

<b>Comprehensive Behavioral Health Management/College Health IPA Policy and Procedure Manual</b>	
<b>Policy Name:</b> Clinical Triage and Patient Access	<b>Accessibility, Availability, Referral and Triage</b>
<b>Date:</b> 8-93 <b>Reviewed by QI Committee:</b> 5-07, 5-08, 9-08, 5-09, 01-10, 5-10, 7-10 <b>Revised by QI Committee:</b> 5-07, 5-08, 9-08, 5-09, 01-10, 7-10	<b>Page:</b> 1 of 4 <b>Policy Number:</b> AR-4

**Purpose:** To ensure Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) patients receive the appropriate level of care based on their clinical needs.

**Policy:**

1.0 Routine Referrals

- 1.1 A routine referral is offered whenever: 1) Patient expresses a subjective level of distress, which has resulted in impairment in functioning; 2) Patient does not express danger to self or others; and 3) Patient does not report risk of child abuse, elder abuse, sexual abuse, or domestic violence.
- 1.2 Intake Specialists in accordance with the Intake and Referral Policy and Procedure (AR-2) give routine referrals.
- 1.3 Routine referrals to psychiatry are given by an Intake Specialist upon patient request or upon a referral from a primary care physician or another licensed clinician.
- 1.4 Routine referral appointments are to be offered within fourteen calendar days. Target for compliance is 85%.

2.0 Administrative Urgent Referrals

- 2.1 An administrative urgent referral is offered whenever: 1) Patient is not at risk of self or other harm or gravely disabled, but his/her level of functioning indicates need for assistance in appointment scheduling to ensure routine time frame is met; 2) Patient previously received a list of routine referrals and/or was unable to schedule an appointment within the routine time frame.
  - 2.1.1 Intake Specialists can determine an administrative urgent appointment is appropriate in response to a patient being unable to schedule a routine appointment.
  - 2.1.2 Following a Risk Assessment, licensed clinicians may determine need for administrative urgent referrals based upon patient’s level of functioning and need for assistance scheduling appointment within routine time frames.
- 2.2 Administrative urgent referrals to psychiatry are given based upon patient request or upon a referral from a primary care physician or another licensed clinician.
- 2.3 Administrative urgent referral appointments are scheduled based upon patient preference, provider availability, and licensed clinician guidance. Time frame is not to exceed 14 calendar days from the time of the original request for services. Target for compliance is 90%.

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3.0 Urgent Referrals

- 3.1 An urgent referral is offered whenever: 1) Patient expresses a subjective level of distress, which has resulted in significant impairment in functioning; 2) Patient is emotionally distraught over the phone; 3) Patient does express danger to self or others but is contracting for safety and has a support system; and/or 4) Patient does report risk of child abuse, elder abuse, sexual abuse, or domestic violence.
- 3.2 Licensed clinicians determine need for urgent referrals following a clinical assessment with patient and/or guardian.
- 3.3 Urgent referrals to psychiatry are based upon clinical presentation or upon a referral from a primary care physician or another licensed clinician.
- 3.4 The licensed clinician will follow-up with all referral sources to ensure that the patient was assessed and receiving appropriate treatment.
- 3.5 Urgent referral appointments are to be scheduled within health plan guidelines, not to exceed forty-eight hours. Target for compliance is 100%.

4.0 Emergent Referrals

- 4.1 An emergent referral is offered whenever: 1) Patient expresses a subjective level of distress, which has resulted in significant impairment in functioning; 2) Patient is emotionally distraught over the phone; 3) Patient expresses danger to self or others and cannot contract for safety; and/or 4) Patient reports imminent risk of child abuse, elder abuse, sexual abuse, or domestic violence.
- 4.2 Licensed clinicians determine immediacy of emergent referral following a clinical assessment with patient and/or guardian, which includes evaluation of: 1) Current suicidal or homicidal ideation; 2) Presence of suicidal or homicidal plan; 3) Access to means to carry out plan; 4) Personal and/or family history of suicide or homicide; 5) Available support system; and 6) History of substance abuse.
  - 4.2.1 If a patient has suicidal or homicidal ideation and no plan or history of suicide or homicide, can contract for immediate safety, and is willing to go to a psychiatrist appointment or an emergency room for evaluation, and has support to transport, a referral will be made to either see a psychiatrist within six hours or go to the closest contracted facility for an assessment within six hours.
  - 4.2.2 If a patient has suicidal or homicidal ideation and no plan or history of suicide or homicide and can contract for immediate safety but has no support to transport to a facility, a referral will be made for a Psychiatric

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Evaluation Team (PET) assessment. The patient will be advised that the PET personnel will be accompanied by the Police Department.

- 4.2.3 If a patient has suicidal or homicidal ideation or has plan for either and cannot contract for immediate safety, the licensed clinician will notify the nearest 911 Call Center to respond to patient’s home. To determine the nearest 911 Call Center, the clinician can
    - 4.2.3.1 Call local 911 and ask to be redirected
    - 4.2.3.2 Complete web search and call local police department number.  
Web site: <http://www.usacops.com/ca/>
  - 4.2.4 The same referral procedure will be followed if a patient is determined to be gravely disabled and needing immediate assessment.
  - 4.3 The licensed clinician follows up with all referral sources to ensure that the patient was assessed and receiving appropriate treatment.
  - 4.4 Emergency referrals are scheduled based upon above assessment needs. Target for compliance is 100%.
- 5.0 Clinical Supervision
- 5.1 Decisions to call 911 for a safety check are immediately reported to the designated clinical supervisor after the call has been placed. The after hours clinicians can leave a voicemail for pick-up the next business day.
  - 5.2 If the decision to call 911 for a safety check is unclear, the designated clinical supervisor is notified and after review a determination made. As needed the Medical Director is contacted for final review. The after hour clinicians contact the designated clinical supervisor by telephone.
  - 5.3 Designated clinical supervisors may be any of the following positions
    - 5.3.1 Vice-President of Clinical Services (primary)
    - 5.3.2 Director of Intensive Services (secondary)
    - 5.3.3 Director of Care Management (secondary)
    - 5.3.4 Vice-President of Product Management and Compliance (tertiary)
  - 5.4 A quarterly log of all 911 referrals is given to the Medical Director for review and reported in the corresponding UM Committee meeting. The log includes:
    - 5.4.1 Member ID
    - 5.4.2 Date and Time of Call
    - 5.4.3 Medical Necessity for Call
    - 5.4.4 Outcome of Call

6.0 Monitoring Compliance

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- 6.1 Monthly reports are run by the QI Assistant, which measure routine, urgent, and emergent appointment access.
- 6.2 Routine access is reviewed through the Network Management Committee to ensure provider availability is adequate and compliance target met.
- 6.3 Urgent and Emergent access is reviewed through the Utilization Management Committee to ensure all patient safety issues were addressed and that compliance target met.
- 6.4 Whenever compliance targets are not met, corrective action is initiated and this is reported to the Quality Improvement Committee.