Quality Assurance Bulletin

Quality Assurance Unit
County of Los Angeles – Department of Mental Health
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ACCESS TO CARE EXPECTATIONS AND REMINDERS

The Los Angeles County Department of Mental Health (DMH) is committed to providing our clients timely access to mental health care that is the right service by the right provider at the right time. In an effort to support our providers in this commitment, this Bulletin provides expectations and reminders related to access to care throughout the DMH system.

No Programs Are Exempt from Access to Care

Access to care requirements are across the board. No programs (e.g., Full Service Partnership (FSP), Wraparound, Multidisciplinary Assessment Team (MAT), Specialized Foster Care, CalWorks, AB109) are exempt from the access to care requirements in DMH Policy 302.07 – Access to Care and 302.14 – Responding to Initial Requests for Service. As a reminder, based on policy 302.14, all requests for services when the client/potential client is not currently being treated at your provider must be logged into the Service Request Log (SRL) or other DMH approved application (e.g., Service Request Tracking System (SRTS) or SRL web service).

Routine Requests - Inability to Accept Requests

The Department is committed to ensuring efficient management of the capacity of the DMH system of care. To that end, it is crucial that there are established criteria around the inability to accept new requests for services. The following criteria have been developed to provide guidance on when a provider should reach out to DMH to discuss when they can no longer accept new requests for services for routine requests (refer to DMH Policy 302.07 for the definition of routine):

1. Over the past three consecutive months, the typical (median) wait time for a routine appointment is greater than fifteen (15) business days AND the percentage of initial appointments offered within 10 business days is less than 60% OR
2. Over the past three consecutive months, the typical (median) wait time for a routine appointment is greater than twenty (20) business days OR
3. For Legal Entity providers, the LE has minimally reached 60%, but no later than 75%, of their Maximum Contract Amount (MCA) and/or Funded Program Amount for the fiscal year and as a result believes they will no longer be able to accept additional clients.

If one of the above three criteria exists, the provider must notify their Service Area Chief and Lead Contract Monitor (for Legal Entity providers) as soon as possible. If the inability to serve routine clients is for an intensive program (e.g., Full Service Partnership or Wraparound), the lead for the intensive program must also be notified. The notification should be made as soon as it is known there may be factors that prevent serving new clients and prior to not accepting new clients. At the point of notification, there should be a conversation to determine if/when a provider will not accept new requests.

At the point when it is agreed upon that a provider will not accept new requests, the provider must immediately update the Network Adequacy: Provider and Practitioner Administration (NAPPA) application to reflect that they are no longer accepting new clients. This allows the ACCESS Center, all service providers and the public to have current information into which providers are and are not accepting requests by ensuring the Provider Directory is up-to-date. In addition, the Quality Assurance

Unit will utilize this information to provide a list of providers no longer accepting requests to Department management.

Urgent / Hospital Discharge / Jail Release Appointment Requests
All providers must make every effort to accept urgent, hospital discharge and jail release appointment requests for service. If a provider is currently not accepting routine requests, the provider must discuss with their SA Chief and CMMD Lead (if applicable) whether they must continue to accept urgent/hospital discharge/jail release requests. Providers may not have agency policies that prevent accepting these requests. However, providers may determine on a case-by-case basis that specific urgent/hospital discharge/jail release requests cannot be accepted based upon inability to provide timely services. Providers should have a detailed written procedure on handling requests that cannot be accepted (e.g., through active linkage/warm handoff). Providers who are not open on the weekend should likewise have a detailed written procedure on handling urgent appointment requests, which must be seen within 48 hours (e.g., connection to a local urgent care center).

Refusing Requests
Providers have a responsibility to provide the services for which they are certified. Providers should rarely refuse a client an assessment and/or turn a client away. For example, an assessment should not be denied simply because a client states they do not want psychotherapy or a client is currently receiving services from another provider. Providers may only refuse to provide clients with specific services they are certified to provide after having completed an assessment of the client and with appropriate clinical justification. Providers cannot have a blanket policy in which the provision of one service is dependent upon another (e.g., a “no medication-only” policy). Each case must be individually evaluated. The provider may only impose limitations on services based upon community standards of care including professional ethical standards.

Providers should not refuse clients who reside outside of their respective service area and/or outside of the time and distance standards to appointment location if it is the client’s preference to receive services from them. In addition and under most conditions, providers should accept indigent clients in the same manner they accept all other clients. If a contracted provider believes funding issues will prevent acceptance, they should discuss this issue with their Lead Contract Monitor. Any policies or procedures that may lead to refusal of services should be discussed with the Service Area Chief, Lead Contract Manager or the Quality Assurance Unit.

The above direction should not be interpreted to prohibit providers from referring individuals back to their private insurance carrier (e.g., Kaiser) when appropriate. However, individuals with dual coverage that includes Medi-Cal must be served. In the majority of cases, Medi-Cal is the payer of last resort. Therefore, for clients with other health coverage, the other health coverage should normally be claimed to first. Please contact the Central Business Office (CBO) for additional information (CBO@dmh.lacounty.gov).

Monitoring Plan
As of September 2020, the Quality Assurance Unit has been monitoring access to care timeliness across the DMH system of care. All directly-operated and legal entity providers are monitored at the provider level on a quarterly basis. The metrics being monitored include (1) percent of untimely appointments across each of the request types (Urgent, Hospital/Jail Discharge, and Routine), (2) Notice of Adverse Benefit Determination (NOABD) issuance, and (3) quality of data (SRTS dispositions

entered timely, SRL records finalized timely, and SRL webservices submitted timely). The DMH benchmark for timeliness is 80%, and providers falling below that value are notified by the QA Unit as follows:

- 70-79% - notification email only
- 60-69% - notification email and request to submit a plan of correction
- Below 60% - notification email, request to submit a plan of correction, and technical assistance meeting (as needed)

The monitoring process for access to care is meant to be a collaborative process with providers working towards problem-solving and identifying solutions to ensure timely access to care for our clients.

DMH Policies 302.07 and 302.14 have been updated to reflect the information in this Bulletin and are awaiting final signatures. Other notable changes to these policies include:

- Added time and distance standards to appointment location per DHCS requirements (i.e. the time and distance it takes a client to travel from their residence to the nearest provider site shall be no more than 30 minutes and 15 miles unless the client prefers another location);
- Removed the need to record the initial request or transfer in *both* the SRTS and SRL, and clarified when each log must be used;
- Replaced reference to the Notice of Action (NOA) form with the NOABD form and referenced DMH Policy 200.04 - Beneficiary Problem Resolution Process;
- Incorporated applicable elements of former DMH Policy 302.04 - Triage and DMH Policy 302.12 - Provision of Services Without an Appointment.

If directly-operated or contracted providers have any questions related to this Bulletin, please contact the QA Unit NetworkAdequacy@dmh.lacounty.gov

cc: DMH Executive Management
DMH Administration Managers
DMH QA Liaisons
Legal Entity Executive Management
DMH Clinical Operations Managers
DMH Quality, Outcomes & Training Division
DMH CIOB Managers
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