.03 and 28 CCR § 1300.67.2.2 for more information.

Closure Date

- CLOSURE DATE is required whenever there is an unsuccessful connection, whether to the first service or the follow up appointment.
- If the member does not attend the First Service Appointment, or if the member is not offered or does not attend the First Follow Up Appointment, CLOSURE DATE and CLOSURE REASON are required.
- CLOSURE DATE is not required if the client successfully engages in treatment.
- CLOSURE DATE is the date Closure Reason was determined and timeliness tracking was no longer required.
- CLOSURE REASON allows for identification of service access issues, such as gaps in member supports (e.g. transportation, childcare) and lends to system improvement opportunities.
- Closure reasons include:
  - Member did not accept any offered appointment dates.
  - Member accepted offered appointment date but did not attend initial appointment.
  - Member attended initial appointment but did not complete assessment process.
  - Member attended first service appointment but declined treatment.
  - Member did not meet medical necessity criteria.
  - Out-of-county/presumptive transfer.
  - Unable to contact (e.g. deceased or unresponsive).
  - Other (please specify)