

### *Access to Services*

NBH must ensure that Providers offer hours of operation that are no less than the hours of operation offered to commercial Members or comparable to Medicaid fee-for-service, if the Provider serves only Medicaid Members.

NBH makes medically necessary services available twenty-four (24) hours a day, seven (7) days a week. NBH Centers and independent Providers must have 24-hour/7 days-a-week coverage for their clients. NBH does not require individuals who cover for independent providers to be credentialed but do require state licensure.

NBH provides through its Centers and independent Providers access to services based on the severity of each case, i.e., emergency, urgent and routine.

**Emergency Services:** Emergency condition means a condition when acute symptoms are of sufficient severity that the prudent layperson, or one who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention or mental health services could result in the following:

- (1) Placing the health, safety, and/or well-being of the individual, or another person in serious jeopardy.
- (2) Leaving the person in a state of psychiatric impairment so severe that the person could not be reasonably expected to take care of him/herself.

Telephone emergency services shall be available in 15 minutes. In-person emergency services shall be available within one hour in urban areas and within two hours in rural areas.

**Urgent Services:** Urgent care shall be available within twenty-four (24) hours.

**Routine Services:** Routine services are available within seven (7) calendar days.

### *Compliance*

NBH has established mechanisms to ensure compliance by Providers with standards for timely access. Providers are monitored regularly to determine compliance with standards for timely access; and actions are taken if there is a failure to comply with standards for timely access.

Each Center shall track access data on a monthly basis and provide a summary report to the Director of Quality Improvement on a quarterly basis. Each Center is also required to provide a description of how they collect the data, describe how they assure the validity of the data and have detailed data available for inspection, if need be. Service Delivery must be clearly documented. All required data must be

submitted to NBH 15 days prior to the dates when access reports must be sent to HCPF.

Independent Providers are expected to adhere to the same standards and are monitored during quality assurance and for complaints which occur because of delays in accessing services. Independent Providers are required to report access when requesting initial authorization by completing the section on the Application for Initial Authorization (refer to Utilization Management section of this manual for the form)

If a Center or Independent Provider does not comply with the reporting guidelines, a corrective action plan is required that documents how compliance will be attained. The corrective action plan shall be in writing and will be reviewed by the Executive Director and Director of Quality Improvement.

### *Standards for Emergency Services*

Emergency telephone contacts must be responded to within 15 minutes.

For in-person emergency services the acceptable standards are:

- In-person within one (1) hour of contact in urban and suburban
- In-person within two (2) hours of contact in rural and frontier areas.

The standard applies to the time that occurs for a qualified mental health professional to contact the consumer requesting emergency services. If a consumer does not accept the offered appointment and chooses a later appointment the intent of the standard has been met, so long as the offered appointment is within the prescribed timeframes as stated above.

### *Specific Guidelines for Measuring Access Time*

#### **Emergency Services**

**General Rule:** The population to be counted includes each instance where NBH or a Center designated point of emergency access for NBH, receives a request for emergency services, and has an opportunity to respond to this request. The population to be counted does not include instances where people seeking services bypass NBH and the Center(s) designated to be a point of access for NBH, to locate services on their own. The following guidelines further explain this general rule

#### **Phone Calls**

Phone call that have been made by consumers needing emergency services are to be responded to within 15 minutes of first contact by the consumer.

Measurement begins when a telephone contact has been made and the minutes it takes for a response from a qualified professional. Random telephone calls are made to providers to determine the response time of an emergency call. An action plans will be developed if response time is not within the standard.

Measurement Ends when the qualified professions talks with the consumer.

Face to face emergency contacts

- The population to be counted includes each instance where a consumer or someone authorized to act on behalf of a consumer (e.g. hospital emergency room, police, family member, etc.) contacts NBH or a Center designated point of emergency access for NBH, seeking mental health services. It has been determined that the consumer requires face-to-face contact because they have an emergency as defined by the prudent layperson standard included in the federal regulations for managed care.
- The population to be counted does NOT include instances when the party requesting services goes to a site to receive emergency services, and there is a reasonable plan for the consumer to get to the service site, but the consumer does not show up at the service site. The exception to this guideline is that if the emergency response staff traveled to the service site in order to meet the consumer and provide emergency services, then the incident would be included in the population to be counted.

Measurement begins when a NBH or Center designated point of emergency access for NBH is first contacted by a consumer, or someone acting on behalf of the consumer, seeks in-person emergency services. The actual measurement time begins when there is an agreement between the consumer and the emergency care worker where and when to meet for the delivery of such services. For consumers who present for services at a hospital emergency room or who are referred to a hospital emergency room or other crisis center, measurement of access time begins when the individual is present and medically cleared and Center designated to be a point of access is notified that the consumer is medically cleared

Measurement ends when a face-to-face clinical mental health intervention begins to screen and stabilize the consumer, or when the mental health emergency response staff arrives at the agreed upon service site and is ready to begin the clinical intervention, whichever comes first.

The clinical intervention may be conducted by, an employee of a Center designated provider, a non-center network provider, or a provider outside NBH's network.

The provider must be qualified to provide emergency mental health services.

### **Urgent Services**

General Rule: This population is to be counted includes each instance where a designated point of access for the NBH receives a request for service that needs to be provided within 24 hours of the initial contact. An urgent request for service is determined through a triage process.

Measurement begins when the designated point of access determines through a triage process the request for service is urgent.

Measurement ends when the date and time of the first offered appointment is established.

### **Routine Services**

General Rule: The population to be counted includes each instance when an NBH Independent Provider or an NBH Center designated to be a point of access for NBH, receives a request for routine services, and has an opportunity to respond to this request. The population to be counted does not include instances where people seeking services bypass NBH and the Center(s) designated to be a point of access for NBH, to locate services on their own. The following guidelines further explain this general rule.

- The population to be counted includes each instance when a consumer or someone authorized to act on behalf of a consumer (e.g. family member, advocate, referral agency, etc.) contacts NBH or a Center designated to be a point of access for NBH, seeking to initiate mental health services. The consumer could be new to NBH, or a previous client who is seeking services after an absence.
- The population to be counted does NOT include instances when a consumer or someone authorized to act on behalf of a consumer contacts a provider directly, and without the knowledge of NBH or any Center designated to be a point of access for NBH.
- The population to be counted does NOT include instances when a consumer or someone authorized to act on behalf of a consumer seeks access through a specialty program with which NBH is affiliated. For example, if NBH participates in funding and/or staffing a program for children that is operated by a school, then instances where a consumer or someone acting on his/her behalf seek services directly through that program are not included in the population to be counted.
- The population to be counted does NOT include instances when a consumer or someone authorized to act on behalf of a consumer requests the services of a specific practitioner and does not wish to consider any other practitioner. This provision is meant to exclude from the population only those instances when a consumer truly has a preference for a specific clinician. It may not be used to exclude from the population instances when a consumer accesses services through

a CMHC intake system, is told that the first available appointment is not for several weeks, and then agrees to accept the appointment that was offered.

- If NBH refers a consumer or someone authorized to act on behalf of a consumer to the non-Center provider because NBH cannot offer a timely appointment with a Center provider, NBH has a method of follow-up to determine whether the consumer accessed services. To the extent that information is available on when a reasonable appointment was offered, these cases should be included in the data on access to routine services.

Measurement begins when NBH or a Center designated to be a point of access for NBH is first contacted by someone seeking routine services. For court ordered services, or services requested by another entity (probation, DHS, etc.), if there is a need for NBH to discuss and/or clarify the services with the agency, then measurement begins when the issue is resolved. Or, when the Department of Social Services has custody of a youth, and written consent is received by NBH or a Center to provide mental health services to that youth. Contact may be in-person, by phone, or by other means.

Measurement ends when NBH or a Center designated to be a point of access for NBH offers an appointment with an appropriate, qualified provider, at a reasonable time, while making reasonable accommodation for cultural/language needs and geographic accessibility.

The provider must be qualified to perform the services, as defined by the contract between NBH and the State.

The appointment must be for a clinical contact. The contact must include an assessment of the consumer's mental health care needs.

The date and time of the first offered appointment is the end measurement point.

Rejection, cancellation, or postponement of the appointment by the consumer, or failure of the consumer to keep the appointment, does not change the measurement point.

Cancellation or postponement of the appointment by the provider, or failure of the provider to keep the appointment, does change the measurement point. In this event, the measurement begins at the date and time of the initial contact, and ends on the date and time of the next reasonable appointment that is offered.

#### Offer of a Reasonable Appointment

There is no definition of what constitutes a "reasonable appointment" that fits every possible situation and set of circumstances. The determination of a

reasonable appointment calls for some judgment. The following guidelines may be helpful:

- Distance – Ensure Providers are located within 30 miles or 30 minutes travel time to the extent such services are available. In a rural area, a reasonable distance to travel for services is one that would be comparable with the distance that area residents have to travel for other common health care and human services. If someone lives in an area where they must travel 50 miles to see a primary care doctor, a dentist, a pediatrician, and a social services caseworker, then this is a reasonable distance to have to travel for an initial mental health appointment.
- Transportation – If it is determined that transportation is a barrier to accessing health and human services, and then an offer to provide or arrange for transportation could make a mental health appointment reasonable when it might not otherwise be a reasonable appointment.
- Hours – Appointments offered during normal business hours are reasonable. Appointments offered outside normal business hours are reasonable if they meet the needs of the consumer, but are not reasonable if the consumer is unable to make an appointment outside normal business hours and those are the only times offered. For example, if a consumer requests a Saturday appointment and no Saturday appointment is offered, the offer of a weekday appointment is reasonable. If a consumer is offered ONLY a Saturday appointment and that appointment does not work for the consumer, then the appointment offered is not reasonable.
- Language – Translation services are a reasonable accommodation if services are not available in either the consumer’s primary language or other language with which the consumer is comfortable.
- Cultural – Services by a provider who has training and/or experience in meeting the specific cultural needs of the consumer are a reasonable accommodation if services are not available from a provider who shares the consumer’s culture.

### *Care Coordination and Continuity of Care*

The consumer’s Care Coordinator (primary therapist) is responsible for coordinating all care coordination. This approach to care coordination is based on the belief that the most effective care coordination is provided by a professional who has an in-depth of, and an understanding of how mental health and non-mental health needs are interrelated and a thorough understanding of the individual consumer’s needs. The Care Coordinator model ensures all the consumer’s needs are identified in the

service plan and effective strategies to meet those needs are carried out in a coordinated fashion.

Care Coordination must address the Member's need for integration of mental health and other services. This includes identifying, providing, arranging for and/or coordinating with other agencies to ensure that the Member received the health care and supportive services that shall allow the Member to remain in her/his community maintaining independent living or to move them to independent living when they are ready.

The cornerstone of the NBH strategy for coordination of care toward recovery is its case management services. Inclusion of the case management plan as an integral component of the overall service plan demonstrates the importance of coordination through case management. For consumers with severe levels of impairment, the clinician-care coordinator may have the assistance of a case manager specialist and/or case manager aid. For consumers in inpatient settings and for whom transitioning back to the community involve complicating factors, an Intensive Services Coordinator may be assigned to assist the clinician-care coordinator.

NBH has transition guidelines to assure consumers who move between levels of care, or between service providers, get adequate support and structure to assure a positive transition. Consumers and family members and/or persons with legal custody are involved in the transition planning process to the extent that adult consumer allow, and in all instances with children and adolescents consumers to support this process. The individual service plan is the tool used to support this planning. They will work in consultation with NBH to determine the medical and/or clinical necessity of the covered service.

Coordination between mental health and medical care services is an essential component of successful treatment. NBH coordinates the consumer's mental health services with services of other medical providers to enhance the success of the consumer's recovery plan. NBH will assist Members in obtaining necessary medical treatment. If a Member is unable to arrange for supportive services to obtain medical care due to his/her mental illness, these supportive services will be arranged for by NBH or another person who has an existing relationship with the Member whenever possible.

NBH strongly supports co-delivery of physical health and mental health services in a single setting. Co-located services in a single setting improve consumer service goal achievement and coordination of aftercare. Such co-located services facilitate coordination of prescribed medications for consumers.

NBH is committed to the Recovery Model and using Wellness Recovery Action Plans (WRAP). This plan provides consumers a strong voice in directing their recovery efforts. The plan is strength-based and assists consumers in identifying, defining, and focusing on their strengths and resources. The WRAP plans encourage consumers to develop individualized crisis plans that include instructions and preferences or emergency treatment. The WRAP enables consumers to learn

practical approaches to recognizing the onset of symptomology and implementing their own strategies for helpful intervention

NBH is committed to establish preventive health programs based on the needs of its members. NBH will select preventive health programs to prevent or detect the incidence, emergence or worsening of behavioral disorders.

Medicaid recipients who reside in skilled nursing facilities receive medically necessary mental health services. NBH provides on-site services for residents who cannot travel to an NBH service delivery site.

### **Coordination of Care Case Management**

A case management plan is an essential part of the recovery process and must be written when ongoing or periodic contact exists with health and human service agencies, other support services, and family or significant others. This plan must be specific about the goals of the interaction with the other agencies or providers. Such plans are subject to supervisory review and are included in the peer review process of Quality Improvement Committee of each mental health center provider.

Different care coordination strategies are needed in different circumstances. When a consumer is receiving outpatient services, the consumer's individual care coordinator assumes primary responsibility. When consumers move between levels of care (i.e., from inpatient treatment to a lower level of care), Intensive Services Coordinators assist the primary care coordinator to assure that all possible avenues have been explored to find the appropriate level of care for that consumer.

### **Coordination with Medical Health Care Providers**

Providers will discuss with the consumers the need for coordination of his/her care with his/her Primary Care Physician or medical provider. Coordination with medical providers is most essential when the results of the medical screen included in the intake indicate a physical examination is needed or when the care coordinator becomes aware of a significant medical condition that is not being treated. If the consumer has no primary care physician, the Care Coordinator assists the consumer in finding a medical service provider. The Primary Care Physician or Medical Provider Notification form will be completed and, with the consumer's permission, sent to the medical provider.

The Care Coordinator determines if children, adolescents, and young adults up to age 22 have had an Early Periodic Screening and Diagnostic Testing (EPSDT) screen. If not, the Care Coordinator arranges for an appointment with medical personnel to complete the screen. The Care Coordinator attempts to obtain appropriate releases to allow consultation with primary care physicians when significant medical problems affecting the consumers are identified.

NBH Providers assist consumers in the qualification and enrollment process for medical benefits from other agencies, including HMOs that may be part of the

Medicaid benefit system. Consumers are informed of available resources, and the Provider exchanges medical and mental health information as authorized by the consumer when doing so facilitates accessing benefits.

NBH care coordinators work with nursing facility staff to arrange for travel to service delivery sites when consumers are able to do so. When private providers furnish mental health services to Medicaid eligible consumers in nursing facilities, NBH coordinates services with the nursing facility and the private providers.

### **Continuity of Care**

Continuity of care is an essential part of maintaining and enhancing the recovery process for the consumer. As the consumer utilizes different components of the service system, continuity of care must be maintained to facilitate the recovery process and ensure that consumers do not get "lost" within the system or failed to have medically necessary services provided.

*Transitions* is the movement between levels of care or between providers of services, which implies concurrent and bi-directional responsibilities of all relevant elements of the service system as specific aspects of the treatment plan change and collaboration among providers, which is required for a successful progression through the continuum of care

*Designated Care Coordinator* is the Care Coordinator who is assigned as the primary person responsible for the development and updates of the Individualized Service Plan.

NBH adheres to the following:

- Level of care guidelines shall be the clinical tool used when determining when a change of level of care is needed.
- Consumer involvement and choice shall guide the development of the transition planning and provider selections.
- Transition planning shall detail specific timelines and responsibilities of all parties involved in the transition period
- Transition plans that involve movement to a lower level of care shall include relapse prevention planning.
- In cases when a consumer moves to a high level of care due to safety, the providers of care will provide support and information to assure a smooth transition to the higher level of care.
- A case management plan will reflect the periodic contact with health and human services agencies, other support services and family or significant others. This plan must be specific about the goals of the interaction with the other agencies or providers and how these interactions relate to the overall service plan goals.

### **WRAP Plans**

- All NBH Providers will be trained in the WRAP concepts.

- Consumers will be identified when a WRAP plan is appropriate and discussed with consumers
- A WRAP plan will be completed if the consumer indicates a wish to do so
- Director of consumer affairs and consumers who have attended training on the WRAP concepts will also present training to consumers within the region.

### **Maintenance of Health**

- NBH Provider Newsletter will list preventive behavioral health programs that are available in the region
- The Director of Consumer Affairs will discuss and collect information from consumers about Health Maintenance Programs needed
- Brochures will be posted at areas where consumers can easily get information about preventive behavioral programs such as club houses, mental health center offices.
- The Club Houses News Letter will contain information about preventive health program.
- Providers and Consumers Advocates from NBH will be involved with health fairs throughout the region to make available information regarding preventive health programs.

### *Provider-Member Communications*

NBH shall not prohibit, or otherwise restrict, a health care professional acting within the scope of practice, from advising or advocating on behalf of a Member who is his/her patient, for the following:

- Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the Members needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or non-treatment; and
- The Member's right to participate in decision regarding his/her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

### *Nursing Facility Residents*

NBH shall provide medically necessary services on-site in facilities for Members who cannot reasonably travel to a service delivery site for their services. NBH requires residents who are able to travel to receive their services at a service delivery site. NBH will arrange for transportation, but will not be responsible for the cost of

transportation. If transportation cannot be arranged, services will be provided at the facility.

**NORTHEAST BEHAVIORAL HEALTH  
PRIMARY CARE PHYSICIAN OR MEDICAL PROVIDER NOTIFICATION**

**FORM #  
046**

<b>To:</b>			
<b>Address:</b> <small>(Street, PO Box, City, State, Zip)</small>			
<b>Telephone:</b>		<b>Fax:</b>	

**The Patient named below is receiving mental health services and has identified you as his/her Primary Care Physician or medical provider.**

<b>Patient Name:</b>		<b>Date of first appointment:</b>	
<b>Date of Birth:</b>		<b>Medicaid ID:</b>	
<b>DSM IV-TR Diagnoses</b>			
<b>Provider:</b>			
<b>Address:</b> <small>(Street, PO Box, City, State, Zip)</small>			
<b>Telephone:</b>		<b>Fax:</b>	

**The following initial/ongoing services has been recommended to the Patient and authorized as medically necessary:**

Outpatient Treatment:     Individual     Family  
 Group – Type

- Community Based Program     Residential Care     Vocational Services      
 Psychological Evaluation     Psychotropic Medications – Date referred for evaluation:

Check All That Apply:

- Copy of the Release of Information has been attached.  
 Please provide us with a summary of this patient's medical history and any medications you are currently prescribing.  
 Please contact me if you would like further information regarding the mental health treatment of this patient.

Signature of Provider	Date
Print name:	

**To be completed by Patient:**

- I do not have a primary care physician or other primary medical provider.  
 A referral has been made to a primary care physician or medical facility.  
 I do not want you to contact my primary care physician.

Patient Signature:	Date:
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## **INSTRUCTIONS FOR COMPLETING THE PRIMARY CARE PHYSICIAN OR MEDICAL PROVIDER NOTIFICATION**

All information must be completed. If the consumer does not want the PCP or Medical Provider notified then complete only the bottom section and file in consumer's chart.

- TO:** Write the name of the Primary Care Physician or other Medical Provider whom the consumer listed.
- ADDRESS:** Write the address of the Primary Care Physician or other Medical Provider to whom this form is being sent.
- PHONE #:** List the phone number of the Primary Care Physician or other Medical Provider to whom this form is being sent.
- FAX#:** Write the fax number if known of the Primary Care Physician or other Medical Provider to whom this form is being sent.
- PATIENT:** Write the legal name of the consumer, or the name for which the Physician is familiar.
- DATE OF ADMISSION:** Write the date when you first saw the consumer.
- DOB:** Write the consumers date of birth (MM/DD/YYYY).
- MEDICAID#:** Write the consumer's current Medicaid number.
- ADMITTING DIAGNOSIS:** Provide the DSM IV-TR diagnosis that was given to the consumer upon admission.
- PROVIDER:** Write the name of the clinician who will be treating the consumer.
- ADDRESS:** Write the address where the consumer will be receiving treatment.
- PHONE#:** List your phone number where the Primary Care Physician or other Medical Provider can contact you.
- FAX#:** Write your fax number where correspondences can be received.

**THE FOLLOWING INITIAL/ONGOING SERVICES HAS BEEN RECOMMENDED TO THE PATIENT AND AUTHORIZED AS MEDICALLY NECESSARY:** Complete this section as it pertains to the services the consumer will be receiving. For Group and Psychotropic Medications-referred for evaluation, be as specific as possible.

**COPY OF THE RELEASE OF INFORMATION HAS BEEN ATTACHED:** Always put a check mark by this statement and attach the Release of Information with this form prior to sending it to the Primary Care Physician or other Medical Provider. (If the consumer has given consent for a letter to be sent.)

**PLEASE PROVIDE ME WITH A SUMMARY OF THIS PATIENT'S MEDICAL HISTORY AND ANY MEDICATIONS YOU ARE CURRENTLY PRESCRIBING:** Always put a check mark by this statement when completing this form. (If the consumer has given consent for a letter to be sent.)

**PLEASE CONTACT ME IF YOU WOULD LIKE FURTHER INFORMATION REGARDING THE MENTAL HEALTH TREATMENT OF THIS PATIENT:** Always put a check mark by this statement when completing this form. (If the consumer has given consent for a letter to be sent.)

**SIGNATURE/DATE:** The Clinician who is completing this form must sign his/her name and provide the date the form was completed in the space provided.

**PRINTED NAME OF PROVIDER:** The Clinician who is completing this form must print his/her name in the space provided.

**FOR CONSUMER ONLY:** (Check all that applies.)

**I DO NOT HAVE A PRIMARY CARE PHYSICIAN OR OTHER PRIMARY MEDICAL PROVIDER:** It is imperative that this statement be checked if the consumer reports he/she does not have a Primary Care Physician or Other Primary Medical Provider.

**A REFERRAL HAS BEEN MADE TO A PRIMARY CARE PHYSICIAN OR MEDICAL FACILITY:** If a consumer reports he/she does not have a Primary Care Physician or other Medical Provider and the consumer appears to be in need of medical attention, or the consumer request a referral, give the consumer the toll free phone number for medical Medicaid: 1-800- 221-3943. If a referral was provided put a check mark next to this statement.

**I DO NOT WANT YOU TO CONTACT MY PRIMARY CARE PHYSICIAN:** If the consumer states he/she does not want you to contact the Primary Care Physician it is imperative that this statement be checked as it constitutes a refusal. Even if the consumer refuses contact with the PCP, the Primary Care Physician and Other Medical Provider Notification form **MUST** be placed in the consumer's chart.

**PATIENT SIGNATURE:** Legal name of the consumer.

**DATE:** The date in which the consumer signed the form.