DAVIS BEHAVIORAL HEALTH
Community · Commitment · Change

Policies & Procedures

ACCESS TO CARE

Section: Administrative

Pages: 3

Subject: Access to Care

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PURPOSE

This policy was developed in accordance with the Department of Health Medicaid Provider Contract.

POLICY

Davis Behavioral Health (DBH) will provide timely access to care for all clients qualifying for services. DBH will utilize an Electronic Health Record (EHR) for tracking, monitoring, calculating, and reporting adherence to performance standards for the first face-to-face appointment for initial contacts made during regular business hours.

An initial contact is defined as a Medicaid enrollee requesting services for a new episode of care.

PROCEDURE

1. DBH will adhere to performance standards as outlined by the Department of Health Medicaid Provider Contract.

    a. If based on the initial contact it appears the enrollee has an emergency, a qualified mental health worker from DBH will respond to the enrollee within 30 minutes. If DBH determines that the enrollee has an emergency, DBH offers face-to-face emergency services within one hour from the time of the initial call or within a time frame mutually agreed upon by the enrollee or his or her agent and DBH.

    b. If it is determined during the initial contact that the enrollee required urgent care, DBH will offer face-to-face covered services within a maximum of five working days of the initial contact. DBH will also provide appropriate information regarding emergency services to the enrollee with instructions to contact DBH if more immediate services are needed.

c. If it is determined during the initial contact that the enrollee requires non-urgent care, DBH will offer face-to-face covered services within 15 working days of the initial contact.

2. DBH intake will utilize the intake form located in Credible to capture required information. The following elements will be captured in the system:

    a. Enrollee name, birth date, Medicaid ID, episode and intake date.
    b. Whether emergency face-to-face service was provided within the required time frame and, if not, the reason.
    c. Whether DBH sent a Notice of Action letter if DBH was unable to provide the initial face- to-face service within the required time frame and the enrollee was not satisfied with waiting beyond the required time frame.
    d. Whether information on emergency services was given to the enrollee with instructions to contact DBH if more immediate services were needed.

3. Measuring and monitoring timely access standards for the first face-to-face appointments.

    a. New Medicaid clients are entered into the EHR intake form. Clients are classified by level of urgency and payer type.
    b. Client appointments are scheduled using Credible calendar.
    c. In the event that data changes, corrections, exclusions or inclusions occur, assigned DBH employees will document those changes on the intake form by editing the record.
    d. Tracking and monitoring of the access to care data is conducted monthly by the Main Street Clinic intake supervisor to assure accuracy in the data entry (reviewing all dates, Medicaid IDs, if appointments were offered within standard etc.). The intake supervisor will communicate findings back to Intake for correction.

4. Procedures used for calculating and submitting the performance measures report to UDOH.

    a. All calendar year access to care data (information from the Credible intake form system) is compiled into one excel spreadsheet by the data manager.
    b. Utilizing Credible reports, initial contact data is separated into areas of Emergency, Urgent, and Non-urgent.
    c. Calendar year initial contact data is totaled by those who have met the standard of care and those who have not met the standard of care in each of the three categories (Emergency, Urgent, and Non-urgent).
    d. Information gathered is then entered in the qualitative section of the Performance Measures Annual Report (PMAR) form by the data manager and submitted to the Corporate Compliance Officer for review.
    e. The Corporate Compliance Office reviews the PMAR and compares it with the initial contact data for accuracy.

f. The PMAR is then submitted by the Corporate Compliance Officer.

5. Enrollees who are placed on a waiting list for non-urgent care are queued in accordance with established criteria that treat like individuals in like circumstances similarly.

    a. If an appointment time for outpatient services is not immediately available within the required non-urgent time frame, the enrollee or his/her agent will be contacted with an available date and time not less than 24 hours before the required time frame lapses.
    b. DBH will place an enrollee on a waiting list only after providing an initial mental health evaluation and only if there is agreement between enrollee or the enrollee's agent and DBH that the need for general outpatient services is not urgent.
    c. The enrollee, regardless of diagnosis or treatment needs, is given a follow-up appointment not to exceed 20 working days from the date of placement on the waiting list.
    d. If the enrollee is placed on waiting list for specialty services (e.g., specialized therapy groups, psychosocial rehabilitation groups or programs, etc.) or for services with a specific provider, DBH offers or provides other needed outpatient services in the interim.
    e. Enrollees may remain on waiting lists for specialty services or for services with specific providers until openings become available as long as other appropriate outpatient services are offered or provided in the interim.
    f. If the enrollees (or their representatives) do not want other outpatient services in the interim, DBH documents the services that were offered and the enrollee's (or his or her representative's) decision.
    g. All enrollees will receive education about how to access emergency services.

6. Monitoring access to care

    a. The Executive Leadership Team will run the access to care report from the Credible data base every two weeks.
    b. The clinical director will take corrective action when necessary to adjust clinical capacity or individual assignments to ensure timely access to care.
    c. The corporate compliance officer will review access to care data by quarter with the QAPI committee.