Timely Access Desk Guide

Population Health, Network Quality and Planning (NQP)
San Diego County Behavioral Health Services (SDCBHS)



COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

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Section 1: Timely Access Guide

1.1 Introduction

The San Diego County Behavioral Health Services (SDCBHS) Timely Access Manual establishes standardized guidance for documenting, measuring, reporting, monitoring, and improving Timely Access to behavioral health services across the County's System of Care.

The purpose of this manual is to provide a single, comprehensive source of guidance regarding Timely Access requirements and County methodology. This manual translates the California Department of Health Care Services (DHCS) requirements into standardized operational procedures and documentation expectations to support consistent implementation across the entire provider network, including County-operated programs, contracted providers, subcontracted providers, Fee-for-Service (FFS) providers, and other participating entities.

This manual serves as the official SDCBHS reference for Timely Access methodology and should be used in conjunction with current regulatory guidance, Behavioral Health Information Notices (BHINs), DHCS reporting instructions, and County-approved workflows and procedures.

1.2 Scope

This manual applies to all behavioral health services subject to Timely Access requirements and reporting obligations. The manual applies to all Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services including:

- County-operated behavioral health programs.
- Contracted behavioral health providers.
- Subcontracted providers.
- Fee-for-Service providers when applicable.

This manual addresses:

- Timely Access standards.
- County methodology.

Timely Access Record requirements and SmartCare documentation expectations.

- DHCS and Local reporting.
- Data quality monitoring.

1.3 Regulatory Framework

Timely Access requirements are established through Federal and State regulations and are administered through the California Department of Health Care Services (DHCS).

DHCS requires Behavioral Health Plans (BHPs), to establish and maintain systems for tracking, measuring, and monitoring access to behavioral health services. DHCS utilizes the Timely Access Data Tool (TADT) to evaluate compliance with Timely Access standards.

When DHCS State guidance changes, SDCBHS will review and update County methodology as appropriate.

1.4 Monitoring Access to Behavioral Health Care

Timely Access information serves both operational and regulatory purposes. SDCBHS uses Timely Access data to support quality improvement, technical assistance, monitoring, and dashboard reporting. DHCS uses TADT submissions to assess compliance with Timely Access requirements and Network Adequacy standards. Consistent documentation across the provider network is critical to maintaining data integrity, informing quality improvement efforts, and meeting state monitoring and compliance requirements.

Timely Access data are also used by SDCBHS to support local quality improvement activities, identify access barriers, monitor trends, guide technical assistance efforts, and improve consistency across the System of Care.

Section 2: Timely Access Fundamentals

2.1 Understanding Timely Access

Timely Access requirements are intended to ensure that Medi-Cal beneficiaries are able to obtain behavioral health services within established timeframes. DHCS utilizes annual Behavioral Health Network Adequacy Certification Requirements to evaluate compliance with established appointment wait time standards. DHCS calculates compliance using the member's Date of First Contact to Request Services and the *First Available Offered* appointment that qualifies as a billable service. The measure focuses on system responsiveness and a member's ability to access services in a timely manner.

Timely Access is not intended to independently measure:

- Provider productivity
- Program performance
- Clinical outcomes

While these factors may influence Timely Access performance, the primary purpose of Timely Access reporting is to evaluate access to care and compliance with DHCS requirements.

2.2 Timely Access Standards

Timely Access requirements vary based on the type of service being requested. Certain appointment categories are subject to specific State-established standards and must be tracked and reported through the Timely Access Data Tool (TADT).

The below appointment categories are subject to Timely Access standards:

Specialty Mental Health Services (SMHS)

Appointment Type	Standard
Non-Urgent Outpatient Specialty Mental Health Services	First appointment offered within 10 business days
Psychiatry Services	First appointment offered within 15 business days
All Urgent SMHS Appointments	Within 48 hours without prior authorization Within 96 hours with prior authorization
Non-Urgent Follow-Up Appointment with a Non-Physician	First appointment offered within 10 business days of the prior appointment

Drug Medi-Cal Organized Delivery System (DMC-ODS)

Appointment Type	Standard
Outpatient Substance Use Disorder Services	First appointment offered within 10 business days
Residential Treatment	First appointment offered within 10 business days
All Urgent DMC-ODS Appointments	*Within 48 hours without prior authorization* *Within 96 hours with prior authorization*
Non-Urgent Follow-Up Appointment with a Non-Physician	First appointment offered within 10 business days of the prior appointment
Withdrawal Management Services	Within 48 hours (all WM are Urgent)
Opioid Treatment Program (OTP) Services	Within 3 business days

Timely Access requirements apply regardless of whether services are delivered through County-operated programs, contracted providers, subcontracted providers, Fee-for-Service providers, or qualifying Out-of-Network providers when those services fall within reportable categories.

Timely Access Clock and Holiday Exclusions

For non-urgent Timely Access standards measured in business days, the Timely Access clock begins on the first business day following the Request for Services. For example, if a Request for Services is received on a Monday, Tuesday is counted as Business Day 1. If a Request for Services is received on a Friday, the following Monday is counted as Business Day 1, unless Monday is an observed holiday. This methodology is intended to ensure consistent calculation of appointment wait times across the System of Care and aligns with DHCS business-day measurement practices for Timely Access standards.

Key Note: The "timeliness clock" for referrals submitted on behalf of members by other agencies (e.g., justice system referrals, inpatient hospitals, etc.) begins when the Behavioral Health Plan (BHP) assumes full responsibility for providing SMHS, Psychiatry, or DMC-ODS services. BHPs are not required to report timely access data in the TADT for members who remain hospitalized or are still justice-involved. Please refer to DHCS FAQ, 2026 for further information.

Timely Access business-day calculations exclude holidays recognized by DHCS for Timely Access reporting purposes. Days designated as holidays are not counted as business days and are not included when calculating compliance with Timely Access appointment standards. In addition to DHCS-recognized holidays, SDCBHS excludes Juneteenth (June 19) from local Timely Access calculations to align with County of San Diego observed holiday schedules. Refer to BHIN 26-023, page 39 for further information.

Request Received	Business Day 1
Monday	Tuesday
Tuesday	Wednesday
Wednesday	Thursday
Thursday	Friday
Friday	Monday (unless holiday)
Weekend	Monday (unless holiday)
Day before Holiday	First business day after holiday

For Timely Access calculations, the following holidays are excluded from business-day counts:

Holiday	Date Observed
New Year's Day	January 1
Martin Luther King Jr. Day	Third Monday in January
Presidents' Day	Third Monday in February
Farmworkers Day	March 31
Memorial Day	Last Monday in May
Juneteenth*	June 19
Independence Day	July 4
Labor Day	First Monday in September
Veterans Day	November 11
Thanksgiving Day	Fourth Thursday in November
Day After Thanksgiving	Friday following Thanksgiving
Christmas Day	December 25

*SDCBHS local holiday exclusion. Included to align Timely Access calculations with County of San Diego observed holidays (refer to DHCS FAQ, 2025, Page 3 for further information).

Holiday Calculation Example

A member requests services on Friday, July 3, and July 4 is observed on Monday, July 6.

Date	Counted
Friday, July 3	Request received
Monday, July 6	Holiday (not counted)
Tuesday, July 7	Business Day 1
Wednesday, July 8	Business Day 2

In this example, the Timely Access clock begins on Tuesday, July 7, because the observed holiday is excluded from the business-day calculation.

Important Note: SmartCare and Timely Access dashboards automatically calculate business days and Timely Access performance measures. Users should focus on accurate documentation of request dates, appointment offers, Member Choice, urgency, and other required data elements, as calculation of applicable business days is automated.

Section 3: Timely Access Methodology

3.1 Establishing Methodology

The purpose of this section is to establish standardized County methodology for operationalizing Timely Access requirements. Where DHCS provides explicit direction, SDCBHS follows that direction. Where DHCS allows operational flexibility or does not prescribe a specific workflow, SDCBHS establishes a standardized methodology to promote consistency across the System of Care.

For County operational purposes, staff must identify four core elements:

- The original Request for Services Date.
- The requested service line and applicable Timely Access standard.
- Whether the request is urgent or non-urgent.
- The first available qualifying appointment actually offered to the member.

3.2 Date of Contact/Request for Services

Timely Access measurement begins when a member requests behavioral health services. The *Request for Services Date* is the date a provider receives a request or referral for behavioral health services and has sufficient information to document the request in SmartCare. A request is considered sufficiently documented when staff have the minimum information required to identify and/or create the client record, identify the requested service, document the referral source, and record the date the request was received (further details provided in section 4).

Requests for services may originate from multiple sources, including, but not limited to:

- The client/member directly
- A parent or legal guardian of a dependent child or youth
- Schools, healthcare providers, or community-based organizations
- County departments or contracted providers
- Other third-party referral sources

The date the request is first received and documented constitutes the *Request for Services Date* for Timely Access purposes. The *Request for Services Date* remains unchanged throughout the life cycle of the referral and associated service request. This date does not change because 1). The referral is transferred between programs, or if 2). The receiving program receives the referral on a later date. The original Request for Services Date must be maintained through completion of the requested service line and remains associated with the Timely Access record until the record is either:

- Fulfilled and signed, or
- Closed and signed

3.3 New Service Request

A New Service Request is a request for a covered service that the client is not currently receiving, regardless of whether the client is new to treatment or already engaged in other services. A New Service Request exists when: 1). the client is seeking a different service type than they are currently receiving (e.g., a client receiving outpatient non-psychiatric services is referred for psychiatric services); 2). the requested service represents a new treatment pathway, modality, or level of care that the client is not currently receiving; or 3). the client is requesting services from a different delivery system, such as moving from SMHS to DMC-ODS services. A new Timely Access Record should be created for each New Service Request.

3.4 First Available Offered Appointment

First Available Offered Appointment Defined

The earliest qualifying appointment, including an appropriate walk-in slot, that is available and is offered to the client at the time the request/referral is received and processed in accordance with program procedures. The appointment must be one that could reasonably be scheduled based on current program/provider availability and must be communicated to the client through an approved method consistent with privacy and program requirements. *The client is not required to accept the appointment for it to be recorded as the First Available Offered Appointment*. Provider or program availability alone does not constitute an offer; the appointment must be actually offered to the client. This reflects DHCS timely access requirements that measure the earliest available appointment offered, regardless of whether the member accepts a later date.

The First Appointment Offered Date must be based on: 1). Program capacity and provider availability, and 2). The actual appointment date offered to the client.

As verified by DHCS, an appointment offer may be communicated through various methods, including:

- Direct verbal communication with the client;
- Telephone communication;
- Secure voicemail messages;
- Secure mail or written correspondence;
- Other program-approved communication methods that comply with privacy and security requirements.

When an appointment offer is communicated through voicemail, mail, or another indirect communication method, the offer may be considered valid for Timely Access purposes only when:

1. A specific appointment date and time is offered;
2. A response deadline is communicated to the client;
3. The offered appointment remains reserved for that individual client until the stated response deadline has passed; and
4. The communication method is consistent with program workflows and applicable privacy, confidentiality, and PHI requirements.

For Timely Access purposes, one offered appointment may only be reserved for one client. Programs shall not document the same offered appointment slot as being simultaneously offered to multiple clients.

3.5 Urgent and Non-Urgent Requests

Timely Access standards differ depending on whether a request for services is determined to be urgent or non-urgent.

A request should not be classified as urgent solely based on the language used by the member, referral source, provider, or other individual making the referral. Rather, urgency should be determined through the provider's screening and assessment process using applicable clinical and operational criteria. Urgent referrals require both the *Date of Contact to Request Services* and *Time of the Request*.

If screening changes the initial determination, the request must be reclassified and the applicable standard updated. Section 4 explains how to document the original designation and any correction in SmartCare.

3.6 Follow-Up Appointments

For Timely Access purposes, a follow-up appointment offer represents the next available qualifying appointment offered to a member following the first rendered service. *With the exception of psychiatric services*, all reportable service categories require documentation of a follow-up appointment offer.

Section 4 identifies the workflow for completing required follow-up fields and addressing rescheduling, declination, or unavailable appointments.

3.7 Member Choice and Other Member-Related Circumstances

Members may choose to wait for a preferred provider, appointment time, modality, or location even when an earlier appointment was available. Member Choice should only be used when a delay beyond the applicable Timely Access standard occurred, and the member chose to wait for a preferred appointment, provider, location, or other scheduling preference after being offered available alternatives. If no appointment is available within the required timeframe, the member should be offered an alternative provider with availability that meets the standard, including an out-of-network provider when applicable. If the member declines the available option(s) and elects to wait for a preferred option instead, Member Choice may be selected as the reason for the delay.

3.8 Refer to Out-of-Network Provider

When services cannot be provided through an available in-network provider, members must be afforded access to covered services through an appropriate out-of-network provider consistent with DHCS requirements.

Section 4: SmartCare Workflow and Documentation

4.1 SmartCare Workflow and Documentation

Timely Access Records are required for any new service request. The purpose of the record is to document key Timely Access milestones throughout the access process, including the request for services, appointment offers, service initiation, and applicable follow-up appointments.

Unlike many clinical documents, Timely Access Records often remain open for an extended period because required data elements may occur over several days or weeks. Information may also be collected by multiple staff members throughout the access process. For this reason, Timely Access Records are designed to allow updates throughout their lifecycle and may be completed by individuals other than the original author when appropriate.

Staff should update the Timely Access Record as information becomes available and save the document throughout the access process. A Timely Access Record is considered complete once all required Timely Access elements have been documented and, when applicable, the member has received the first required follow-up service. In situations where the member does not proceed through the full access process, the Timely Access Record may be closed using the appropriate closure status. Once a Timely Access Record has been completed or closed, the document should be reviewed and signed by the appropriate author.

CalMHSA: Timely Access Records

4.2 Inquiry Screen Workflow

Completing the Inquiry Screen

The Inquiry Screen serves as the starting point for documenting a request for BHS and supports consistency in Timely Access reporting across the System of Care.

The Inquiry Screen should be completed by the program or provider that initially receives the request for services whenever sufficient information is available to document the request in SmartCare. The Inquiry Screen establishes the original Request for Services date and serves as the source document for subsequent Timely Access activities. The information documented on the Inquiry Screen may be used by another program if the request is transferred due to capacity limitations, service availability, or other operational considerations.

Minimum Information Necessary to Save the Inquiry Screen

Every effort should be made to enter all clients' demographic and insurance information at the time of the request. If all information is not available, the minimum information necessary to save the Inquiry Screen is:

1. Complete the First Name and Last Name fields.
2. Complete the SSN and DOB fields, entering the client's Social Security Number (SSN) and Date of Birth (DOB), respectively. If the client does not know their SSN or declines to provide it, select the "SSN Unknown/Refused" checkbox. Once saved, SmartCare will automatically populate the SSN field with "999999999," which serves as SmartCare's placeholder for clients without a documented SSN.
3. Complete the Language field.
4. Demographics and insurance tabs should be completed if the program receives this information.
5. Complete the Urgency Level, Inquiry Type, and Contact Type fields. Refer to the tables below for available options and descriptions of when to select each.
6. Click Save.

Key Note: There should be one Inquiry Screen entry for each service request. The Inquiry Screen entry follows the service request until completed.

How to Document an Inquiry - 2023 CalMHSA

Using Inquiry Screen to Document Crisis Referrals

The Crisis tab is only visible when the Crisis checkbox is selected. This tab allows crisis services to be documented directly from the Inquiry Screen.

As with other services, a Program must be selected before entering a Procedure Code. A Start Date and Start Time are also required. Unlike other service entries, the Crisis tab requires an End Time (for example, 11:35 PM) rather than a Service Time duration (for example, 62 minutes).

All required fields must be completed before the record can be saved.

Please refer to the SmartCare Guide for Crisis Stabilization Units for further information.

Transfers Between Programs

Because Timely Access is intended to measure access across the behavioral health system rather than at the individual program level, the preferred County methodology is to maintain a single Timely Access Record for the same service request when a referral is transferred between programs. The original Request for Services date should be preserved, and the receiving program should continue documenting the record. A new Timely Access Record should only be created when the member is requesting a new service.

Example

- Program A receives a referral and completes the Inquiry Screen.
- Program A does not have capacity.
- The referral (Inquiry) is transferred to Program B.
- Program B initiates the Timely Access Record using the original Request for Services date.
- Timely Access reporting continues without restarting the Timely Access clock.

4.3 Selecting and Initiating Timely Access Records

A Timely Access Record should be created after the Inquiry Screen. When completing the Timeliness Record, staff must verify the request for service date in the Inquiry Screen. Upon receipt of the referral and determination that the program is responsible for addressing the service request, the program shall initiate the appropriate Timely Access record.

Select the Appropriate Timeliness Record

Use the service requested to select the appropriate SmartCare Timeliness Record. For DMC-ODS outpatient and residential requests, staff use the same record and select the applicable service type within the record.

Service Requested	SmartCare Timeliness Record	Selection Within the Record
Urgent and Non-urgent SMHS outpatient services	MH Non-Psychiatric Timeliness Record	No additional service-type selection.
Urgent and Non-urgent Psychiatric Services	MH Psychiatric Timeliness Record	No additional service-type selection.
Urgent and Non-urgent DMC-ODS Outpatient Services	DMC-ODS Outpatient Timeliness Record	Select Outpatient.
Urgent and Non-urgent DMC-ODS Residential Treatment	DMC-ODS Outpatient Timeliness Record	Select Residential.
Opioid Treatment Program (OTP)/NTP/Withdrawal Management Services- **For Opioid Services ONLY**	DMC-ODS Opioid Timeliness Record	No additional service-type selection.
Withdrawal Management (WM)	DMC-ODS Opioid Timeliness Record or DMC-ODS Outpatient Timeliness Record	**WM is always an urgent service.**

DMC-ODS utilizes a single Timely Access form for both outpatient and residential services. When initiating a DMC-ODS Timely Access Record, staff must identify the service type being requested and select the appropriate service category within the OP timely access form.

DMC-ODS Opioid Timeliness Record is ONLY for opioid treatment. MAT services that are not providing opioid treatment should use the DMC-ODS Outpatient Treatment Record (refer to DHCS FAQ 2025 and NAOS BHIN Webinar FAQ FY25-26 for further information).

4.4 Complete Timeliness Core Fields

SmartCare Field	Completion Guidance
Referral Source	Identify the person or entity that referred the member to services. Select Self when the member requests services directly. For Psychiatry referrals from an MHP program, select Other County/Community Agency. For non-psychiatric services, excluding walk-in services, refer to the Client Inquiry - Referral Type.
Urgent	Select when the request meets the applicable urgency criteria. For non-psychiatric services, excluding walk-in services, refer to the Client Inquiry - Urgency Level. Urgent requests require completion of date and time fields.
Date of First Contact to Request Services	Enter the date the member initially requested services or agreed to a request made by a third party. For non-psychiatric services, excluding walk-in services, refer to the Client Inquiry - Request Date.
Date of First Contact to Request Services - Time	Complete only when the request is marked Urgent because urgent Timely Access is measured in hours rather than days. For non-psychiatric services, excluding walk-in services, refer to the Client Inquiry - Start Time.
Prior Authorization Required	Indicate whether prior authorization is required for the requested service. Apply the approved County and payer-specific workflow.
First Service Appointment Offered Date	Enter the earliest available qualifying appointment actually offered to the member, regardless of whether the member accepts it. For same-day services, enter the current date. If no appointment is offered, the member declines all available appointments, or the member refuses the referral, leave the field blank and complete the applicable Closure fields.
First Service Appointment Offered Date - Time	Complete only when the request is marked Urgent.
Referred to an Out-of-Network Provider	Complete this field only when an initial appointment cannot be offered within the applicable Timely Access standard, and the member is referred to an out-of-network provider.
Reason for Delay	Complete when the first offered appointment falls outside the applicable Timely Access standard. Select the applicable reason and provide supporting documentation as required.

First Service Appointment Rendered Date	Enter the date the member completes the first qualifying service. For a same-day service, enter the current date. The Rendered Date may differ from the originally accepted appointment. If the member does not attend, leave the field blank and complete the applicable Closure fields.

SmartCare Field	Completion Guidance
Follow-Up Appointment Not Offered	Select when a follow-up appointment was not offered for any reason. Complete the applicable Closure fields before signing the Timeliness Record.
First Follow-Up Appointment Offered Date	Enter the earliest available qualifying follow-up appointment offered after the first rendered service. The follow-up appointment may occur on the same day as the initial service but must represent a separate service encounter.
Documentation of Clinical Appropriateness of Wait-Time Extension	Complete this field when the first follow-up appointment offered falls outside the applicable Timely Access standard and the provider determines that the extended wait time is clinically appropriate. The provider must document that the longer wait will not have a detrimental impact on the member's health or treatment needs.
First Follow-Up Appointment Rendered Date	Enter the date the member completes the follow-up service. The follow-up service may occur on the same day as the initial service or after a rescheduled appointment. If the member does not attend, leave this field blank and complete the applicable Closure fields.

Reason for Delay

Regardless of the reason, if the First Available Offered Appointment falls outside the applicable Timely Access standard, the Reason for Delay field should be completed in accordance with SmartCare and County guidance. SmartCare makes delay fields available when appointment dates fall outside required timelines.

[How to complete a Timely Access Record- CalMHSA]

4.5 Urgency Determination

Determination of Urgency

Urgency determination is required for all Timely Access requests. To promote consistency across the System of Care, SDCBHS utilizes the following operational questions to support urgency determinations. A response of "Yes" to any one of the applicable questions generally indicates that the request should be managed as an urgent request for Timely Access purposes. These questions are intended to support operational decision-making and do not replace provider clinical judgment.

Specialty Mental Health Services (SMHS) Urgent Service Operational Questions

1. Is the member pregnant or experiencing a severe medical condition and at risk for complications if behavioral health symptoms are not addressed within the next 48 to 96 hours?
2. Does the member appear to be at imminent risk of:
    - Suicide;
    - Homicide;
    - Grave disability;
    - Significant property destruction;
    - Loss of housing; or
    - Incarceration within the next 48 to 96 hours?
3. Is the member indicating they will run out of antipsychotic medications, mood stabilizers, benzodiazepines, or other critical psychiatric medications within the next seven days?
4. Is there any other indication that the member requires urgent mental health treatment services?

Drug Medi-Cal Organized Delivery System (DMC-ODS) Urgent Service Operational Questions

1. Does the member require Withdrawal Management services?
2. Is the member pregnant?
3. Does the member appear to be at imminent risk of overdose within the next several hours or days?
4. Is the member indicating they are running out of anti-craving or medication-assisted treatment medications, including:
    - Naltrexone;
    - Buprenorphine; or
    - Methadone?
5. Is there any other indication that the member requires urgent substance use disorder treatment services?

4.6 Updating the Timely Access Record

Timely Access Records are intended to remain active while information continues to be collected. As milestones occur, staff should update the record to document:

- First appointment rendered date.
- Follow-up appointment information.
- Closure information (as applicable).

The record should be updated as information becomes available rather than waiting until all access activities have occurred. Additionally, live records should be updated if earlier appointments become available. For example, if a program has an earlier available date than the original documented offered date, the offer date should be modified to record the new date.

4.7 Closing and Signing the Record

Once all required/applicable Timely Access milestones have been documented, staff should review the record for completeness before signing. Please refer to Section 6 for Timely Access Section data validation.

Key note: For a record to be completed, Follow-up Offered Appointment and Follow-up Rendered Appointment must be complete (or First Available Offered and Rendered if MH Psychiatric Timeliness Record), and the record is signed. For all other scenarios, the record is closed. When a record is closed, a closure date *and* a closure reason are mandatory before signing the form.

Section 5: Common Scenarios

5.1 Initial Inquiry

Scenario A: Receiving Program Can Meet Timely Access Requirements

1. A request for services is received by Program A.
2. Program A initiates an Inquiry Screen in SmartCare and documents:
    - Request for Services Date
    - Referral source
    - Presenting need/request
    - Any other required referral information
3. Program A determines it can provide the requested service within applicable Timely Access standards.
4. Program A initiates the appropriate Timely Access record using the original Request for Services Date documented on the Inquiry Screen.
5. Program A completes the Timely Access process through fulfillment or closure.

Scenario B: Receiving Program Cannot Meet Timely Access Requirements

1. A request for services is received by Program A.
2. Program A initiates an Inquiry Screen in SmartCare and documents:
    - Request for Services Date
    - Referral source
    - Presenting need/request
    - Any other required referral information
3. Program A determines it cannot provide the requested service within the required Timely Access timeframe.
4. Program A completes the Inquiry Screen and transfers the referral to Program B.
5. Program B reviews the Inquiry Screen and initiates the appropriate Timely Access record.
6. Program B must use the *original Request for Services Date documented on the Inquiry Screen*.
7. Program B must **not** use the date the referral was received from Program A as the Request for Services Date.
8. Program B completes the Timely Access process through fulfillment or closure.

Workflow scenarios are available in the appendix.

5.2 Unable to Contact

Services are Requested, and Contact is Not Made

If the program is unable to reach the client, staff will:

1. Create the appropriate Timely Access record.
2. Document outreach attempts in accordance with program policy.
3. Enter contact attempts through the documentation process required by the program (e.g., contact notes, information notes, or other approved documentation methods).
4. Follow program-specific requirements regarding:
    - Outreach procedures;
    - Number of outreach attempts;
    - Acceptable communication methods;
    - Documentation standards; and
    - Criteria for closing referrals due to inability to contact the client.

Because outreach and engagement procedures vary among providers, each program's established policy should be followed when determining the number of contact attempts required and how those attempts are documented, and when a referral should be closed due to no contact.

If contact with the client is not established and the referral is closed due to inability to reach the client:

- The First Appointment Offered Date field in the Timely Access record will remain blank.
- Staff will select the appropriate closure reason and date.
- Unable to Reach Client will be selected when closure is due to unsuccessful outreach efforts.
- The Timely Access record needs to be signed upon completion of the closure process.

A First Appointment Offered Date should only be entered when an actual appointment has been offered to the client in accordance with Timely Access requirements. Please refer to DHCS FAQ, 2026, page 6 for further information.

Contact Established After Timely Access Standard Has Been Exceeded

In situations where a program is unable to reach a client within the applicable Timely Access timeframe, but later makes contact after the standard has been exceeded, staff will document the appointment offered at the time contact is ultimately established.

Under this proposed workflow:

1. The program will enter the actual First Appointment Offered Date in the Timely Access record based on the date the appointment was offered to the client.
2. Because the applicable Timely Access standard has been exceeded, the Reason for Delay field will be activated.
3. Staff will select "Other" from the Reason for Delay dropdown menu.

4. In the accompanying free-text field, staff will enter: **Unable to Reach Client to Offer Appointment. Original program offer date: [date]**
5. Save the Timely Access record.
6. Staff will continue documenting subsequent Timely Access milestones and appointment information as services are rendered.
7. Once all required service events have been documented, the Timely Access record will be completed and signed in accordance with established procedures.

5.3 Delay in Services

If a delay in services occurs for reasons other than the program's inability to contact the client (addressed in Section 5.2), staff must select the appropriate reason in the timely access form under "Reason for Delay." The available options include:

- Beneficiary Choice: Treatment Modality Unavailable
- Beneficiary Choice: Preferred Provider Unavailable
- Beneficiary Choice: Preferred Service Medium Unavailable
- No Available Provider
- Other

Key Note: Beneficiary Choice options should only be selected after the client has been informed that the provider/program can connect them with another provider/program that can offer services within the timely access requirements.

If no available provider can offer the client an appointment within the required access timeframes, staff must select "No Available Provider" and refer the client to an out-of-network provider.

If the client has been informed of an available alternative that meets timely access requirements but chooses to wait for their preferred treatment modality, provider, or service medium, staff should select the corresponding Beneficiary Choice option to document the delay.

5.4 New Service Request for Current Member

As reviewed in Section 3.3, each new service request requires completion of an Inquiry Screen. When an existing member submits a request for a new service, staff must complete a new Inquiry Screen, even if the requested service is within the same program (e.g., MH Psychiatric). Staff must also complete the appropriate timely access form, as applicable.

Key Note: Each new service request must have an associated Inquiry Screen. However, not all inquiries will result in the completion of a timely access record. Conversely, every timely access record must be associated with an Inquiry Screen.

An inquiry may not result in a timely access record when the client declines services or staff are unable to reach the client before the client is assigned to a program.

Individual programs may have variations in their workflows and processes. This section provides a general overview to support consistent understanding and application across programs.

Section 6: Identifying and Correcting Timely Access Record Errors

See Section 7 for information on report monitoring and Quality Assurance.

6.1 Missing or Invalid CIN

Error: The client is identified as having Medi-Cal, but the CIN is blank or incorrectly formatted. A valid CIN begins with 9 and contains eight digits followed by one letter (e.g., 9#######A). The CIN is used to determine the member's age group for Timely Access reporting.

Correction: Verify the CIN using an approved eligibility source and update the CIN field in SmartCare with the complete, correctly formatted value.

6.2 Urgency Status

Updating Status Error

Error: The Urgent field is blank.

Correction: Review the service request and select the appropriate urgency status in SmartCare. Select Urgent when the client's condition is time-sensitive or delaying care could worsen the situation. Otherwise, select Non-Urgent**.**

1. Open the client's existing Timely Access Record (Psychiatric or Non-Psychiatric SMHS Timeliness Record).
2. Locate the saved record and select Modify.
3. Navigate to the Urgency field.
4. Update the urgency level based on the client's current need:
    - Non-Urgent: Routine request for services.
    - Urgent: The client requires services within 48 hours (or 96 hours if prior authorization is required), based on DHCS Timely Access standards.
5. Review any dates, appointment offers, or related fields that may be impacted by the urgency change.
6. Enter a brief note documenting the reason for the update, if applicable.
7. Click Save to retain the changes.
8. Verify that the updated urgency status is displayed correctly on the record.

Note: Timely Access records should be updated whenever new information indicates that the client's level of urgency has changed.

Prior Authorization is Missing

Error: The request is marked Urgent, but the Prior Authorization Required field is blank.

Correction: Determine whether prior authorization is required and complete the Prior Authorization Required field in SmartCare.

6.3 Rendered Date Occurs Before the First Available Offered Appointment Date

Error: The First Service Appointment Rendered Date occurs before the *First Service Appointment Offered Date***.**

Correction: Verify both dates and correct the inaccurate field. The Rendered Date must be the same as or later than the Offered Date. If an earlier appointment became available after the initial information was entered, modify the First Service Appointment Offered Date to reflect the earlier offer.

When initial Timely Access information is entered, and an earlier appointment later becomes available and is offered to the client, the existing Timely Access record should be modified to reflect the updated offered date. The Timely Access record should always reflect the earliest appointment offered to the client.

1. Open the client's existing Timely Access Record
2. Locate the saved record and select Modify.
3. Navigate to the Initial Offered Date or Follow-Up Offered Date field that requires updating.
4. Update the offered date to reflect the earliest appointment that was offered to the client (An offered date cannot occur after a rendered date. If an earlier appointment became available, the record needs to be modified and the offer field should be updated).
5. Click Save to retain the changes.

Important: SmartCare currently allows a Timely Access record to be saved or signed even when an Offered Date occurs after the corresponding Rendered Date, and it does not prompt staff to correct this. Staff are responsible for reviewing records for accuracy. A Rendered Date should never occur before the corresponding Offered Date for either initial or follow-up services. If a Rendered Date precedes the Offered Date, this is a data entry error, and the record should be modified/corrected. When an earlier appointment is offered after the initial Timely Access information has been entered, staff should modify the record to update the Offered Date accordingly.

6.4 Reason for Delay is Missing

Error: *Was the client delayed access to initial services beyond the timely access standard?* is marked Yes**,** but Reason for Delay is blank**.**

Correction: Select the applicable Reason for Delay from the SmartCare dropdown.

6.5 “Other” Reason for Delay has No Explanation

Error: Reason for Delay is marked "Other," but the If other, explain field does not contain a meaningful explanation. Entries such as "N/A" or "None" are not sufficient.

Correction: Enter a brief, specific explanation of the delay in the If other, explain field under Reason for Delay.

6.6 Delay Response Conflicts with the Calculated Standard

Error: *Was the client delayed access to initial services beyond the timely access standard?* is marked *Yes*, but the calculated appointment-offer timeframe shows that the applicable access standard was met.

Correction: Verify the first-contact and offered dates. If the dates are correct and the standard was met, change the delay response to *No*. If either date was entered incorrectly, correct the date first and then confirm that the delay response is accurate.

6.7 Follow-up Offered Date is Missing

Applies to: Signed MHP Non-Psychiatric, DMC-ODS Outpatient, and DMC-ODS Opioid records.

Error: *Was the client offered a Follow-up Appointment*? is marked *Yes***,** but the First Follow-up Appointment Offered Date is blank.

Correction: Enter the date the follow-up appointment was first offered. If no Follow-up Appointment was offered or will occur, enter the applicable Closure Date and Closure Reason instead.

6.8 Closure Date is Missing

Error: The record was signed before all required offered and rendered appointment dates were entered, but the Closure Date or Closure Reason is missing.

Correction: If services continued, enter the missing appointment dates. If the Timely Access episode ended before the appointments occurred, enter both the Closure Date and Closure Reason. For MHP Psychiatric records, this applies to the initial appointment fields. For applicable non-psychiatric and DMC-ODS records, it also applies to required follow-up appointment fields.

6.9 Closure Reason is Missing

Error: A Closure Date was entered, but the Closure Reason is blank.

Correction: Select the appropriate Closure Reason from the SmartCare dropdown. Confirm that the reason is consistent with the closure date and the circumstances of the case.

6.10 "Other" Closure Reason is Missing

Error: Closure Reason is marked as **"**Other**,"** but the If other, explain field does not contain a meaningful explanation. Entries such as "N/A" or "None" are not sufficient.

Correction: Enter a brief, specific explanation of the closure in the If other, explain field under Closure Reason.

Section 7: Monitoring and Quality Assurance (QA)

Programs are responsible for monitoring the accuracy of Timely Access data and correcting errors as they are identified. As Timely Access reporting continues to evolve, programs should identify staff within their program who can review reports, detect potential errors (common errors are detailed in Section 6), troubleshoot issues, and ensure records are updated as needed.

The County is continuing to develop and refine monitoring and reporting processes. Future reports are expected to provide programs with visibility into Timely Access data and errors in near real time, allowing programs to identify and address issues more efficiently. Additional guidance regarding reports, monitoring expectations, and error correction processes will be provided as it becomes available.

Section 8: Questions and Resources

8.1 Operations and Manual Maintenance

The SDCBHS Timely Access Manual serves as the primary source of guidance for Timely Access methodology, operational expectations, documentation standards, and reporting practices.

The purpose of Timely Access operations is to promote consistency across the System of Care, evaluate questions involving Timely Access methodology, review changes to State requirements, and maintain this manual as the authoritative County reference document.

For questions about the information in this guide, please contact:

- Team: Population Health, Network Quality and Planning (NQP)
- Email: pophealth.bhs@sdcounty.ca.gov

8.2 Resources and References

The following references informed this manual and should be consulted when questions arise about Timely Access requirements, methodology, documentation, reporting, or compliance expectations.

Users should always consult the most current version of a referenced document, as DHCS, CalMHSA, SmartCare, and County guidance may be updated periodically.

State Regulatory Resources

Behavioral Health Information Notice (BHIN) 26-023, Timely Access Requirements

This BHIN serves as one of the primary sources for Timely Access requirements, appointment standards, TADT reporting expectations, and compliance methodology.

Link: (BHIN) 26-023

Publication Date: April 2026

CalMHSA & SmartCare Resources

SmartCare Training Materials

SmartCare Basics for All Users is the introductory training for all SmartCare users. The training provides an overview of the SmartCare electronic health record, navigation of the system, and basic functionality that staff need to perform their work.

Link: CalMHSA SmartCare Training Repository

Publication Date: August 2026

CalMHSA Timely Access Record Instructions

CalMHSA provides field-level completion instructions and workflow guidance for Timely Access forms used within SmartCare.

Link: SmartCare Timely Access Instructions

Publication Date: January 2026

CalMHSA SmartCare Knowledge Base

Provides SmartCare training materials, workflow guidance, implementation updates, and documentation resources.

Link: SmartCare Knowledge Base

Publication Date: June 2026

Section 9: Appendices

Appendix A: Decision Tree Guidance

These decision trees are intended to support consistent decision-making for common Timely Access scenarios but do not cover every situation that may arise.

If a scenario is not addressed or you are unsure how to proceed, follow the established escalation process and consult the appropriate supervisor, COR, or Timely Access contact for guidance. The examples provided are not exhaustive.

Decision Tree: Request or Referral Received

SCENARIO: Program A initiates the SmartCare Inquiry Screen and documents the original Request for Services Date, referral source, requested service, and required information.

↓

Can Program A fulfill the requested service within the applicable Timely Access mandate?

Yes · Scenario A	No · Scenario B
1. Program A initiates the appropriate Timely Access record. 2. Program A uses the original Request for Services Date from the Inquiry Screen. 3. Program A completes the requested service line until the record is fulfilled and signed, or closed and signed.	1. Program A completes the Inquiry Screen only and transfers the referral to Program B. 2. Program B initiates the appropriate Timely Access record. 3. Program B uses the original Request for Services Date documented on the Inquiry Screen. 4. Program B DOES NOT use the date it received the referral from Program A. 5. Program B completes the requested service line until the record is fulfilled and signed, or closed and signed.

KEY RULE: The original Request for Services Date follows the referral and remains unchanged through completion of the requested service line. The Timely Access clock does not restart when outreach, member contact, acceptance of services, or a program-to-program transfer occurs.

Decision Tree: First Appointment Offered

Use after the Inquiry Screen and the program initiates the appropriate Timely Access record.

SCENARIO: Program attempts to contact the client and offer the earliest appointment based on program availability. Communication must follow PHI requirements and the individual program workflow.

Was the client reached, or was a valid appointment offer communicated by an approved secure method?

Yes · Appointment offered	No · Client not reached
Valid indirect offer For secure voicemail or mail to count as offered, include a specific appointment date/time and the date by which the client must reply. Hold that appointment exclusively for the client through the reply deadline. One offered date = one client. **Was the appointment offered within the applicable Timely Access standard?** **↳ Yes · Within standard (Scenario A)** Enter the actual date offered in the First Appointment Offered Date field. Save the record and continue entering data as appointments are rendered. Complete and sign when the service line is fulfilled or otherwise closed. **↳ No · Client Reached After Standard has passed** Enter the actual date offered at the point of contact. When Reason for Delay engages, select Other and type "Unable to Reach Client." Save the record and resume entering data as appointments are rendered.	**Unable to reach client** Document each contact attempt according to program policy using the required method, such as Contact Notes, Information Notes, or another approved process. Complete the number and type of outreach attempts required by program policy. Follow program requirements for how attempts are documented and when a referral may be closed. **Close Record** If outreach is complete and the referral is being closed: leave the First Appointment Offered Date BLANK, close the Timely Access record, select Unable to Reach Client as the closure reason, document the reason for closure, and sign the form. Non-urgent referrals should not remain active when contact has not been established, outreach is complete under program policy, and the applicable Timely Access threshold has been exceeded.

KEY RULE: Enter a First Appointment Offered Date only when an actual appointment has been offered. The original Request for Services Date remains unchanged throughout the service request.

Decision Tree: Request for New Service

SCENARIO: A client is currently receiving services through a program and requests an additional service that was not previously included in their treatment. Programs must determine whether the request represents a new service line or new treatment modality requiring Timely Access tracking or a continuation of existing services.

Is the client requesting a new service that requires a new assessment, admission process, or provider type?

Yes · Scenario A	No · Scenario B
A new Timely Access record is required. Examples include: • Client is receiving therapy services and requests a psychiatric medication evaluation. • Client is receiving outpatient mental health services and requests services at a higher or different level of care. • Client is receiving MH services and requests DMC-ODS services. • Client is receiving DMC-ODS services and requests MH services. **↳ Yes · one of the above applies** • Initiate the applicable Timely Access record (e.g., MH Psych Timely Access Record for medication evaluation requests). • Follow all established Timely Access documentation and tracking requirements for the requested service. • Continue to follow the workflow associated with the requested service until the appointment is completed or otherwise resolved.	A new Timely Access record is not required. Examples include: • Client changes service location or region but continues receiving the same service. • Client changes to a different therapist, prescriber, or provider within the same service type. • Client transfers between programs that provide the same level of care and same service. **Required Action:** • Manage the request through normal operational procedures. • Continue existing Timely Access tracking, if applicable. • Do not create a new Timely Access record solely because the provider, location, or region has changed.

Note: The examples above are provided for guidance only and are not exhaustive. Programs should evaluate each request individually and determine whether the client is seeking a new service type, level of care, or provider specialty that would require initiation of a new Timely Access record.

Appendix B: Glossary

Behavioral Health Plan (BHP)

A managed behavioral health delivery system responsible for ensuring access to covered behavioral health services and compliance with applicable Timely Access requirements.

Business Day

Any day used for Timely Access calculations that is not a Saturday, Sunday, or recognized holiday. Business day calculations for non-urgent Timely Access standards begin on the first business day following the Request for Services date.

Contracted Provider

A provider organization under contract with the County of San Diego to deliver behavioral health services.

Date of First Contact to Request Services

The date used by DHCS as the starting point for Timely Access measurement. SDCBHS operationalizes this requirement through the Request for Services date documented in SmartCare.

Drug Medi-Cal Organized Delivery System (DMC-ODS)

California's organized delivery system for providing substance use disorder treatment services to Medi-Cal beneficiaries.

First Available Offered Appointment

The earliest qualifying appointment that is offered to a member based on program availability at the time the request for services is received. Timely Access compliance is measured using the appointment offered, not necessarily the appointment that is ultimately rendered.

Follow-Up Appointment

The next qualifying appointment offered following a completed service. Follow-up appointment offers are tracked for applicable service categories and are subject to Timely Access monitoring requirements.

Follow-Up Appointment Offered Date

The date of the next available qualifying appointment offered to the member following a completed service.

Follow-Up Appointment Rendered Date

The date on which the member actually receives the follow-up service.

Member Choice

A situation in which a member voluntarily elects to wait for a preferred provider, location, modality, or appointment time despite an earlier qualifying appointment being available. When appropriately documented, these situations may be excluded from Timely Access compliance calculations.

Mental Health Plan (MHP)

The entity responsible for providing Specialty Mental Health Services (SMHS) to eligible Medi-Cal beneficiaries.

Out-of-Network Provider (OON)

A provider that is not part of the contracted network but may be utilized under specific circumstances to ensure access to services.

Prior Authorization

A requirement that approval be obtained before certain services can be provided. For urgent service requests, Timely Access standards differ depending on whether prior authorization is required.

Program Transfer

Movement of a member between programs during the access or treatment process. Depending on the service line involved, a transfer may or may not require creation of a new Timely Access Record.

Qualifying Service

The first appointment that would meet applicable billing requirements if rendered. Administrative activities such as outreach, scheduling, and referral processing generally do not independently satisfy Timely Access requirements.

Referral

A request directing a member to behavioral health services from a provider, agency, organization, family member, or other referral source.

Request for Services

The date a provider receives a request or referral for behavioral health services and has sufficient information to document the request in SmartCare. SDCBHS uses this operational definition to support implementation of the DHCS Date of First Contact to Request Services requirement.

Service Line

The category of behavioral health service requested by the member and subject to a specific Timely Access standard. Service Lines are based on the type of service needed rather than the specific program, location, or provider delivering the service.

SmartCare

The electronic health record (EHR) utilized by SDCBHS and participating providers to document, monitor, and report Timely Access information.

Specialty Mental Health Services (SMHS)

Medi-Cal covered specialty mental health services delivered through the Mental Health Plan.

Timely Access

The measurement of a member's ability to obtain behavioral health services within State-established appointment standards.

Timely Access Record

The SmartCare document used to record and track required Timely Access information throughout the access process.

Timely Access Data Tool (TADT)

The DHCS reporting tool used to collect Timely Access information and assess compliance with Timely Access and Network Adequacy requirements.

Urgent Request

A request for services that requires an expedited appointment based on clinical need. Urgent requests are subject to a 48-hour or 96-hour Timely Access standard depending on whether prior authorization is required.

Withdrawal Management (WM)

A service category providing support for individuals experiencing substance withdrawal. For SDCBHS Timely Access purposes, in alignment with BHIN 26-023, all Withdrawal Management requests are considered urgent requests.

Unable to Contact

A situation in which a provider receives a request for services but is unable to establish contact with the member despite documented outreach efforts.

Appendix D: Revision History

Purpose

The Timely Access Manual is a living document intended to support consistent implementation of Timely Access requirements across the System of Care. As State requirements, reporting expectations, SmartCare workflows, and County methodology evolve, updates to this manual may be necessary.

This appendix documents substantive revisions made to the manual and provides a record of changes for transparency, audit readiness, training, and version control purposes.

Minor administrative updates that do not alter methodology, workflow, or operational expectations may not require formal revision documentation.

Revision Categories

The following categories may be used when documenting revisions:

Revision Type	Description
Administrative Update	Formatting corrections, grammar updates, hyperlink changes, contact information updates, or other non-substantive edits
Clarification	Additional explanation or guidance that does not change methodology or workflow

Revision Type	Description
Workflow Update	Changes to SmartCare workflows, documentation processes, forms, or procedures
Methodology Update	Changes to County Timely Access methodology, definitions, or operational expectations
Regulatory Update	Changes resulting from new DHCS guidance, BHINs, TADT requirements, or other regulatory changes
Major Revision	Significant restructuring of the manual or substantial updates affecting multiple sections

Revision History Log

Revision Date	Version	Revision Type	Section(s) Updated	Description of Change	Approved By
11/2026	1.0	Major Revision	All Sections	Initial publication of the County of San Diego Timely Access Manual.	
TBD	1.1	TBD	TBD	Placeholder for future revisions.	TBD

Planned Review Cycle

This manual should be reviewed periodically to ensure continued alignment with:

- DHCS Timely Access requirements.
- Behavioral Health Information Notices (BHINs).
- SmartCare workflows and documentation requirements.
- Operational and quality improvement needs.

Formal review should occur at minimum on an annual basis and whenever significant regulatory, workflow, or methodology changes are identified.