SUD Access Time

Access Time FAQ/Tip Sheet

- **What is access time?**
  - How long a client must wait to get a service at your program from the date the service was requested.
  - This means that there are limits on how long clients must wait to get care appointments:
    - Non-urgent with nonphysician SUD care provider (routine) – within 10 business days from request
    - Non-urgent with NTP 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, making it required for DMC-ODS certified providers.
  - Short wait times to access services is a client right.

- **Why is it problematic if data is inaccurate, entered late, or missing?**
  - Counties are required to submit data to the State showing that we as a health plan, and our programs in the health plan, have adequate availability of services for clients seeking care. This is called Network Adequacy.
  - 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 system/network changes.
  - Additionally, DHCS updates Network Adequacy reporting requirements regularly, so there is a need to ensure the basic requirements are documented.

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

- **How do I make sure my data is accurate/correct?**
  - Programs shall develop processes to ensure information collected upon the initial request for services meets the minimum standards for access time reporting.
  - If programs have workflows that include staff having their own template to record client information and client access times vs entering information in SmartCare in real time during a call with a client, programs shall develop processes to ensure the data documented on logs/templates is entered in SmartCare timely and accurately.
  - Programs shall develop processes to reconcile data collected with data entered into SmartCare.
  - There are reports available on demand in SmartCare that can be used to monitor compliance internally. See the Q&A below for more information about available reports.

- **What is the difference between capturing access times in SmartCare vs SanWITS?**
  - The naming conventions, where the data is captured, reports, and workflows may be

different, but the regulations have not changed.
- In SanWITS, access time data was collected in the Contact screen.
- In SmartCare:
  - We are no longer collecting the 2nd and 3rd available appointment data.
  - Access time reporting is referred to as "timely access", "timeliness record", and "TADT" (*Timely Access Data Tool*). The report is called "TADT".
  - There are two SmartCare screens for documenting access times, including one required for state reporting. See Q&A below outlining for more information.
  - The data fields include the term "offered" which may create confusion previously cleared up in past tip sheets. See Q&A below for explanation.
  - The SmartCare reports are different from SanWITS. See Q&A below for explanation.
  - There are new data points required for additional county reporting for access time standards.
    - First follow-up appointment (includes option to indicate if not offered, date if offered, and date of the follow-up service)
    - Referring to an out of network (OON) provider when there is a lack of adequate access within our health plan network *(NOTE: If your program's next available appointment is not within timelines, you should provide warm handoffs to another network provider. If all warm handoff attempts are unsuccessful, this step of referring out of network is required. Resources for out of network providers is under review and will be shared once available.)*

- **How do I keep track of or document client access times? Is there a data entry standard?**
  - The local BHS data entry standard for documenting client access times in SmartCare is 3 days.
  - Client access times are captured in SmartCare in the Inquiry screen and/or Timeliness Record (also labeled or referred to as Timely Access and TADT).
  - CalMHSA guides are available on their website:
    - DMC Opioid Timeliness Record
    - DMC Outpatient Timeliness Record
    - Inquiry Overview
  - For Residential programs:
    - The requirement for residential programs to document client access times has not changed; it is still required.
    - We realize SmartCare excludes an option for residential. This oversight is under review.
    - The workaround is for residential providers to use the outpatient timeliness record because the timelines are the same.

- **What is the difference between the Inquiry screen and the Timeliness Record/TADT screen?**
  - The initial expectation for SmartCare client workflow included documenting initial client contacts and requests for services starting with the Inquiry screen. Then the Timeliness Record/TADT screen would pull over and pre-populate client access time data for county required reporting. But the functionality is not working as planned.
  - The Timeliness Record/TADT is required for all requests for services to be captured for state

reporting, and the Inquiry screen can be bypassed to avoid duplication of data.
    - The Inquiry screen required for:
        - MH Walk-in clinics (not applicable for SUD programs)
        - Program inquiries that do not result in a scheduled appointment
    - Programs should review internal processes to determine which workflow best meets the needs of your program. Noting that starting with the Inquiry screen for a client admitted into your program will require manually capturing some of the same data in the Timeliness Record for state reporting.

- **What is the difference between first/next available vs first "offered" appointment?**
    - DHCS guidance includes "offered" verbiage because the assumption is that programs are offering their first available appointment to clients requesting services.
    - The CalMHSA explanation for the first offered field supports this assumption and further explains that this data point is for the first available appointment.
    - Previously, QA identified that programs were documenting the dates clients requested as "offered" without considering the first available appointment requirements, and this was impacting compliance with the timelines.
    - Example for "offered" date:
        - Client calls program on 4/1/25 to request services and indicates they are not available until 4/17/25.
            - Program documents the date the client requested because they have availability, and it was "offered".
            - The access time standard for SUD outpatient routine services is 10 days from the date of request. By documenting the "offered" date of 4/17/25, the program's access time is recorded as 16 days and out of compliance.
    - Example for "first/next available" date:
        - Client calls program on 4/1/25 to request services and indicates they are not available until 4/17/25.
            - Program documents the first available appointment they have open regardless of the client's availability, such as 4/3/25. Meaning on this date when the services were requested, this is when the program is available to see this client.
            - The access time standard for SUD outpatient routine services is 10 days from the date of request. By documenting the "first/next available" date of 4/3/25, the program's access time is recorded as 2 days and compliant.

- **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.

- **There are reports in SmartCare for timeliness or TADT data. Which report should programs use to track compliance and confirm accuracy of data?**
    - There are several reports available in SmartCare for timeliness data, but all do not meet the needs of our San Diego system of care.
    - A COSD specific report was developed and is available for use called COSD TADT. This report

has two viewing options, Detail and Summary.
    - Detail – Provider client level data include dates of request, first available appointment, first rendered appointment and if the access time timelines were met.
    - Summary – Very limited summary of total records reported via TADT average timeline and % of compliance.
  - Additionally, there is an inquiry report called New Client Inquiries without Program TADT Report. This report should be used by programs when reviewing TADT reporting data to ensure all TADT reports required were completed.
  - NOTE – we are aware there is the term "offered" included in this report; we are working with leads to make changes to align with requirements to avoid ongoing confusion.

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

- **My program has several levels of care, with different services, including standalone services, but it is setup in SmartCare as separate "programs". Is timely access data required for each level of care or change in services?**
  - In most cases, documenting client access time for every level of care change within the same program is not necessary.
  - It is only necessary and required if the client's request for services within the same program is different (routine vs urgent).
  - Standalone services is a group of different services. Programs need to focus on the type of services requested (recovery services, care coordination, peer services, etc) to determine if these services are considered routine or urgent, which is the deciding factor for reporting a new request for services.
    - Example: If a client is currently receiving routine OS services and is requesting routine recovery services at the same program, there is no need for another timeliness record.
    - Example: If a client is currently receiving urgent services such as withdrawal management (WM) at a residential program, and is requesting to receive routine residential services, such as 3.1 or 3.5, at the same program, a new timeliness record is required.

- **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)

- **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.
  - This should be captured using the Inquiry screen.

- **If a client calls daily requesting services, are programs required to document each call?**

- Yes, the requirement is about each request for services vs each client. Every day a client calls is a request for services.
- If clients are calling daily, the assumption is that the client has an immediate need, and programs should be providing supports to assist clients accessing services at other programs within the system of care.

- **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 whether a client or family is aware of or accepts the referral. This means it is no longer a requirement to have contact with a client/family for documenting access time data. This is due to SmartCare functionality.
  - Access times for referrals are based on when the referral was received versus when the program contacted the client/family or when the client/family agreed to services.
  - Programs should review internal workflows for processing referrals received to determine how referrals will be entered into SmartCare, Inquiry screen vs Timeliness record, ensuring the data entry standard is met.
  - In SmartCare, referrals should be documented directly in the TADT using the guidance outlined in the previous Q&A provided in this document

- **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 to submit to QA quarterly.
  - Lack of NOABD is a client rights issue that can result in a State Fair Hearing.